

RICE UNIVERSITY

Distributive Justice and Patient Selection

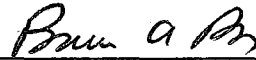
by

Rebecca Bartley Yarrison

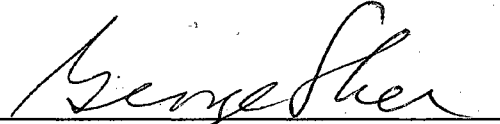
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ABSTRACT

Distributive Justice in Patient Selection

by

Rebecca Bartley Yarrison

There are not always enough medical resources to go around and pluralist theories of decision making generally do not explain the principle of justice in a way that provides action-guidance. I adopt a modified and expanded form of the claims-based approach of Rescher and Broome as the framework for a substantive and action-guiding theory of distributive justice. The resulting theory is that limited resources should be distributed according to the strength of a person's entitlement to a resource. In order to determine a person's entitlement, one must determine what context-relevant rights the person has and the strength of his or her claim to the resource, which is determined by a weighing up of context-relevant considerations, which are facts about a person's condition or situation within a certain context that *ceteris paribus* generate some kind of duty that they be given (or denied, depending on the consideration) the resource. Since both of these are context dependent, I discuss patients' entitlements in terms of limited medical resources.

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Chapter 1: Introduction

There have been libraries of books written on the topic of justice that cover justice's application to numerous areas including those in political justice, social justice and distributive justice. However, one area that has not been sufficiently canvassed is the area of distributive justice under conditions of scarcity. And the question of who should get a resource when there is not enough of it to go around is a difficult one. The broad understanding of justice is that people should be treated according to what they are due but what a person is due and what it means to treat someone accordingly are both highly contentious. And in cases of scarcity, the question of justice becomes not a question of what a person is due, but one of what a person is due *in light of what others are due*.

Complicating the matter, scarcity is not a rare phenomenon. Throughout the world, there are very real shortages of food, clean water, shelter and money to buy necessities. There are also situations, such as distributions of prizes or awards that require some distribution scheme. However, no one single distribution scheme will be able to cover such a wide variety of contexts and so any scheme will have to be context dependent, as the specific criteria for distributing a prize in a science contest, for example, will certainly be different from the specific criteria for distributing food in a famine. A prime example of this scarcity is in medicine. People alternatively argue that patients are due some basic decent minimum of care, that they are due whatever they can pay for, that they are due what they need or what they deserve. There are questions about whether a patient's age can increase or lessen what she or he is due or whether having donated organs or money can change what a person is due. This

complicates an already difficult matter immensely as it becomes a patient selection problem—a matter of choosing which patient should be given the resource.

Though the particulars of a theory of distributive justice will have to change with the context of the distribution situation, providing a framework for making distribution decisions in situations of scarcity would still be a step toward providing action guidance in such situations. My project, then, is to develop such a framework, which I will do by articulating a claims-based approach to distributive justice in scarcity within the context of medical decision making.

The Problem

(Distributive) Justice

Most moral thinkers who are pluralists in any form, including those who accept a pluralist theory of the good, include justice as an important moral consideration.

Medical decision makers typically appeal to a pluralist theory, such as Beauchamp and Childress's principlism and Brody's appeals. Most pluralist theories of medical decision making (and consequentialist theories that accept a pluralist theory of the good) recognize the principles of (or appeals to) beneficence, non-maleficence, respect for autonomy and justice among others. And, for the most part, there is consensus about what each of these encompasses though there is certainly disagreement about their application in particular cases. Take, for example, beneficence. Two different people discussing a case may agree entirely that it is important to consider what the beneficent course of action would be yet disagree as to what course of action is actually

the beneficent one. When arguing about which action to take, there is at least a common ground of understanding from which to argue.

However, the situation is not so clear with the principle of justice. Discussions about distributive justice in healthcare have had a completely different focus from discussions of other principles. Discussions of justice focus on the distributions of benefits and burdens in research and macro-allocation issues such as funding primary care versus funding secondary and tertiary care or funding this program versus that program. Unfortunately, for those making micro-allocational decisions, any discussion of micro-allocation decisions tends to either focus narrowly on a single factor (e.g., should illegal immigrants have access to healthcare?) or offer such broad advice as to be non-action-guiding. This problem, however, is not unique to medical distributions, as there is generally very little guidance for any distribution of scarce resources. There is no consensus on what factors should play into micro-allocational decisions and how those factors fit together into a useable theory of distributive justice. Thus, the person making the decision about who should get a scarce resource is left with minimal guidance in understanding how justice should play into his or her decision. It is not clear what the principle of justice is meant to encompass, let alone how to apply it¹.

This is particularly remiss because justice is the only one of the four principles offered by Beauchamp and Childress (and possibly also the only appeal provided by Brody, though the appeal to consequences might have some purchase here) that can directly account for the effects that a specific treatment decision has on people other than those immediately involved in the decision. After all, the principles of autonomy,

¹ Beauchamp and Childress do offer what Rescher refers to as the “canons of justice” but they offer no explanation or justification for these canons, nor any guidance in applying them. The individual canons will, of course, be discussed later.

beneficence and non-maleficence are all patient-oriented; they are about a specific patient's autonomy, or what is beneficent or non-maleficent for a particular patient².

Justice, alone among the other principles, is uniquely positioned to deal with the interpersonal complications that arise in situations of medical scarcity because justice does not focus on a single patient but looks at all patients who are concerned.

Especially in situations of scarcity, when there are not enough resources to go around, there needs to be a normative principle of justice that can help sort out situations on the micro-allocation level.

But this does not explain why this is a question of justice in the first place.

There is a wide-ranging discussion in the literature about the place of justice in situations of scarcity and there are some formidable figures that argue that justice does not apply in situations where it cannot be ideally satisfied. I will follow Winslow¹ in addressing both Hume's argument that self-preservation replaces justice in situations of dire scarcity and Vlastos's argument that decisions made in situations of scarcity are neither just nor unjust but "non-just". I will then discuss a third problem and one that is probably more pressing in practical situations and that is the Nozick-esque issue of possession; that is, it is not a matter of justice but a matter of what the owner of the resource wants done with it.

Hume's Argument

David Hume begins with the idea that "public utility is the *sole* origin of justice, and that reflections on the beneficial consequences of this virtue are the *sole* foundation of its merit"ⁱⁱ. The justification for justice is not an issue about which I want to quibble; I

² Brody does offer the appeal to respect for physician integrity but this, while not patient-oriented, still does not consider the impact of a decision on other patients and regards the physician only with regard to the specific patient.

will simply grant this for the sake of argument and argue from there. A second aspect of Hume's understanding of justice that needs to be brought out is that Hume has a property-based understanding of justice. The rules of justice are rules "governing the possession, utilization, and transfer of property"ⁱⁱⁱ. I will take issue with this further on.

Hume's argument is this: first, a society of absolute abundance will have no need of justice because everyone would have more than s/he needs or wants. To divide the resources with property divisions would be entirely unnecessary because leaving the goods in common would still allow for everyone to have more than s/he would ever want³. And in a society where resources are neither abundant nor scarce but the people are absolutely benevolent, there will be no need of justice because everyone will be willing to share and ensure that everyone has a fair share. And, Hume says,

Suppose a society to fall into such want of all common necessaries, that the utmost frugality and industry cannot preserve the greater number from perishing, and the whole from extreme misery; it will readily, I believe be admitted, that the strict laws of justice are suspended, in such a pressing emergence, and give place to the stronger motives of necessity and self-preservation^{iv}.

Thus, the only society that requires justice is the non-benevolent society with neither abundance nor scarcity. This is because people are jealous and want so much of the resource that not everyone would have enough. So there must be property distinctions and justice.

Now, Hume does not make this argument with medical scarcity in mind. And it is important to note that Hume argument only makes use of across-the-board scarcity or abundance. Particularly in America, the most basic needs, such as food, clean water and shelter are at a level of sufficiency for most. Certainly, some people are hungry and

³ Of course, it is not clear how everyone could have everything he or she wants if more than one person wants to have more than everyone else. But the point that everyone has an overabundance at his or her disposal is well taken.

homeless, but for the most part, even those below the poverty line have their basic food and shelter needs met. The situations of medical scarcity that are taken as the context for this project do not reflect the kind of across-the-board scarcity that Hume thinks is necessary to unseat justice. Thus, I think this argument of Hume's does not apply to situations where an individual resource is in short supply. However others could disagree and so I have two alternative objections to this argument; the first is more practical and the second is more theoretical.

The practical objection is this: even if there is scarcity, there is no reason to suppose that a free-for-all better serves the public utility than a just, ordered approach (in other words, simply because justice *would* break down under such conditions does not mean that it *should*). If property distinctions really do break down, they could do so violently; the result might even be a Hobbesian state of nature, where life is nasty, brutish and short. The bad potential consequences of a breakdown of justice in a society of dire scarcity are very bad: civil war could erupt. And what problem would a breakdown of justice solve? Since there are only enough resources to keep x number of people alive, then only x number of people will survive whether justice determines who gets what or not. Of course, fewer than x people may survive if the ensuing battles in the state of nature kill off more than the famine would, but even if strife in the state of nature does not lead to any extra deaths and all resources once pooled are distributed evenly among the people, they are still only enough to keep x people alive and those in misery.

I believe it is this latter situation that Hume envisions and this leads to the second, more theoretical objection. He asks, "Would an equal partition of bread in a

famine, though effected by power and even violence, be regarded as criminal or injurious?"^v The key is the phrase "equal partition". The objection is this: while we may agree that property distinctions would break down, there would still be a need for a just system to distribute the resources there are. Thus, Hume's understanding of justice simply as property rights is far too narrow to encompass even most situations of distribution. Winslow also notes this when he states that "the problem with [Hume's] position when applied to contemporary problems of distributive justice is his lack of concern for the distribution of goods to which no individual has exclusive property rights"^{vi}. After the granaries have been knocked over and the grain becomes a resource for public consumption, owned by no one, what makes the people distribute an equal portion of grain to each if not justice? After all, this is not the benevolent, sharing society that has knocked over the granary.

It is important to notice that a slight change in the situation of the society of dire scarcity can (under particular circumstances) avoid the practical problem, but the theoretical problem remains. Suppose in the society, the scarcity is caused not by a lack of resources but a hoarding of resources by a few rich and powerful citizens who look at the hungry and say, "Let them eat cake!" Then, breaking into the granaries of the wealthy might better serve the public utility⁴ but once the granaries of the wealthy have been thrown open, it is still unclear from Hume's account how the people can choose to equally divide the grain, or how they can decide to divide the grain at all instead of grabbing and fighting for whatever one can get without some idea of justice.

⁴ Provided, of course, that the ensuing revolution is not more devastating than the original lack of resources.

One other issue is that Hume's argument pertains to individuals, not to society. That is, in situations of scarcity, Hume thinks that it would be rational for individuals to break open the granaries in the hope of securing what they need (which I have questioned above). But what does this mean for social institutions such as hospitals? Clearly, maintaining justice is paramount for social institutions and society in general for the sake of self-preservation. Without justice, the resulting free-for-all is would certainly break down the structures of society; this would certainly reduce to the Hobbesian state of nature since society is comprised of individuals. But in the hospital situation, it is unclear how this would happen anyway. After all, medical expertise and treatments are not like grain in a granary; one cannot throw open the hospital and grab a needed surgery. Thus, even if the above arguments against justice no longer applying for individuals in situations of scarcity fail, there is still good reason for social institutions to maintain justice.

Vlastos's Argument

Even though both Hume and Vlastos think that justice does not apply in situations of scarcity, Vlastos has a wholly different understanding of justice than Hume. Where Hume connects justice with property rights, Vlastos connects justice with human rights, and his definition of a just action reflects this. The definition is this: "An action is just if, and only if, it is prescribed exclusively by regard for the rights of all whom it affects substantially."^{vii} And because of this definition, and Vlastos's understanding of rights, he is committed to saying that no distributions in situations of scarcity are just. Vlastos actually claims that, because a person *cannot* act justly (that is, it is impossible because

of the scarcity to act with regard to the rights of all involved), it does not make sense to say to say that s/he has acted unjustly; the matter of justice simply does not arise.

Again, whenever one is in no position to govern one's action by regard for rights, the question of justice, or injustice, does not arise. Two strangers are in immediate danger of drowning off the dock on which I stand. I am the only one present, and the best I can do is to save one while the other drowns. Each has a right to my help, but I cannot give it to both. Hence regard for rights does not prescribe what I am to do, and neither 'just' nor 'unjust' will apply: I am not unjust to the one who drowns, nor just to the one I save^{viii}.

Later, Vlastos describes such situations as "non-just"^{ix}.

Though there are objections that can be raised against the claim that both drowning people have a right to the help of the person on the dock, I will accept this for the sake of argument. A much more telling objection is the one raised by both Winslow and Anscombe; while it may not necessarily be unjust to save one drowning person over another, there are certainly ways that people can act unjustly in that situation. In Winslow's example, the rescuer finds that one of the "drowners" is German. The rescuer, for whatever reason, hates Germans and thinks, "That horrible kraut! I won't save him; I'll save the other person who's not a German." Now, the German drowner could claim that he was treated unjustly because "the rescuer could not be said to have impartially respected the rights of all who were substantially affected."^x Justice, then, is not merely an element of a resulting distribution but is also important in the procedure used to arbitrate between people when not all can be fully satisfied.

But this might merely be a friendly amendment. After all, from Vlastos's discussion in the rest of the article, it is not clear that he would be entirely against such an interpretation that gives equal consideration to the rights of all involved. But Anscombe describes a situation where, even if equal consideration is given to the rights of all involved, the act is still unjust. Her example is actually given in the context of

Foot's example of providing a life-saving drug, but the example can be recast in terms of the rescuer and the drowners. Suppose the rescuer chooses not to save either of the drowners. In that case, Anscombe claims, both of the drowners would be justified in claiming that they had been wronged since it was in the rescuer's power to save one of them and s/he did not do so. It would be unjust, then, to not save either person even though their rights had been taken equally into consideration^{xi}. Thus, justice is still required in situations where there is not enough of something for everyone with rights to it.

The Property Problem

This problem is different because it does not claim, as Hume and Vlastos do, that justice does not apply in situations of scarcity. Rather, it asserts (in direct opposition to Hume) that property rights should be respected even in situations of scarcity and does not oppose some theory of justice for goods that are not owned, or goods that are publicly owned. So this argument does not directly challenge the idea that distributive justice has a place in situations of scarcity, it rather proposes that the correct distribution of property is whatever the owner chooses to do with it and says nothing about the distribution of resources that are not owned by anyone or are publicly owned.

And there are clear examples of cases where the distribution of some resource is entirely up to the owner, such as if a philanthropist intends to distribute a large endowment, for example, or when a living person offers a kidney to his sister. When the owner is a government or public institution, the picture is much more complicated. In the case of hospitals, for example, even private institutions may distribute public goods. And it is not always clear who the owner of some goods is. Who owns

allogenaically donated blood? Who owns the MRI machine in a public hospital supported by tax dollars? Who owns the heart-lung machine that was purchased by a private hospital but was developed using tax dollars for research funding? Who owns the terribly expensive drugs that were developed using grants from the NIH? In the case of medical care, the private is infused with the public and it is hard to tell who has a sufficient ownership of the resource to determine its ultimate disposition. If the institution receives public funds, are its resources public? Are the resources of private institutions public resources if they were developed using public funds?

In most cases, the resources are sufficiently public that determination by their owner is not the way to distribute the resource. Certainly, there are not simply two categories, publicly-owned and privately-owned, but a continuum. On one extreme, there are those things that are clearly privately owned, such the philanthropist's money or the living organ donor's kidney. On the other end are resources such as allogenaic blood donations (which account for around 95% of all blood donations, at least at one typical institution^{xii}) and cadaveric kidney donations. The blood and organ donations are public because the donors have donated them to whomever in the public needs them and so have been designated by the previous owners as a public resource, whereas the public hospitals are public because they are supported by public funds that are generated by taxes. The difficult cases are those that lie somewhere in the middle of the continuum. A theory of just distribution in situations of scarcity is necessary for distributing sufficiently public goods even if a private institution controls those resources. Additionally, even within a private institution, there may be a scarcity of a particular resource and the decision makers at the private institutions will have to have a

scheme for distributing the resource. A private philanthropy, for example, might not have sufficient capital to fund all of relevant projects that apply for funding and decisions will have to be made about which projects are funded.

Thus, such an interpersonal distribution question requires an understanding of justice in order to come to a conclusion. This does not mean, of course, that justice is the only thing that matters in making distribution decisions; beneficence, autonomy, consequences, compassion and all the rest still play into the decision as they would for any other decision. However, justice is a particularly important principle in making resource distribution decisions.

Scarcity in the Medical Context

Unfortunately, there are not enough medical resources to go around. This is true on both the macro level and the micro level in rich countries as well as poor around the world. Consider the HIV/AIDS epidemic in sub-Saharan Africa. In some countries, as much as 40% of the population is infected with HIV and relatively few people receive the expensive treatments and drugs. The expense of the drugs and lack of funds are not the only barriers to treatment; there are also very few doctors and pharmacists trained in prescribing and dispensing the drugs in the relatively few medical facilities that exist. Even the ordinary and inexpensive measles vaccine cannot be properly distributed because of the lack of facilities and practitioners^{xiii}.

But it is not only poor countries that suffer from medical scarcity. Even in America, the “land of plenty”, patients are not always able to get the medical treatment that is medically indicated. There are a number of reasons for this. In some cases,

funding cuts on the macro level trickle down to the micro level, making fewer expensive machines, practitioners and other resources available. In other cases, shortages stem from runs on the resource such as blood supplies. Or there may simply not be enough of a resource in existence, such as is the case with transplantable organs or some new technologies or treatments that have not yet become widespread.

One might claim that medical scarcity is the result of a lack of funding and that by investing more money in medical resources, one could solve the problem and all patients could receive the resources, procedures and care they require. There are two ways that increasing funding could alleviate scarcity: by direct purchase of more of the needed resource and/or by the more indirect method of funding research. With regard to the former, with more money, one can increase the size of ICUs, pay for more doctors and nurses and buy more medical equipment. For example, if the problem is that there are not enough ICU beds to accommodate the demand, a hospital could directly pay for an expansion of its ICU, buy more equipment and hire more nurses and doctors. With regard to the latter, one might try to alleviate a scarcity by funding research into alternate and more plentiful treatments. For example, one might fund research into developing synthetic blood and inexpensive methods of manufacturing it in order to alleviate shortages of blood for transfusions.

Simply throwing money at the problem of medical scarcity, however, will not eliminate the problem of scarcity or render the philosophical patient selection problem moot. Even if increasing funding for healthcare will alleviate scarcity, the scarcity (and thus the philosophical problem of distributing resources) will exist until the amount of money necessary to completely alleviate the scarcity is funneled into the healthcare

industry or until the research projects come to fruition. Even with unlimited funding, building ICUs, training nurses and doctors, research and all the rest takes time. During that time, the scarcity persists. And that is if throwing money at the problem will actually solve it, a solution in which I have little confidence for two reasons: first, not everything can be (legally) purchased and, second, there is not an infinite supply of money and eventually the money will run out.

First, and most simply, not every resource can be immediately and indefinitely increased by an infusion of funds. One cannot simply buy more blood for transfusions or hearts for transplantation (not legally, anyway). Of course, giving more money to dialysis centers can certainly help those who need kidneys by providing more patients with dialysis; but the problem of not having enough kidneys cannot be solved with money because one cannot buy kidneys. Of course, one might argue that, while one cannot directly buy such things, one might be able to help the situation in a more indirect way by funding research into synthetic blood products and artificial kidneys. Certainly the scarcity of kidneys would be neutralized if an inexpensive and permanent biomechanical alternative without the morbidity issues associated with dialysis were found. And, more practically, one can fund awareness campaigns that encourage people to become blood and organ donors. These possibilities (particularly the latter) would surely have the effect of reducing scarcity to some degree but it is unclear exactly how far such things can go to solve the problems of scarcity. As it is, there are campaigns for blood and organ procurement and yet there is still a scarcity of these resources. Also, though there is research directed at developing synthetic blood,

mechanical hearts and better alternatives for dialysis patients, it is not clear when or if these will ever be feasible options for people needing blood, hearts and kidneys.

But even if synthetic blood, mechanical organs and cancer cures are just over the horizon, there is a second and more pressing objection to the “throw money at the problem” solution to scarcity. At some point, the money runs out. This is true of money for all medical resources, whether it is money for research or money for preventative, basic or emergent care. In 2007, the United States spent 16.2% of its Gross Domestic Product on medical care and it is projected that by 2018 the U.S. will spend over 20% of its GDP on healthcare^{xiv}. No other country spends as much of their GDP on health care as the United States. Great Britain, for example, spent only 8.4% of its GDP on healthcare in 2006^{xv}. And even with this large amount of spending, there are still many who lack basic medical care. Healthcare, it seems, is a bottomless pit as far as money is concerned. Eventually, the U.S. will hit the point where it cannot spend any more money on medical resources and healthcare will have to be rationed. Rationing is already implicit in the British National Health Service, which started in 1948 as an attempt at free and unlimited healthcare. Since the early 1950s, the BNHS has worked under a budget cap that has resulted in doctors having to deny treatments that are known to be effective because of shortfalls in funds^{xvi}.

It is worth pointing out that either of these reasons for supposing that we cannot buy our way out of the problem of medical scarcity is sufficient to show that the solution is ineffective. One need not accept both reasons to realize that this solution would not work. And so, even in the land of plenty, medical scarcity is a fact.

A Proposed Solution

Currently, with only a few notable exceptions, patient selection decisions are made without reference to any guiding theory of patient selection or principled methodology. Jagsi, et al. note that “Rationing often occurs implicitly, via mechanisms such as price, delay, physician discretion, or social barriers to access...Implicit rationing has dominated in the United States, and Americans have thus largely been protected from the debates over prioritization that have plagued state-funded systems of health care”^{xvii}. Of course, addressing the problem of patient selection is not likely to solve all justice problems in medicine, such as implicit rationing due to price, social barriers to access or some kinds of delay. However, it will address implicit rationing due to physician discretion and other kinds of delay. Implicit rationing is problematic for a number of reasons, including the fact that such rationing is likely to be arbitrary with everyone applying his or her own standards and done without a critical evaluation of the rationing process. Discussions of rationing need to take place “in the sunshine”, so to speak, and face a critical evaluation process and be based on the principles of medical decision-making, including justice.

My project is to give content to the principle of justice by offering a functional theory of distributive justice. I intend the theoretical framework to be applicable to any distribution of a scarce resource, but, as is stated above, the particulars are context dependent. Thus, I will focus on one particular context and generate a theory that determines what a just distribution of medical resources would be in situations of medical scarcity on a micro-allocation level. There are three parts to this project.

The first part, which I tackle in Chapter 2, is to set out the theoretical framework for distributions in situations of scarcity and explain why this framework is superior to other alternative frameworks. The framework I will adopt and defend is a claims-based theory expanding the work of Rescher and Broome in which resources are distributed to the patient with the strongest entitlement to the resource, with entitlement understood as a combination of a patient's claim relative to others and his or her rights to the resource.

The second part, presented in Chapter 3, is to fill in the gaps in claims-based theories by discussing which reasons (called considerations) constitute a patient's claim to a resource. The reasons are simply possible facts about the patient or the patient's situation, such as a patient's age, whether or not the patient needs the resource and so on that can strengthen or weaken a patient's claim to the resource. The considerations I discuss are not taken from a canonical list or generated by some theory of claims but from the literature, the media, anecdotal stories- in short, anywhere that someone argues that a particular patient or group should or should not get a resource because of some consideration. Of course, not all considerations discussed (especially in the media) can withstand ethical scrutiny and so in the course of discussing these considerations, I will determine which are morally relevant in determining what a person is due. The considerations I will discuss are need, potential benefit, urgency, age, ability to pay, responsibility for dependents, desert, conservation, past resource use, queuing, squatters' rights and immigration status. At the end of this chapter, I will have a list of considerations that constitute patients' claims.

The third part, which is the work of Chapter 4, is to explain how those accepted considerations from Chapter 3 fit together to determine patient's entitlements relative to

one another. I will discuss the nature of the considerations as claim-determinants, weighing the considerations against one another, situations that might affect their importance relative to one another and strategies for handling possible future claims and competing claims. Finally, I will apply this theory to two paradigmatic cases in order to demonstrate its functionality and to show how the principle of (distributive) justice thus understood contributes to the overall pluralistic theory of medical decision making.

Chapter 2: Framework

There are a number of ethical theories (most notably consequentialism) that offer mechanisms for determining optimal distributions in situations of scarcity. However, the focus of this project is to work out a substantive theory of the appeal to justice within a pluralist framework (such as Beauchamp and Childress's principlism or Brody's appeals). This does not mean that theories such as consequentialism are necessarily irrelevant here, since consequentialists who have a pluralist theory of the good that includes justice will also benefit from this project. It simply means that this project is intended to be situated within a pluralist framework that accepts justice as an element of decision making. Thus, the framework for this project will have to be one that works within a pluralist theory.

There are a number of theories of distributive justice that would fit this minimum requirement. However, many of these general theories of distributive justice do not address patient selection problems; they break down when there is not enough of a resource to go around. Egalitarian theories ("to each according to his need") and theories that propose a basic decent minimum for all do not offer any way of distributing resources when there is not enough of a resource to satisfy everyone's needs (egalitarian theories) or to provide it to everyone (if it is part of the basic decent minimum) or distribute it if it is not part of the basic decent minimum package. However, there is a third set of theories that have been proposed that do attempt to address distributive justice in situations of scarcity. These theories include monistic theories, lottery theories, prioritarian (or maximin) theories and claims-based theories.

In this chapter, I will discuss each of these theories as a framework of distributive justice before adopting a claims-based approach for this project.

Monistic Theories

The most common theories of distributive justice are monistic theories. Monistic theories hold that a distribution is just so long as it is distributed according to a single criterion. The particular criterion varies, depending on the theory, though the most popular monistic criteria in the medical context are need, benefit and market mechanisms. Each of these will be discussed at length in Chapter 3 (as the considerations “need”, “potential benefit” and “ability to pay” respectively) and so I will not here go into these concepts in depth. Rather, here I will focus on the strategy of distributing goods according to a single criterion. Often, these monistic theories are assumed rather than argued for, especially when the distribution principle is need or benefit.

However, whatever the strength of the arguments in support of the individual values proposed by monistic theories, Rescher points out that all of these criteria have the same problem: “they are all *monistic*. They all recognize but one solitary, homogeneous mode of claim production...to the exclusion of all others...As a result these canons all suffer the aristocratic fault of hyperexclusiveness. As we see it, they err not so much in commission as in omission”^{xviii}. It is not so much a problem of including, say, need or market mechanisms but of excluding all other considerations. When making moral decisions and judgments, especially in the medical context, people really are concerned with more than a single value. Appealing to only one value only

tells part of the moral story and ignoring all but one part of the moral story and focusing on only one value tends to lead to seriously counterintuitive results. The (counter) examples given in the above discussions of the various monistic theories all demonstrate this problem. And it makes sense that this would be the case. Consider other kinds of decisions- the decision to buy a house, for example. In buying a house, it is not wise to only consider one value, such as price, without considering other values, such as the location or condition of the house. Although the decision to buy a house is not particularly analogous to medical decision-making, the example illustrates that it is not clear why a variety of values should be rejected simply for the sake of simplicity. Advocates of various monistic theories reject the other monistic theories because of the counterintuitive results of the rejected theories and claim that their own theories can provide better results in such cases. But of course only looking at one value will result in counterintuitive results in cases where other values are central.

For example, suppose two patients are both candidates for a lifesaving treatment but only one of the patients can receive the lifesaving treatment. If the single criterion is market mechanisms, then the treatment would be auctioned to the highest bidder. However, without even questioning the appropriateness of considering ability to pay in determining distributions, one can still object that this distribution would neglect important factors of the medical situation, such as whether or not either of the people would actually benefit from the treatment. If they cannot benefit, one might argue, they should not even be part of the bidding. Or what if one of the patient's had previously contracted for the treatment or had been waiting longer for it? The point is that, whether or not it is valid to consider the criterion, considering any criterion solely

would lead to such counterintuitive results and most often without any explanation of why the others should be excluded. Of course, this can be offset by interpreting the single criteria so broadly as to encompass several considerations, which is often what is going on when need is asserted as the single criterion; need is interpreted as encompassing, at least, benefit and urgency as well as need. However, this approach simply is to consider more than one consideration under an umbrella of a single concept.

It is concerns like these that lead people to pluralistic theories in the first place and using a pluralistic approach to any ethical question reflects how people actually think about moral problems. Because monistic theories are only concerned with a single value, decisions on moral questions are a matter of calculations. Disagreements about what one should do are disagreements about facts of the situation or how the relevant value applies in the situation, not about the value used in making the decision. According to monistic theories, everyone with the same knowledge of the situation would come to the same conclusion simply by applying the theory. Under such a system, there are no moral dilemmas and no difficult decisions⁵. But people really do feel morally conflicted about some decisions, not because of a lack or misinterpretation of information but because of there is moral ambiguity. Such moral difficulties are not possible in monistic theories because a monistic value system does not allow for value conflict since there is not a multiplicity of values to conflict.

Additionally, rejecting a monistic approach does not automatically reject the values that monistic theories champion; those values can still be incorporated into a

⁵ That is, the decision about what should be done is not difficult. If that decision has some unhappy side effects, it may be difficult to do the "right thing".

pluralistic theory. The only bit that is rejected is the idea that one particular value is the only one that should be considered.

Lottery Theories and Fairness

Few people, if any, actually advocate using an unrestricted lottery as the primary distribution system for medical resources. However, there is some support for a restricted lottery to distribute scarce medical goods, the restriction being that the only people given a lottery tickets are simply those who need the resources, will benefit from them or some other such restriction since it does not make sense to give everyone a lottery ticket for, say, a kidney, when most people have two perfectly adequate kidneys and cannot really use an additional kidney. There are two types of justifications for lottery distributions: deontological and teleological^{xix}. “According to the deontological version, a fair distribution of goods is obtained by applying a certain procedure (lotteries) for distributing goods. It is the procedure itself that guarantees the fairness of the distribution”^{xx}; thus the emphasis is not on the outcome of the distribution (which is the focus of most other distributive theories) but on the process of distribution. And ensuring fairness in the procedure becomes paramount, with the classic example being the U.S. court system. If the rules of jurisprudence are followed, the outcome of the trial will be a fair one. However, this is not always the case, as there are two ways that following rules might not result in a just outcome. First, following unfair procedures is not likely to yield a just outcome. Consider the Jim Crow laws and other laws designed to keep the supposedly free vote within a very specific demographic. Certainly there were precise and detailed procedures for implementing these laws but if the procedures

themselves are unfair then the outcome is not likely to be just. Thus, the procedures to be followed must themselves be fair.

Second, consider the classic example of the person who is in the wrong place at the wrong time and accused of a crime. All of the evidence points to him and he is convicted. In this case, even though the trial procedures may have been perfectly fair and followed exactly but since a person is wrongly convicted, the outcome is unjust. The first case illustrates that fairness cannot simply be about following procedures since the procedures followed must themselves be fair and the second case illustrates that, even if the procedures are fair, there is not a direct correlation between fairness in the procedure and justice in the outcome.

But these comments all belie a more interesting issue: the relationship between justice and fairness. There is a slip in purely procedural theories that allows the move from fair procedure to just outcome and that it to equate justice with (procedural) fairness. But understanding justice simply as “the outcome of a fair procedure” seems to severely violate intuitions about justice. After all, saying that the conviction of the innocent man is just (simply because it is fair) goes completely against intuitive understandings of justice. Thus, a thicker theory of fairness is necessary to explain the connection between justice and procedural fairness.

Barry analyzes fairness related to procedures and finds that there are two aspects of fairness involved: procedural fairness and background fairness⁶. Again, procedural fairness is merely adherence to the procedural rules. “To say that a procedure is being fairly operated is to say that the formalities which define the procedure have been

⁶ Even if this distinction is a false one, as Carr believes, because the background fairness does all of the work, I believe it is still a helpful one for explication of the concept.

correctly adhered to”^{xxi}. But whether the rules are fair or not is the purview of what Barry calls “background fairness”: “The fairness of prescriptive rules that regulate and govern some event or practice apparently depends upon the way these rules facilitate the spirit, ideals, purpose, or point that underlies and inspires the event itself; they rely, that is, on the way these rules promote the end, or telos, of the practice they govern”^{xxii}. This notion of background fairness is echoed in Rawls’s understanding of fairness and unfairness. Unfairness is not simply a matter of breaking the rules, according to Rawls, but is “more generally, acting contrary to the intention of the practice”^{xxiii}. That is, what is fair with regard to background fairness varies dependent upon what the aim of the project at hand is^{xxiv}. Recall the example of the Jim Crow laws. The aim of extending suffrage was to allow black men to vote, but the Jim Crow laws (which were essentially procedures put in place to keep the vote within a narrow demographic) effectively and intentionally thwarted this aim even though such laws were followed. Thus, it is only with an eye to the outcome and the effect of the procedures upon that outcome that this aspect of fairness can be determined.

There is a difficulty with the claim that establishing procedures that are consistent with background justice is to establish procedures that are consistent with the purpose of the practice. It is problematic to assume that actions (and practices) have a purpose, or telos. And this is quite a problem for an account such as Barry’s that assumes there is an “end, or telos, of the practice [the rules] govern”^{xxv}. But one can still understand background fairness without holding that practices have purposes. Consider, for example, that I endeavor to write a paper. There are some things that I can do that contribute to the writing of the paper, such as research, outlining arguments,

etc. But there are also things I can do that frustrate the writing of the paper, such as going out with friends or getting far too involved in a television program. When one undertakes an endeavor, one generally wants to achieve something and there are some actions or procedures that help achieve whatever it is and there are some that do not help. To say that an action is conducive to fulfilling a purpose is not the same as saying that an action has a purpose.

However, even this further explanation of fairness of procedures does not avoid the initial problem of the connection between fair procedures and a just outcome; it simply defines what procedures would be fair ones and places constraints on the framework to be applied. Some may argue that there are other criteria usually implied by the term fairness. Carr provides a list of possible accounts of fairness found in the literature on the topic:

1. Fairness involves not disadvantaging others in a way contrary to the purpose of the endeavor (as using steroids is contrary to the purpose of determining which athlete is the best).
2. Fairness involves being unbiased, impartial, or neutral in our treatment of others.
3. Fairness involves sharing burdens or benefits equally, or maintaining a proper proportion between benefit and burden.
4. Fairness involves treating equal or similar cases equally or similarly.
5. Fairness involves adhering to the rules.

6. Fairness involves treating others with the concern and respect they deserve.^{7xxvi}

But with the possible exception of #3, none of these offers any substantive guidance for concrete distribution decisions. All that any of these criteria offer are constraints on the framework that can be adopted. Thus procedural fairness by itself cannot be a basis for distribution decisions in situations of scarcity.

To illustrate this, recall the rules of jurisprudence. If properly followed, the rules of jurisprudence are generally considered (background) fair procedures and the outcome that results from following these procedures is a (procedurally) fair one. But the wrongful conviction of the person who was in the wrong place at the wrong time is still unjust. Further, even if such a connection could be drawn between procedural fairness and justice, this understanding of justice is not helpful to the current project. After all, in order for the procedures to be fair, they must promote the purpose of the practice they govern, and this is fairly clear in the case of sporting events or prizes or awards with specific goals in mind. But the distribution of medical resources is not so clearly situated with respect to the goals of medical practice and this is especially apparent when there is not enough of the resource to go around. If the goals of the medical practice relate to healing, palliation and in other ways to promoting as much as possible the well being of people vis-à-vis their health, and there are not enough medical resources to satisfy this goal, there is little guidance solely from the idea of background fairness and the resulting fair procedures. When confronted with nebulous

⁷ Carr actually has a seventh account, the one that he favors, "fidelity to social practice" but I have omitted it for the sake of clarity. As I understand that account, it is either little more than Rawls's intention of the practice revisited or problematic because it lacks the components of background fairness necessary for judging a social practice.

goals and a shortage of resources, justice as the outcome of procedural fairness is simply unable to offer any substantive guidance.

Thus, most supporters of distribution by lottery offer teleological justifications of lotteries. “A distribution is, according to the teleological lottery approach, morally fair just in case each member of the group receives a lottery ticket entitling him or her to an equal chance of winning some good. Note that according to this view, the proper “goods” to be distributed is not money, wellbeing, or capabilities, but rather chances of receiving money, wellbeing, or capabilities^{xxvii}.” What each person receives, then, is the equal opportunity to receive the resource to be distributed. As an extreme example, Goodwin advocates for what she calls a Total Social Lottery, or TSL, where all goods, services, jobs and rewards of a society are distributed by lottery not once but many times over. She acknowledges that some jobs and goods, for example, should be distributed by lot amongst those who are qualified or in need (such as doctors and medical care) but even these limited lotteries have restrictions such as annual lotteries to ensure that no one person accrues more benefits than others from his or her position. The upshot is that the TSL would guarantee a roughly equal opportunity for need and desire satisfaction: “The TSL constitutes unequal but impartial treatment, which leads to the long-term equalization of chances through repeated sortition, although not to short-term substantive equality; but short-term equality or equalization of chances is in fact unattainable in the context of diverse goods^{xxviii}.” Goodwin justifies her equal outcome measures on egalitarian grounds that people are roughly equal regarding their needs, their desires (which, although different, count equally) and their capabilities^{xxix}.

However, the distribution of benefits and burdens by lottery in this way has some serious flaws, particularly in the medical context. Such a comprehensive lottery system does not account for differences between individual patients' situations. Now, advocates of a lottery system might see this as a virtue since suppressing particulars of patients' situations can lead to a more impartial, egalitarian distribution. But even accepting that people are roughly equal in their general needs, their desires and their capabilities, it is still the case that people's specific needs, particularly their medical needs, are quite different. Sher notes that "It *is* part of our concept of strongest claims to goods... that when someone has such a claim, no one *else* is entitled to enjoy or dispose of the relevant good as he alone prefers"^{xxx}. Distributing goods by lottery thus systematically ignores legitimate stronger claims to a resource. The problem here is that by distributing resources by lottery independent of individual circumstances and what may be very good reasons to give a resource to a particular person, people are indeed treated equally, but they are not treated as equals. Giving an equal opportunity to receive, say, a donor liver to two people, one of whom is in desperate straits and will soon die without the liver and the other who is certainly sick but who is not in such desperate straits fails to give equal respect the lives and situations of the two people. Thus, while a lottery might treat people equally, it fails to treat them as equals.

Additionally, from a practical perspective, if decisions are made without reference to the medical particulars of a case, then the decisions are likely to be highly inefficient. If everyone who needs an appendectomy is thrown into a lottery to see who receives it without reference to how urgently it is needed or how likely it is to be successful, the resulting distribution of surgery is likely to help fewer people than could

otherwise be helped if a more nuanced distribution plan were adopted, allowing the distributors to be better stewards of the resources under their control.

Of course, one could respond that the lottery can be further narrowed by considerations such as urgency or benefit. Sher^{xxxix} and others, for example, describe lotteries as a fair way to distribute goods among those with equal claims to the resource. Certainly, using a lottery as a final “tie-breaker” is the most popular role for lotteries in medical decision making. This Goodwin, however, rejects this method of narrowing the lotteries, calling it “‘relevant equality’ rather than being truly egalitarian”^{xxxix}. But it is not clear why, once she is willing to concede that a lottery may be circumscribed by need or (in the case of jobs) skills, she is unwilling to circumscribe the lotteries further. She does say that “all stronger [than egalitarian] assumptions (for example, that some people are more valuable to society than others) rest on value judgments and may already contain covert assumptions about social justice”^{xxxix}. The concern seems to be, then, that if we distinguish between people at all, then the basic premise of egalitarianism, that people are fundamentally equal, is violated by treating equals unequally; introducing additional restriction on who may enter the lottery reduces impartiality in the distribution process. However, the problem of treating people equally vs. treating people as equals in medical situations again rears its head.

Again, rejecting distribution by lottery does not necessarily reject the values (impartiality and fairness) it tries to promote. Like the values proposed by monistic theories, these values can be promoted by other distribution frameworks. However, lottery systems are too problematic to be used as a framework for distribution for this project.

Prioritarian Theories

The much more promising framework is prioritarianism. Prioritarianism has become the most prevalent framework for distributive justice, particularly in the medical context, and is generally taken as the default view. Prioritarianism essentially states that the (morally) best distribution is the one that benefits the person who is the least well off and is thus concerned with both well-being and with prioritizing the least well-off. Though most people recognize this as Rawls' Difference Principle, Rawlsian maximin is but one (extreme) example of prioritarianism. Parfit defends a more nuanced version of prioritarianism. Both of these versions are discussed below.

Rawls does rely on procedural fairness to yield justice but, unlike pure procedural theories, he uses the procedure to determine substantive principles of justice that would be agreed to under a social contract. Rawls devises the Original Position, in which contractors are behind a Veil of Ignorance; that is, they are ignorant of their own talents, abilities, places in society and all other such facts about themselves and their own situations. Rawls argues that these blinded, hypothetical contractors would choose principles two principles of justice, the Liberty Principle and the Difference Principle^{xxxiv}. The Liberty Principle ensures people the most extensive system of equal basic liberties that is compatible with a similar system of liberties for all. The Liberty Principle has lexical priority over the Difference Principle, which ensures fair equality of opportunity in offices and positions and that any inequality of distribution of basic goods (such as wealth, power and opportunities) should be to the advantage of the least well off^{xxxv}. These substantive principles of justice provide the framework for a just

society because they are derived from the procedure that is akin to a common procedure for distributing cake among children: having one child cut the cake and having the other choose. Instead of cutting cake, the contractors are finding ways to divide the liberties and goods (such as positions and offices) and Rawls argues that there would be a strong presumption in favor of liberty and equality since the contractors would want to guard against being desperately badly off if they find themselves in the least well-off group^{xxxvi}. Though Rawls himself does not address health care or the distribution of medical resources, other indivisible or scarce goods that cannot be distributed evenly are distributed according to the difference principle and so it seems logical that medical resources would follow this track and be distributed to the least well-off.

There are numerous objections to Rawls' theory of justice and they have been covered extensively in the literature. The objections cover all aspects of Rawls' theory and include issues with the set up of the original position (including the contractors being understood as heads of households^{xxxvii}), the psychology of the contractors (how risk-averse they would actually be) and especially whether or not the contractors in the original position would actually choose the principles Rawls argues they would⁸. This massive catalog of objections, and the fact that Rawls does not address distributions of medical resources directly, seems like a good reason to be wary of applying Rawlsian principles to medical resource distributions. However, Norman Daniels champions Rawls' theory of justice and extends it to the healthcare arena. Daniels argues that a system akin to universal healthcare is justified by Rawls' principles of justice: "by maintaining normal functioning, healthcare protects an individual's fair share of the

⁸ See, for example, Michelbach et al, for an empirical study on what such contractors might actually choose.

normal range of opportunities (and plans of life) reasonable people would choose in a given society”^{xxxviii}. Thus, providing healthcare in such a way as to bring as many people as possible to a level of health at least close to normal functioning promotes equality of opportunity.

But when Daniels tackles the question of how to distribute medical resources that are indivisible or scarce, he retreats from Rawls’ principles of justice. The natural extension, as I mentioned above, would be to apply the Difference Principle to medical resources. But even Daniels, who accepts the Rawls’ principles of justice generally, does not think the Difference Principle would work for medical resources^{xxxix}. Daniels argues that people would, in practice, reject both the maximin position and the utilitarian maximization position in which goods are distributed according to whatever distribution will yield the greatest amount of benefit regardless of the recipient of the benefit. He argues that in cases where there is a large overall benefit that would be forfeited in a maximin distribution, people would prefer a maximization distribution and in cases where there is less difference in overall benefit between two choices for distribution, people would favor a maximin distribution^{xl}. People’s commitment to equality is not so strong as to override large gains in overall utility. Instead of turning to another principle of justice, Daniels makes the following argument:

1. We have no consensus on principled solutions to a family of morally controversial rationing problems, and general principles of justice for health and healthcare fail to give specific guidance about how to solve them.
2. In the absence of such a consensus, we should rely on a fair process for arriving at solutions to these problem (sic) and for establishing the legitimacy of rationing decisions^{xli}.

He argues that this approach is still within the Rawlsian framework since it is the same approach Rawls takes (justice as procedural fairness) initially in setting up the Original Position.

Daniels' fair procedure for determining in what way health care is limited is what he calls 'accountability for reasonableness' by which he establishes four criteria to govern fair procedures: the publicity condition, the relevance condition, the appeals condition and the enforcement condition. Essentially, the idea is that any distribution scheme must be transparent to the public (or "in the sunshine"), based upon reasons that "people who are disposed to finding terms of cooperation that are mutually justifiable"^{xlii}, incorporate an appeals process in case of disagreements and be enforceable by regulations^{xliii}. Thus, fair-minded people who are willing to come together to discuss principles of distribution (die-hard utilitarians or other extremists need not apply) agree to the principles and process for distribution, a process that includes a process for appeals. The process and principles are then vetted through public scrutiny and enforced by law or regulation. But this solution to the problem of rationing has many problems. First, it is not in the least bit action-guiding and offers no substantive help in making rationing decisions. Second, it suffers from all of the problems discussed above attributed to purely procedural theories, but more egregiously. One could easily argue that the framers of the U.S. Constitution met all of these requirements in establishing the United States of America and yet the institution of slavery was still protected by the Constitution.

However, prioritarianism does not rely upon a Rawlsian maximin theory or justification. Parfit argues in favor of a less extreme version of prioritarianism; he defends the Priority View, which states that "benefiting people matters more the worse off these people are"^{xliv}. Parfit proposes his version of prioritarianism as opposed to egalitarianism and unlike Rawls' maximin principle, Parfit argues that "the priority is

not, however, absolute. On this view, benefits to the worse off could be outweighed by sufficiently great benefits to the worse off^{xlv}. This is not because of a concern about equality but out concern for those who are worse off because they are at a worse absolute level, not because they are worse than others^{xlvi}. Thus, even if the people who are worse off do not know they are worse off than others, they should still receive the resources because of the concern for their situations.

However, there are two main problems with this view. First, if a person is in a concern-causing situation, why does it matter if they are worse or better off? If the concern is about absolute condition, why not help anyone who needs help and not worry whether they are better or worse off, especially since this version of prioritarianism is supposed to be non-relative? Of course, Parfit might respond that those who are in worse situations (even if, say, everyone's situation is bad) are more properly the subject of concern because their situations are more dire and, if significantly more benefit accrues helping those who are better off, then the priority principle could be outweighed in favor of the large amount of benefit. But if everyone's situation is bad, it is not clear why it would be worse to help anyone who needs help as opposed to the person who is the worst off.

A more interesting question is if large amounts of overall benefit can offset giving the resource to the worse off person, why not other reasons? Even without challenging the idea that potential benefit plays into distribution decisions and accepting that a person's condition plays into distribution decisions, there are still no argument why other reasons, such as the affect of the distribution on others, whether or not the person can pay for the resource and so on. In some distributions, these reasons may not

be important or even relevant, but there is no argument offered for why to include benefit but then not to include any other reasons. A theory of distributive justice for medical resources would have to at least be able to deal with other reasons, even if they are ultimately rejected, since so many are offered in the literature, the media and in anecdotes from the medical context.

Claims-Based Theories

The heading “claims-based theories” loosely covers those theories that hold that goods should be distributed in proportion with a person’s claim to the resource. The idea is that distributive justice is concerned with giving to each his what he or she is due in light of what is due to others. Rescher, writing before the rise of prioritarian theories, argues that the litany of monistic theories that had been previously proposed as “canons of distributive justice” (such as ‘to each according to his or her ability to pay’ or ‘to each according to his or her needs’) each had some element of the moral story but not all of it^{xlvii}. And so, he proposes a “canon of claims” in which “distributive justice consists in the treatment of people *according to their legitimate claims*, positive and negative”^{xlviii}. Rescher points out that the “Canon of Claims plainly avoids the fault of overrestrictiveness: indeed, it reaches out to embrace all of the other canons. From its perspective, each canon represents one particular sort of ground (need, effort, productivity, etc.) on whose basis certain legitimate claims- on whose accommodation it insists- can be advanced”^{xlix}. However, as Rescher also points out, by adopting a claims-based approach to distributive justice, “the concept of justice is no solitarily self-sufficient ultimate, but becomes dependent on the articulation of certain coordinate

ideas, namely, those relating to claims and their establishment”¹. Unfortunately, Rescher does not see the need to flesh out this critical element of claims-based theory and leaves the explication of the concept of legitimate claims to others.

Broome’s claims-based theory advances Rescher’s a step or two. Broome’s project is to explain fairness in lotteries and what their role is in a distribution scheme and his claims-based theory is an extension of that argument. As such, he couches his project in terms of “fairness” and not in terms of “distributive justice”⁹. Fairness, he states, “requires...that *claims should be satisfied in proportion to their strength*”¹¹, which he claims is an extension of the well-accepted idea that people should be treated as equals¹¹. However, the argument can just as easily be made in terms of justice. Distributive justice, being concerned with giving each his or her due in light of what others are due, certainly requires that claims be satisfied in proportion to their strength. Rescher makes this same assertion regarding distributive justice and so trading fairness for distributive justice, in this case, can be done. Certainly, this move does not offer any insight into the connection between justice and fairness and it is not meant to. The point is simply that the arguments that Broome makes under the term “fairness” can just as easily be made under the term “distributive justice”.

What Broome adds to Rescher’s theory is the distinction of the types of reasons that can be claims. Broome delineates three types of reasons: side constraints, claims and ‘other reasons’. Side constraints are a kind of absolute rule that cannot be broken; Broome’s example is that rights are sometimes considered side constraints. The

⁹ Broome does say that he believes that fairness is a subset of justice, where “justice is concerned with all claims, but fairness only with fairness-claims”. A reading consistent with this statement is that fairness is somehow equated with distributive justice, with the concept of justice covering retributive justice, political justice and other such subsets but since he is not clear on his terminology, it is not certain what he means by this. See Broome, p. 96.

presence of a side constraint automatically settles the issue of who should get the resource^{liii} and so side constraints are not considered in the distribution scheme because they arrest the distribution. Claims, which are the focus of the discussion, are reasons that are “duties are owed to the candidate” for distribution^{liv}. The third set of reasons do not fall into any of these categories; these are simply other reasons that might be put forth as a reason to give a resource to a person that are not reflected in claims or side constraints, such as compassion for a person’s situation. He argues that teleologists go wrong by lumping all reasons together and weighing them up as if all of the reasons had equal weight^{lv}. He argues that weighing up all of these reasons, even if claims are given particular weight, does not pay proper attention to the separateness of individuals^{lvi}.

Instead, Broome proposes two requirements to be satisfied by a distribution. The first is the ‘satisfaction requirement’ in which all of the ‘other reasons’ are weighed up. The second is the ‘fairness requirement’ in which people’s claims are to be satisfied and to be satisfied proportionally^{lvii}. The fairness requirement is then balanced against the satisfaction requirement for a decision about the distribution. Broome’s example is a situation in which there are a number of people who are candidates to go on a very dangerous mission. All of the candidates are similar in all relevant respects except that one has special talents that make her more likely to successfully carry out the mission, though she is no more likely to survive the mission^{lviii}. Since everyone has the same claim to the good of staying behind (assuming that bypassing a chance for glory or danger pay is a good), then only a lottery would satisfy the fairness requirement since singling the one person out because of her particular talents would be unfair. However, the satisfaction requirement allows for other reasons, such as her special talents, to enter

the equation. Fairness requires a lottery but satisfaction requires sending the candidate with special talents. Thus, on balance, we send the candidate with special talents, knowing it is unfair and efficiency won out when balancing the satisfaction and the fairness requirements^{lix}.

Broome's theory goes beyond Rescher's in delineating what type of reasons are claims: reasons that are duties owed to candidates for the resource. Additionally, he situates these claims in a larger theory of decision making; the translation of the fairness requirement to distributive justice and the satisfaction requirement to the other appeals in a pluralist theory is easily done. Maddeningly, however, Broome, like Rescher, does not see fit to further elucidate exactly what these claims are and is content to simply draw the distinction; "It is clear, then, that there is a distinction between claims and other reasons. It is not so clear which particular reasons are claims and which are not...I am not going to engage in controversy over which reasons are claims and which are not"^{lix}. He is likewise slippery about what counts as a side constraint.

This missing part of claims-based theory is particularly frustrating given the strengths of the theory as a framework for distributive justice. After all, this type of approach to the justice in patient selection problem can accommodate (or at least has a place for discussion of) the values of the monistic and prioritarian theories discussed above as well as other concerns. Potential benefit, age, desert, urgency, need, responsibility for dependents, squatter's rights, etc. can all be evaluated and assessed under this framework. But claims-based approaches are inherently pluralistic and therefore bring all of the benefits and downfalls of ethical pluralism into play. It is outside the scope of this project to provide a comprehensive defense of ethical pluralism

and, frankly, I do not have anything to add to the debate. I would be remiss, however, if I did not address one problem that plagues all pluralist theories and is particularly at issue in this project: the problem of contradicting values. When a theory supposes a number of equally valid values, it is inevitable that in some cases the different values will conflict with one another and support different courses of action. For example, suppose that a man arrives in the emergency room in desperate need of a blood transfusion. The man is a devout Jehovah's Witness. In accordance with his closely held and long-standing religious beliefs, the man refuses the blood transfusion with complete understanding that he will die as a result. Looking at the consequences, one can make a clear argument in favor of forcibly transfusing the man for the sake of saving his life. However, from the perspective of autonomy it is easy to argue that the informed patient has a right to refuse even lifesaving treatment. In this case, appealing to the consequences leads to one course of action and appealing to autonomy leads to another¹⁰. And even though the current project is concerned not with the plurality of general principles but with a plurality of considerations of justice, the problem still applies because different considerations will often support different courses of actions.

There are a couple of possible responses to this. First, the idea of equally valid values could be rejected in favor of a priority of values¹¹. That is, one might decide that all values are not equally valid and establish a kind of chain of command, not unlike the one Rawls establishes between the liberty principle and the equality principle, where value x always takes precedence over value y and value y always takes precedence over value z and so on. However, one of the central motivations of pluralism is that in

¹⁰ There are undoubtedly other appeals at work here than just consequences and autonomy but for the sake of simplicity of exposition, I will only deal with these two in this series of examples.

¹¹ I will revisit to this idea in Chapter 4 when the whole of the substantive theory is assembled.

different circumstances, different values are more important. If one value always takes precedence and the others are tie-breakers, then part of the moral story is still missing. But there is a better method for solving this problem, one utilized in most pluralist theories. The problem is solved by looking at the particulars of the individual case, using reasoned judgment to work out in reflective equilibrium which value or values are stronger or more important and determining which course of action to take based upon these values. In the above example of the Jehovah's Witness, the decision maker would look at the consequences of the two actions (transfuse and the patient lives but is angry and not transfuse and he is dead) and autonomy (which is maintained by not transfusing and not maintained by transfusing). Then, by looking at the circumstances of the case (that the patient knows the consequences of his actions and accepts them and with full understanding accepts them and still refuses treatment) the decision maker concludes that respecting the patient's autonomy would be the best course of action. But consider a case with a different set of circumstances. Suppose that the Jehovah's Witness is also a widower with two small children. Now, the consequences of not being transfused are that the man dies and his children are left parentless; not being transfused now has a major impact on the lives of two people who are dependent upon the patient. This change in circumstances triggers a change in the consequences that may trigger, upon ethical reflection, a change in the decision.

Critics of this method say that this makes moral decision making arbitrary and subject to personal bias. The decision maker could simply go with his or her gut instincts or be guided in the process by personal prejudices. The decision maker in the above example could go with his or her initial reaction and use the principles to justify

that gut feeling. There are two responses to this. First, just because someone can abuse the system does not mean that the system is wrong. After all, one could just as easily use pretty much any other theory incorrectly to go with one's gut feeling; a consequentialist could claim that the consequences support his or her initial gut feeling just as easily. That a theory may be so manipulated is not a problem with the theory but with the person applying it. Second, reasoned judgment and reflective equilibrium are not synonymous with a knee-jerk reaction. Reasoned judgment involves examining the circumstances of the case and reflecting ethically upon how the values apply in that particular case. With ethical reflection upon the values and the circumstances of the case comes reasons and justification for choosing one course of action. It is true that different people can come to different conclusions about what actions to take and this is much more likely to happen with particularly sticky cases like the one above. But each of these people will have good reasons based in the relevant values backing their arguments. This is not a knee-jerk reaction or a bias toward an initial gut feeling but a well-thought-through decision based upon the relevant values.

That said, claims-based theories also have difficulties that arise from their reliance on legitimate claims as the basis of distributive justice. Also unfortunately, no one else really takes up the challenge. Certainly, numerous people have worked to identify a number of values (or reasons for giving a resource to one person over another), including those faced with medical rationing decisions, such as the Seattle Artificial Kidney Center Admissions and Policy Committee (the so-called "God

Committee”)¹², the Northeast Proton Therapy Center^{lxi} and, to a lesser extent, some of the distribution schemes followed by the United Network for Organ Sharing (UNOS). Also Kilner^{lxii} has identified a number of values that might be at work or that might be acceptable in some form, when people do make rationing decisions. But no one has actually taken up the challenge of working out a system of legitimate claims.

The Framework for the Current Project

Though I have not taken the time to conclusively demonstrate that the other possible frameworks for decision making are fatally flawed, the strengths of the claims-based approach make it particularly eligible as a framework for this project; I will build on Rescher and Broome’s theories to develop a substantive theory of distribution for scarce medical resources. In order to do this, I will work out a system of claims (Ch. 3) and demonstrate how that would fit into a pluralist theory (Ch. 4). But first, the theoretical framework needs to be more concretely set out.

Broome’s theory essentially sets out two different kinds of reasons that fit with distributive justice. The first are claims, which are discussed above. Claims are reasons that are duties owed to a candidate for distribution; these duties (positive and negative) are weighed up to determine the person’s overall claim to the resource in question. For the sake of clarity, I will refer to reasons that may be claims (such as need, desert, etc.) as considerations. These considerations that I will discuss in the next chapter are facts about a person’s condition or situation that potentially generate some kind of duty that they be given the resource. A theory of the nature of this duty and how it is that any

¹² The Seattle Committee predates Rescher’s discussion and also did not necessarily follow pre-identified values or any particular theory, but they did incorporate a number of different values into their deliberations.

particular considerations generate duties at all is beyond the scope of this project.

Instead, to identify the considerations, I will look to the literature, media and anecdotes about medical distribution and evaluate the considerations that have been identified in these sources as claims.

The second type of reasons is side constraints, under which heading Broome places rights. Rights are not a particularly prevalent element in medical distribution decisions though they are undoubtedly an important one. This is not to say that there are very few rights in healthcare; rather, not all rights in healthcare have to do with distributive justice. The most prevalent healthcare rights that people have are decisional rights (the right to accept or refuse treatment), the right to confidentiality and so on. These rights do not generally give a person a right to a resource in a distribution (though people do have a right to refuse resources). The right to decide what to do with one's own body is not a right to demand treatment. Rights that are more traditionally relevant to distribution decisions include rights of ownership of a resource, rights generated by contracts and rights guaranteed by law. Ownership rights rarely arise in medical distribution decisions because it is rare that patients own, say, a heart-lung machine or an ICU bed in a hospital. However, there are at least two situations in which patients do have ownership of the scarce resource: directed donation of organs and autologous blood donation. So, even though it is a rare situation that may not arise frequently, ownership rights do play into medical distribution decisions.

Contract rights are also fairly rare since patients generally do not legally contract for specific treatments or healthcare generally. The most common exception to this involves contracts for home health care, for example, or concierge medical practices in

which patients pay an annual fee (usually a few thousand dollars) to the physician in addition to any regular medical costs. In return, the physician is able to limit the number of patients in his or her practice and provide the patients same day appointments and more attentive care. Even in concierge practices, whether or not a contract between physician and patient exists depends upon the specific agreement between the two parties. In most other medical situations, no actual contracts exist between a physician or health care institution.

An interesting question that arises in this vein, however, is whether or not promises can generate contract rights. One might argue that by making an appointment or scheduling a procedure, a patient has been promised that he or she will be seen or given the procedure. This, in turn, generates a right, based on that promise, to the appointment or procedure. But this is a bit of a stretch for several reasons. First, it certainly is not a legal right and so it would have to be a moral right, which is a bit murkier to understand. Further, although it is possible that a physician (or other potential contractor) has said, "I promise", it is unlikely that an explicit promise has been made. Indeed, even the argument for an implicit or understood promise is shaky since the medical scene is rife with stories of resource restriction, triage decisions, and so on. Even accepting (more plausibly) that making an appointment generates a right to be seen by a physician, it is difficult to argue that this is also a right to whatever treatment, especially if the treatment is scarce, or to be seen at a particular time.

The third set of rights in medical distribution are those that are guaranteed by legislation such as the Emergency Medical Treatment and Active Labor Act (EMTALA). These rights, however, are generally had by everyone and even in

emergency room triage decisions, each patient has a right to be evaluated and stabilized whatever their condition. Thus, such rights are much less helpful in distinguishing between competitors for a resource though there may be occasions where the requirements of such laws do help distinguish between competitors, so they should be included. However, the issue of legislated rights raises the much more interesting question about whether or not there is a right to health care. Such a right is certainly not specifically guaranteed in law or the U.S. Constitution, but there is quite a bit of discussion about whether or not there is a moral right to health care (or whether or not there should be a legal right to health care). I do not intend to address that issue in this work. If there is a right to health care, then everyone has a right to health care and we will still have to decide among those who have the right which person should get the resource. Or, if there is no right to health care, then nothing changes in what is discussed here. There is, however, an alternative that would have implications for this project; if there is a right to health care but that right is not had by everyone equally. That is, if some people have a right to health care (or some higher levels of health care) that other people do not. People do have different levels of access and some have little access at all to health care. However, this is not the same as having a right to health care, or levels of health care that others do not have a right to. In any case, I will not take a position on this but assume that there is no such right beyond what is specifically guaranteed by legislation such as EMTALA.

The role that Broome gives to rights is as a potential side constraint (though he does not argue for this position). From a distributive point of view, viewing rights as side constraints actually makes things much easier; if someone has a right to a resource,

that person should get it, end of discussion. This essentially shuts down any discussion of claims and the distribution is simply determined by rights if any of the competitors has a right to the resource in question. But the problem is that it makes rights absolute when the rights that are at issue in distributive justice are generally understood not to be absolute. Even a person's ownership rights can be overcome by sufficiently compelling reasons in eminent domain or adverse possession law. So how should rights be understood? One alternative to accepting rights as side constraints is to do a complete reversal and reject any special role for rights and consider rights as just another consideration. But this does not seem to be the correct way to go, either, since it is true that to have a right to something generates a very strong presumption that no one else can have that thing. This seems to be much stronger than the claims that come from other considerations, even if it does fall short of being absolute. The best solution then, is to accept rights as a separate category from considerations that generate claims. If a patient has a right to a resource, that is an extremely strong presumption in favor of his or her getting the resource, but rights are not absolute. Thus, a patient with a right to a resource might have his or her entitlement¹³ outweighed by another patient's entitlement even if the latter patient's does not have a right to the resource, but in that case the latter patient's claim would have to be very, very strong.

But what happens to a patient's right if it has been outweighed? A right is not like other considerations that contribute to fairness in distribution and so if they are outweighed, it is only fair. In other contexts, when a person's rights are violated, some kind of remuneration or compensation is required. A rights violation might result in a

¹³ For want of a better word, I will use "entitlement" to refer to the overall reckoning of a person's rights and claims.

tort action (or, depending on the type of violation, a criminal charge) and even property appropriations under eminent domain require that the property owner receive payment for the appropriated property. And this is not so different from the medical context, in which EMTALA violations can lead to tort actions and breaches of contract can lead to remunerations. Consider the patient in a concierge medicine practice. The patient has paid an additional sum in return for particular services (e.g., same-day appointments, more time with the physician and more personalized care). Assuming that there is some explicit contract, if the physician fails to reliably deliver these services, then the physician has violated the contract and the patient has a case for breach of contract. Depending on the language of the agreement, the patient may be entitled to having his or her money refunded at the very least and possibly more if some injury has resulted from the contract violation.

Thus, the framework for determining a just distribution of scarce resources will be to give the resource to the person with the strongest entitlement to the resource. Rights are a separate element of a person's entitlement from claims and will be weighed up with a person's claim to determine a person's overall entitlement to a resource. If only one of the competitors for a resource has a right to the resource and others have claims, it would take a very strong claim-only entitlement to override the entitlement of the person with a right to the resource whether or not that person also has a claim. But rights are not absolute and it may be the case that more than one person has a right to a resource. Given this, the system of claims will be doing the most work in most medical distribution decisions. It is to the considerations that will determine claims that I now turn.

Chapter 3: Assessing the Considerations

In this chapter, I will evaluate the various considerations that could impact the strength of people's claims to a resource. Before I begin that discussion, there are a few caveats about what this chapter is and is not. First, in listing these potential considerations, I am not trying to define justice by them or make any theoretical arguments about duties and what generates them. Rather, I am simply taking considerations that have been identified in the literature or have been prevalent in the media and other sources and using them to try and flesh out the idea presented in the previous chapter about claims as a component of a theory of distributive justice in healthcare. Although it is fairly extensive, this list is undoubtedly not exhaustive and there is certain to be disagreement about how I have categorized some claims. For example, I group a number of considerations under the heading of "desert", though one might certainly argue that some (or even all) of them should be pulled out and discussed independently of the desert consideration.

Second, the list of considerations I present are not meant to be a comprehensive list of all considerations that impact all claims in all contexts in which distributive justice matters. This project is limited in scope to micro-allocation issues in healthcare and, as such, the considerations will be evaluated for fitfulness in that context. Some of the claims I reject for this context might be accepted in other distributive contexts and vice versa. This assessment of considerations is not intended to be, nor do I think it is adequate as, an assessment of claims for all distributive contexts. The particular distributive context for this project is micro-allocation of scarce medical resources and I

only intend the discussion to apply to this particular context, though some of the arguments for and against particular considerations likely apply in other contexts as well.

Finally, a full discussion of each of the individual considerations could easily be a book-length project unto itself and most (if not all) of the considerations have books dedicated solely to them. It is simply not within the scope of the project to give a full accounting of each of the considerations I discuss. Rather, the discussion of each consideration is limited to the basic conceptual framework, overarching points and general objections. In some cases, this means compressing centuries of debate or disregarding some smaller theories. That said, I will now turn to the considerations.

Need

Need is one of the most if not *the* most oft-asserted criteria for determining who should be given a scarce resource. But what people mean when they talk about need is not always clear. The term “need” (in both noun and verb forms) is frequently both used and abused in common usage, from the four year old who whines, “I need that *cookie!*” to the forty year old who asserts, “I need *that* house!” In medicine, need is a powerful concept as many physicians (and others) think that medical need (however it is understood) should be the only consideration used when deciding whether or not a patient should get a particular treatment. However, even in medical contexts what is meant by need is confusing, as writers on the subject often combine the concepts of need, want, benefit and urgency to various degrees^{lxiii}. In what follows, I will first discuss what is the moral significance of need before turning to why need should be considered and need’s relationship with other considerations.

1. What exactly is “need” or “a need”?

There are essentially two senses of “need”. The first sense is the instrumental sense (also called the ellipse theory^{lxiv} of need or the non-normative form of need^{lxv}) and the second is the inherent sense of need. According to the instrumental sense of need,

“A needs X in order for A to ϕ in circumstances C if and only if X is a necessary condition of A’s ϕ -ing in circumstances C”^{lxvi}.

So, because obtaining X is a necessary condition for realizing ϕ , ϕ cannot be realized unless X is obtained. What is needed, then, is always necessary for the sake of some further end; people need gasoline *for* driving a gasoline-powered car AND it is the case

that the gasoline-powered car cannot be driven without gasoline. This basic formulation of need generates any number of true “need statements” such as “I need a space suit to go into space” or “I need a bat to play baseball”. These statements are true whether or not I actually have the goals of going into space or playing baseball. But, unless I actually have the goal of going into space or playing baseball, it is not the case that I need a spacesuit or a baseball bat. So, whether or not A actually needs X depends on whether or not A is interested in ϕ -ing. There are an indefinite and vast number of needs statements that are true of A at any given time, since at any given time A will need all sorts of Xs in order to achieve all sorts of ϕ s, but in order for A to actually need X, A must have the relevant goal, ϕ ^{lxvii}.

This non-normative instrumental sense of need is not especially controversial since all it asserts is that there is some X, without which A cannot ϕ . But it is also true that this is not especially helpful for the current project since it does not capture the why it is that need has such wide moral force. As Frankfurt points out, “an assertion that something is *needed* tends to create an impression of an altogether different quality, and to have a substantially greater moral impact, than an assertion that something is desired. Claims based upon what a person needs...are likely to arouse a more compelling sense of obligation”^{lxviii}. In other words, the strictly instrumental view lacks any performative content. And it is precisely the move from a non-normative version of need to a normative version that generates controversy. Taking the example from above, suppose I assert that I want to play baseball and so I assert that I need a baseball bat. This need statement, while true, does not have the moral importance that Frankfurt describes. I do need a baseball bat to play baseball but what is so important, especially morally, about

my playing baseball? The problem is that needing a thing to obtain a further end does not entail that there is any significance or importance to obtaining that further end. Nothing in the wholly instrumental sense of need can explain which need statements take on this moral dimension or why they do so.

An additional problem with a purely instrumental account of need is that instrumental needs are conditional needs; that is, the thing that is needed is only needed if it is needed for some further end. But needing a thing to obtain a further end does not entail that one needs that end. The end something is needed for is only a need itself if it is needed for some further end, which itself is only a need if it is needed for a third end and so on into a difficult regress. For example, I may need surgery to remove a cancerous growth. I need to remove the growth to have health. I need to have health to flourish and, indeed, function as a human being. Why do I need to flourish or indeed function as a human being? The answer is either (logically) I don't or I don't know. The question is either one of logical necessity or it is a bit absurd. There must be some stopping point, some end with a sufficient status, to turn all of these conditional needs into actual needs.

In order to address this problem, some writers shift to a theory of inherent needs. On the inherent account of need, there are some things that are needs simpliciter; that is, there are some things that are needed in and of themselves and not for the sake of some further end and it is these needs that are morally important. This is generally what is meant when the noun form of "need" is invoked and plays out in the form of a list of things that are objectively needed. These lists often roughly correspond to Maslow's hierarchy of needs, which includes food, potable water, breathable air, shelter, clothing,

safety, security and, sometimes, self-respect or self-esteem. In most cases, the things on the list count as “needs” and can explain why some instrumental needs are morally important. If A (instrumentally) needs some X (which is not an inherent need) in order to achieve ϕ and ϕ is the attainment or preservation of an inherent need, then the need for X is morally important. Making this move to determine which needs are morally important closely parallels objective list theories of the good, where what is good is good regardless of whether or not any given person actually prefers it, values it or agrees that it is good. In the cases of inherent need, if A (instrumentally) needs some X (which is not an inherent need) in order to achieve ϕ and ϕ is the attainment or preservation of an inherent need, then A needs X whether or not A actually has the goal of ϕ . On a strictly instrumental account of need, A needs X in order to ϕ might be a true need statement but is not an actual (instrumental) need unless A has the goal, ϕ .

Another similarity with objective list theories of the good is the central problem of an inherent account of need. Just like proponents of objective list theories have to explain what makes the good things on the list good, proponents of inherent needs theories have to explain what gives some things the special status of inherent need. Doyle, who holds a theory of inherent need, argues that those things that are inherent needs are so because they are “goals that all humans should have in common if they are to be able to act in their objective interests”^{lxix}. Doyle argues that there are essentially two inherent needs, the most basic levels of both physical health and individual autonomy, which represent the most basic preconditions of human functioning. He further introduces what he calls “intermediate needs”^{lxx}, which include the things on Maslow’s bottom two tiers, including nutritional food, potable water, physical security,

etc. These are needs because they are also universal goals for human beings but they are intermediate because they are instrumentally needed to satisfy the basic inherent needs. If these goals are not satisfied, Doyle argues, serious harm will result and this is true for all humans. The inherent needs, then, are not contingent on any one person's life choices but on facts of human life that everyone shares. By making universalizability a requirement of inherent needs, Doyle grounds inherent needs in the basic human condition: "Unless individuals are capable of participating in some form of life without arbitrary serious limitations being placed on what they attempt to accomplish, their potential for private and public success will remain unfulfilled, whatever the detail of their actual choices"^{lxxi}.

As a preliminary point, there is a slight hitch between the inherent needs and the intermediate needs. The difference between the inherent needs and the intermediate needs is that the things that are intermediate needs are instrumentally needed to satisfy the inherent needs. But the things that are inherent needs are also instrumentally needed for human flourishing. This is a bit of a semantic point and it may be that the solution to the problem is simply to identify the inherent needs not as contributors to human functioning but as elements of human functioning and that the intermediate needs are things that are needed in order to promote human functioning (or, at least, avoid harm). Making this move, he could still hold that basic levels of physical health and individual autonomy are inherent needs as universal elements of human functioning, without which we certainly suffer serious harm.

It is not clear that the universal importance of inherent needs (and, indeed, intermediate needs) is enough to somehow grant them the special title of "morally

important need” over and above other goals. He is making the claim that, of all things, everyone must have these two things to flourish as human beings. While it is true that no one could practically choose to deny themselves the basic levels of physical health and individual autonomy¹⁴ that Doyle claims as inherent needs, it is not the case that the intermediate needs are universally paramount since any individual’s particular life plan may not grant them priority over other goals. Some people do choose to forgo intermediate needs in pursuit of spiritual growth or other personal goals, such as wandering monks who give up shelter or firefighters who give up physical safety to do their jobs. Also, although Doyle uses universalizeability to avoid making needs too subjective, it is not clear that goals such as some level of preference satisfaction are not at least as universal as some of the other goals he lists. But even if the lists are tweaked to include only things that are universalizeable, the key question remains: why should universal goals be given special status over and above goals that are more (or at least equally) central and important to an individual’s identity or life plan simply because they are widely shared? It is not clear what moral work the idea of universalizeability is actually doing. The moral importance of the inherent needs seems to be derived not from universalizeability but from avoidance of harm, which will be discussed below.

Most need theorists, avoid such complications by avoiding the initial move to an objective list. By far the most popular move is to instead put the emphasis on the ϕ in the need equation; the moral importance of the need depends upon the thing the need sets about to satisfy. Most writers who take this approach argue that the instrumental needs become inherent needs when failing to achieve ϕ would result in some amount of

¹⁴ I am setting aside the issue of martyrs and others who kill themselves, since those cases often involve extenuating circumstances regarding relations with others. The concern here is that Doyle’s needs are so because they are necessary for functioning or flourishing.

harm to A^{lxxii}. The connection to harm is what invests the needs with moral importance. Thomson argues that instrumental needs convert to inherent needs when the thing that is needed is needed to prevent a harm.

The normative claim 'A has a need for X' implies that X is practically necessary specifically for A, and X is practically necessary for A when he cannot do without it, when his life will be blighted or seriously harmed without it... Such a need is non-instrumental in that it related to the overall quality of a person's life rather than a particular goal that he happens to have. This kind of non-instrumental need I call 'a fundamental need'.^{lxxiii}

And on this point, Wiggins agrees: "a person needs x [absolutely] if and only if, whatever morally and socially acceptable variation it is (economically, technologically, politically, historically...*etc.*) possible to envisage occurring within the relevant time-span, he will be harmed if he goes without x "^{lxxiv}. Wiggins calls such needs "*basic* just if what excludes futures in which y remains unharmed despite his not having x are laws of nature, unalterable environmental facts, or facts about human constitution"^{lxxv}. Thus, what makes some needs inherent and morally important is that if they are not satisfied, significant harm will result.

This connection to harm is by far the most popular but it also creates a serious problem: what counts as harm and what harms count as significant? Though Thomson, Wiggins and others who take this approach are a bit sketchy on the details, most approaches are compatible with Feinberg's second sense of "harm", which is "harm conceived as the thwarting, setting back, or defeating of an interest"^{lxxvi} where an interest is set back when it is left in a worse condition that it would otherwise have been. Attaching the idea of "serious" or "significant" to the concept of harm is clearly intended to exclude instances in which a person's interests are set back in unimportant or non-critical ways, such as when I do not get to play baseball. I may feel some unhappiness and, because of this, my interests will have been set back, but no one wants

to argue that my need to play baseball is a morally important one. The challenge in all of this is to lay out what counts as significant without ending up with counterintuitive results.

One way of resolving this issue is simply to claim that only those things that are needed for physical survival count as morally important needs. The implicit assumption in much of the medical literature is that if someone needs something, he or she will die without it. Certainly, cases where A needs X in order to continue living are paradigm cases of morally important needs. But these cases being paradigm cases does not entail that they are the only cases; physical existence being a precursor to other life interests does not preclude those other life interests being morally important. Why should physical survival automatically take moral precedence over other goals and values in people's lives? People do choose to die for a person, principle or idea; this reflects the greater importance accorded other values and goals in individual lives. For example, suppose that people who suffer from Disease X do not die but are quickly left paralyzed with their mental faculties devastated. Now suppose that if Disease X patients receive a single dose of DruGood, the only drug that can help, at any point in their illness, they make a full recovery fairly quickly. It is hard to argue, then, that Disease X patients do not need DruGood in any morally important way. True, they will not die without DruGood, but the massive setback of their interests that they suffer from Disease X surely counts as morally important. Expanding the morally significant harms to include all and only physical harms also suffers from this same problem, since, again, including harms to physical well-being is not an argument against including other harms that are not connected to physical well-being. Additionally, people's well-being consists in

much more than physical well-being, even if physical is taken to include the psychological. Excluding serious harms to people's well-being from the category of morally important harms is counterintuitive and seems to exclude from the category quite a large number of things that people do consider central to their own view of the good life and human flourishing.

But, taking a different tack and arguing that the morally important harms are those that represent setbacks to the well-being and central life goals of individuals has its own problems. Doing this has the benefit of respecting the differences between individuals and their own views of the good life and recognizing that not all serious harms in people's lives are physical ones. However, the problem with expanding the category of morally important harms this way is that it can be far too subjective. Some twisted individuals have life goals that are seriously detrimental to the well-being of others. Adolf Hitler is the paradigm here. Conquering Europe and eradicating minority populations was a key life goal for him that was central to his very identity, yet it does some violence to the idea of need to claim that Hitler needed (in a morally important way) to conquer Europe and kill Jews. It is easy to dismiss this and claim that the subjective life goals of dangerous raving lunatics simply do not count but this problem applies to less extreme cases as well. Suppose a man has been interested in cars since he was very young and has made a life around cars as a collector and salesman. He has made it the project of his life, almost an obsession, to complete his collection of vintage Aston Martins and is missing only one. It seems strange to say that the man needs the final car in any morally important way. Certainly, he will suffer the thwarting of a major life goal if he does not get it but it is still difficult to say that he needs the car.

The critical problem with tying morally important need to harm is that one will either have to defend an objective list of harms (e.g., only physical) or a subjective list (e.g., life goals) of harms that count. But however successful or not these approaches are, there is an even more fundamental problem with this approach and that is that any attempt to determine the moral importance of a particular need with reference to the ϕ in the equation inescapably uses a benefit consideration to determine the moral importance of a need. When differentiating between the ends for which something is needed, need itself, as a concept, has nothing to say because the ϕ for which something is needed is a benefit and the importance of that benefit is not part of the concept of need. This does not mean that “need” is a morally bankrupt concept. It simply means that looking for the moral importance of the concept of need in the end for which something is needed is a non-starter because to look at the end is to look at the benefit in a situation, not to look at need at all.

To illustrate this point, consider the following two statements (and assume that both are instrumentally true):

1a) Maggie needs DruGood to cure her Disease X.

2a) Dave needs DruGood to kill (merely) unsightly Ickweeds in front of his house

(since, in addition to curing Disease X completely, it is also the only herbicide that kills Ickweeds).

All of the above discussions focus on the moral importance of curing Disease X and killing Ickweeds. But such a discussion is a discussion of benefits, i.e., which benefits

are morally important ones and which are not. The above strategies all make the moral importance of the need dependent upon the moral importance of the end it is needed for without actually addressing whether or not the concept of need plays any role in the matter. This comparison is a non-starter for determining whether or not the concept of need itself has any moral importance. Instead, suppose that further study of Disease X reveals that in people with certain genetic mutations, Disease X can be cured by several different treatment regimens, all of which are just as effective as the dose of DruGood. Maggie does not have the genetic mutation, but Bill does. Now consider the following:

1b) Maggie needs DruGood to cure her Disease X.

2b) Bill does not need DruGood to cure his Disease X, though it would cure him.

Maggie and Bill would both be cured with DruGood, but Maggie needs it and Bill does not. Keeping the benefit constant and varying the need condition allows an evaluation of whether or not need itself has any moral importance independent of any moral importance invested in it by the benefit that the thing is needed for. The question, then, is whether or not the fact of needing independent of any benefit considerations generates any moral importance. The answer, as I see it, is yes. Maggie's Disease X cannot be cured if she does not get DruGood while Bill's can. The fact that Maggie has no other means of being cured gives her situation vis-à-vis the DruGood a certain importance that Bill's lacks since he could easily seek another cure. She cannot obtain her end without it while he can.

There is one more issue that should be addressed before moving on. Suppose that the only alternative to DruGood that are effective in people like Bill with the

genetic mutation is AltDrug, a drug that is extremely rare and hard to find because it comes from a plant that grows only on certain hillsides in a remote region of Africa and cannot be synthesized. Bill, then, might have an alternative to DruGood in theory but it is not easily acquired and so he may not have the alternative in practice. His situation, then, is very close to Maggie's except that he has a minute chance of getting an alternative treatment. It seems that this tiny difference should not be enough to make it less important that Bill get the DruGood than Maggie. The question is *not* whether or not AltDrug exists; the question is whether or not AltDrug is available to Bill. Given the economic, social, physical, geopolitical, etc. context of the situation, is AltDrug available to Bill? If not, then he needs the DruGood. If it exists but is not available to Bill, then it is not a real alternative for him and his Disease X will not be cured without DruGood. The person either needs the thing in question or he or she does not and this depends upon whether there are alternatives available to accomplish the goal or not.

An alternative explanation of the situation is that need is not an all or nothing proposition; rather, need admits of degrees depending on how difficult obtaining the alternative is. Suppose that the AltDrug is practically available to Bill but requires extra effort to get it or costs an inordinate amount of money or is difficult to obtain for some other reason. For those reasons, though it is available, it is difficult to acquire. On this account, both Bill and Maggie need the DruGood, but Maggie needs it very slightly more because she has no other alternatives and Bill's alternative is available but is very difficult to obtain. Lucy, who has a specific gene mutation that makes her body convert ten other readily available drugs into DruGood would still need the DruGood, but would need it significantly less than either Maggie or Bill because of all of the alternatives

available to her. This satisfies the intuition that Bill should get some “credit” because of the difficulty in obtaining his alternative cure but it is not without problems because although this explanation satisfies one intuition, it violates another. This blurs the line between “needing a thing” and “the thing is the best option” or, indeed, simply “the thing is an option”. Thus Lucy, with ten alternatives easily available to her, still needs the DruGood, albeit only a little bit. By this, anyone for whom a resource will satisfy an end goal will need that resource regardless of what alternatives are easily available to them, which stretches the meaning of need substantially. In addition, the all or nothing proposal for need is not draconian; recall that the alternative must be practically available. The existence of an alternative is not sufficient to negate considering need.

Thus, the moral significance of need comes from the lack of alternatives available to those in need, not from any connection to harm or any other end for which things are needed. Because of this, all need claims are equal qua need since all cases of need are ones in which those in need do not have any other options for obtaining ϕ . Furthermore, need is an all or nothing concept; A either needs X or does not need X. X cannot be “needed just a little” or “kind of needed” because it is either the case the A needs X in order to ϕ or it is not. If A has any practically available alternatives (even just one) that will enable A to ϕ , then A does not need X. If A has no available alternatives, then A does need X.

II. Why should need be a consideration?

Not all things that are morally important are considerations of justice and the question is whether and how need affects claims to scarce medical resources. There is a strong

intuition that need should be considered and a long history of a connection between need and distributive justice. Often this connection is implicit or assumed such as when distributions schemes are established to distribute resource amongst those in need; that the resource would only go to people in need is assumed. In other cases, it is explicit, such as with Karl Marx's famous "from each according to his ability, to each according to his need". Of course, most of the discussions of the relationship between need and benefit do not have the same understanding of need discussed here so the question is whether this appeal can still be supported when stripped of the moral work being done by the connection to benefit that is generally at work (at least implicitly).

But even without the moral work done by the connection to benefit, many of the same reasons still hold for considering need. The two key arguments in favor of need are an argument from efficient use of resources and an argument from equality. Behind the argument from efficiency is the idea that, by giving the resource in question to people who need it instead of those who do not, more people overall can be helped because the scarce resource is given first to those for whom nothing else will work before it is given to people with alternatives. Suppose that DruGood is in short supply and AltDrug is generally available. Maggie's Disease X will only be cured with DruGood while Bill's can be cured with either the DruGood or AltDrug. Giving the AltDrug to Bill leaves the DruGood available to be given to Maggie; giving Maggie the DruGood while Bill gets the AltDrug makes it so both can be cured. Thus, by giving the scarce resource first to people who have no alternatives, more people can be helped.

The argument from equality is rooted in the idea that people should be treated as equals, with equal concern given to their interests. In Maggie and Bill's case, the only

relevant difference between them is the fact that Maggie needs the DruGood while either the DruGood or the AltDrug will work for Bill; he does not need the DruGood. Thus, giving the DruGood to Maggie and AltDrug to Bill reflects an equal concern for Maggie's and Bill's health-related interests because both patients will be cured, thus serving both patients' interests. Giving Bill the DruGood, which would cure him and leave Maggie to suffer, disregards Maggie's health-related interests and does not show equal concern for her interests. Though this sounds similar to the efficiency argument above, the issue here is not that two people are cured instead of one but that the health-related interests are accorded equal concern. Only by acknowledging that Maggie needs the DruGood and Bill does not can the health-related interests of both Maggie and Bill be protected. Of course, there might be other schemes by which Maggie just by luck gets the DruGood (such as flipping a coin or first come, first served) but only by considering her need and distributing the two drugs accordingly is the concern for Maggie's interests equal to that of Bill's.

It is rare that anyone argues against considering need in a scheme for just distribution. It is much more common for people to argue that only need should matter, though how much other considerations such as benefit and urgency are built into the operative concept of need is often unclear. It is also more common for people to argue against considering need exclusively and that other considerations should be included. For example, one might argue that there are situations in which the person who needs the resource has only a miniscule chance of benefiting. Arguments such as this are not arguments against considering need but are arguments in favor of including other considerations such as benefit when distributing scarce resources.

Despite this popular support for considering need, it is not unanimous. Those who favor a libertarian conception of justice in healthcare argue that what a person has paid for (either directly or by purchasing insurance) is the only morally relevant consideration in healthcare. Helping those in need, libertarians argue, is the proper concern of charity, not justice. This objection is not specifically against need but against any pluralistic approach to distributive justice. Any proposed scheme of just distributions that is not pluralistic will not accept need as a consideration (unless, of course, the proposal is that only need counts). I will not spend time in this chapter arguing against comprehensive views; I will instead address this and other objections from non-pluralist theories in Chapter 4 competing comprehensive understandings of just distributions.

That being said, it seems clear that need (narrowly understood as discussed above) is an important consideration and should be accepted. Because of the limitations it places on the options of those in need as opposed to those who do not need the resource, needing a resource strengthens the patient's claim to the resource. If the patient who needs a resource does not get it, he or she has no other options to accomplish the goal; those who do not need the resource can (by definition) still accomplish their goals through some other means.

III. How does need fit in with other considerations?

As is apparent from the above discussions, need has an interesting relationship with both benefit and urgency. All three of these considerations are conceptually tied to one another, since all situations in which something is needed require that the thing that

is needed is needed for the sake of some end, which will almost always be a benefit of some kind and there is often a time restraint after which the resource is no longer needed, since it will no longer bring about the end for which it was needed. These three considerations are conceptually separate though and, as such, will not always support the same course of action. This will be discussed more in the sections on benefit and urgency. Need is not so strongly tied to the other considerations and so it operates a bit more independently with regard to them. In some cases, need will be the only consideration supporting a claim; in others, it will be one among many.

Also, it is important to remember that the importance of need (and all considerations) depends strongly on the facts of the situation. Recall the intuition mentioned above that Bill should get some credit for his alternative to DruGood being difficult to obtain. Need does not just add five claim-points; it can be more or less important based on the facts of the case. In the case where Bill has a difficult to obtain alternative where Maggie has none, Maggie's need claim can be less important in the assessment of each person's claim. The facts of the case can thus influence the importance of need as a consideration.

Potential Benefit

One of the most prevalent and least controversial reasons for asserting that one person should get a contested resource over another is that the person can derive a greater benefit from the resource. And, given that medicine is primarily concerned with benefiting people through healing and the relief of suffering, that someone can be benefited by a resource seems a good reason to give it to them. But it is not so simple. What counts as a benefit and how can benefits be quantified in such a way that a benefit to one person can be said to be a greater benefit than a benefit to another? And how important is benefit in determining a patient's claim?

1. What is a "benefit"?

Joel Feinberg provides a general definition of benefit: "to produce any kind of favorable effect on another's interest"^{lxxvii}. Feinberg recognizes that this definition encompasses a number of "senses" of benefit. Essentially, any intervention that improves one's situation over what it would have been without the intervention counts as a benefit. This includes situations where a person's interests are furthered beyond a normal baseline or a status quo of sorts such as when one has medical assistance losing weight. Also included are situations where a person is prevented from falling below that status quo such as when one's infection is treated. And there are also situations where a person is prevented from falling farther below that status quo than he or she would have without the benefit such as when a disease progression is slowed. Thus, sometimes simply maintaining the status quo is beneficial when the alternative is getting worse.

In the medical context, an assessment of benefit is often complex; sometimes, such as when one undergoes chemotherapy, harms must ensue in order to obtain a benefit. And just as people have various kinds of interests (health interests, economic interests, etc.) that comprise a person's set of interests, there are also social, economic, emotional, physiological and psychological benefits¹⁵. This list is meant to be an illustrative, not exhaustive, list of possible areas in which people's interests may be affected in a clinical context. And not all of the factors that determine what interests might be favorably affected are strictly clinical factors. Consider the widow having hip surgery. The type of social support network she has in place will strongly influence her discharge plan and the possible long-term success of her surgery. And favorable clinical outcomes might also have unfavorable social or economic outcomes, e.g., when an expensive intervention that drains a man's savings renders him unable to pay for medications that he needs to manage his condition.

One might argue that in the clinical context that is the focus of this project, medical benefit as understood by immediate physiological indicators should be the only kind of benefit that matters since the medical establishment is not in the business of solving the social and economic ills of people; it is in the business of caring for their medical interests. But to take this view is to take a narrow view of the consequences of medical intervention. Certainly, people do not go to the hospital for childcare or because they need help filling out their tax returns. But being diagnosed with a disease, sustaining an injury, falling ill and the variety of other medical problems that people do seek medical help for all have social, emotional and economic implications as well as

¹⁵ In what follows, I combine physiological and psychological benefits under the heading of medical benefits. By doing so, I do not mean to imply that medicine should only be concerned with physiology and psychology.

medical ones. And, as the above examples illustrate, these factors can have a major effect on the amount of even strictly medical benefit derived from a medical intervention.

In addition to the complexity due to the wide affect of medical intervention in so many aspects of life, there is the additional complexity that comes from the concept of benefit itself. Bentham identifies seven factors that are relevant to a calculation of the value pleasures and pains. Though Bentham's purpose is to determine which action would bring about the greatest balance of pleasures over pains, his value calculus can be helpful here in determining the value of various benefits. Bentham includes intensity, duration, certainty, propinquity (how close the pleasure or pain is in time and space), fecundity (whether one can expect more pleasures to follow a pleasure or more pains to follow a pain), purity (whether one can expect pains to follow a pleasure or pleasures to follow a pain) and extent (the number of people who would benefit)^{lxviii}. For the purposes of the current project, this list can be pared down a bit. Intensity, duration, certainty apply to the current project and fecundity and purity can be discussed best in the medical context as the type of benefit one hopes to accrue since it simplifies matters to think of the complex consequences of medical interventions not as generators of pains and/or pleasures but of medical outcomes and the process of generating these outcomes of as a package of events, some of which cause pain and some of which improve a patient's condition. Propinquity makes less sense in the current situation, except as either an influence on intensity or as part of the overall package of type of benefit. Extent of the benefit will not be considered in this section because if "extent" is meant narrowly, then only the one patient receives the benefit of the intervention: the

patient. Understanding “extent” more broadly to encompass all of those who are affected is a much larger issue and is addressed in other sections, particularly the section of responsibility to dependents. Thus, the four fundamental factors in determining the potential benefit of an intervention are: the probability that the expected benefit will accrue, the expected length of the benefit, the quantity of the benefit and the type of the benefit expected.

Probability of Benefit Accruing

In deciding whether a person (or which person) should be given a resource, one can only consider *potential* benefit since one can only guess about what will happen in the future, however much confidence one might have in the prognosis or however educated the guess may be. There is uncertainty about what benefit might accrue, the amount of benefit that will accrue, the amount of time the accrued benefit could last and about how likely it is that any of this will happen. Consider, Mrs. Smith, the widow who has hip replacement surgery. After surgery and physical therapy, there are several benefits that might accrue, including a reduction in pain and an increase in mobility and each of these can be realized to a certain degree and there is a certain probability that any of this will happen. She may be able to walk unaided and without pain or she may only achieve a reduction in pain while still having significant mobility issues. Or, she may achieve none of these and the surgery may fail entirely and leave her with increased pain and reduced mobility.

In one sense, determining the probability is a simply probability calculation. The probability, P , that Mrs. Smith will achieve a certain level of either pain reduction, R , or increased mobility, M , is $P(R) + P(M)$. The probability that she will achieve a

certain level of both R and M is $P(R) \times P(M)$. However, in order to generate any useful information from these equations, both $P(R)$ and $P(M)$ must be determined and this is where difficulties arise. Medical probabilities are not like the probability that a person will roll a 6 on a fair die because the parameters are not fixed, as they are with a fair die. Certainly, patient outcomes can be informed by research data about how many patients achieve pain reduction and increased mobility and to what degree but for an individual patient such as Mrs. Smith, this information is but one factor considered by the prognosticating physician. The other factors are more idiosyncratic, such as Mrs. Smith's specific condition and any comorbid conditions she may have, the skill and experience of the surgeon and the care team, the type of hip replacement device, and so on. This is further complicated by the fact that not all relevant factors are strictly physiological. Compliance, support systems, economic situation and so on can all affect the likelihood that the benefit accrues. If a patient is unwilling or unable to follow the necessary treatment plan, including taking medications on schedule, making follow-up appointments and so on, then the benefit is less likely to fully accrue. Also, more involved or prolonged treatment regimens are easier to follow if a patient has a support network that can help with transportation to doctor's appointments, remembering to take pills and buoying the patient's spirits. Emotional support is important because a patient's attitude can also have an impact on the effectiveness of a treatment. This list is clearly not a comprehensive one of all the things that impact the probability of a benefit accruing. Determining the likelihood of a potential benefit accruing depends upon all these things and others that are entirely context-dependent.

But the list given above does illustrate the main areas that determine the likelihood that a particular benefit will obtain.

In many cases, physicians will have a pretty good idea about the prognosis because of their experience and the knowledge base about a certain intervention or disease process but this is not true in all cases. Ultimately, this problem is irresolvable since there is no way to know the future with perfect certainty. Instead, the level of confidence one has in the probability calculation should influence the role that benefit plays in determining a patient's claim; the more confidence the care team has in the patient's prognosis, the more important potential benefit can be in a discussion of a person's claim. Thus, any probability calculations (and numbers discussed below) are based on clinical judgment and, as such, are estimates and should be taken as such with the weight accorded them proportional with the confidence in the prognosis probabilities assigned.

Length and Quantity of Benefit

Length of benefit, on its own, is fairly straightforward. The idea is that if two people will get the exact same benefit from a particular intervention except that one will benefit for a longer amount of time then the person who will benefit for longer will obtain a greater benefit from the intervention. This is fairly intuitive; when a person is in pain it is clear that they derive a greater benefit from a treatment that provides pain relief for a longer period of time than a treatment that provides pain relief for a shorter period of time. However, there are two important caveats to this. The first caveat is the same uncertainty that plagues calculations of probability; no one can predict the future and there are many physical and medical factors that determine how long a patient will

benefit and even if all of the factors can be identified, patients will get infections, fail to thrive inexplicably or even get hit by a bus leaving the hospital. Because of this, length of benefit calculations must also be taken as probability calculations are: as inherently uncertain with the weight given them proportional to the confidence in the prognosis of length.

The second caveat is that, though the intuition to think that longer is better, especially with regard to life itself, this might not always be the case. Saying that, *ceteris paribus*, sustaining a benefit for a longer period of time is a greater benefit than sustaining a benefit for a shorter period of time does not imply anything at all about the benefit of keeping someone alive. On the superficial level, this issue is not so much a problem because the first assessment should always be to determine if something is a benefit and only then the length of that benefit. A patient who is in intractable pain and has slim chance of recovery might not see continued life as a benefit if it cannot include relief from pain or a patient who can no longer perform basic functions such as going to the bathroom, feeding him- or herself and so on might not think that continuing life in that state has any benefit. As Gems points out, “What is immortality to Sisyphus but the cruelest element of his punishment?”^{lxxxix} Gems also reminds us of the myth of Tithonus of Troy, who Zeus granted eternal life without granting eternal bodily integrity and so he wasted away eternally^{lxxx}. Keeping someone alive longer is only a benefit if any continued life is actually a benefit to that patient.

In some respects, length of benefit is just a component of quantity; generally speaking, an overall greater amount of the benefit accrues the longer the benefit accrues. If a person receives one dollar every day for ten days and another person

receives one dollar a day for twenty days, the person who has \$20 has a great amount of money. However, the duration of the benefit is not the same as the quantity, since the quantity also refers to the intensity of the benefit. Intensity refers to how much one's interests are advanced beyond what they would be without the intervention, in Feinberg's terms, and can be described as the magnitude of the benefit. Crudely, in utilitarian terms, intensity is the number of utiles that accrue from a given action; if relieving the pain of one person's paper cut yields 5 utiles and relieving the pain of another patient's bone cancer yields 500 utiles, then the intensity of the benefit from relieving the bone cancer pain is significantly greater than the relief from paper cut pain. And it is fairly intuitive to claim that the greater the intensity of the benefit, the greater the benefit overall and, in most cases, especially involving pain relief, it is probably correct. However, there are often costs associated with these gains that would blunt the intensity of the benefit. For example, increasingly the dose of morphine for a patient with chronic pain would certainly increase the pain relief but there are also side effects, including depressed respiratory function; increasingly the pain relief maximally might actually harm or even kill the patient. The entire picture of an action's consequences must be looked at in order to determine the quantity of a particular benefit.

Type of Benefit

Type of benefit refers to what it is that a medical practitioner tries to bring about by doing a medical intervention, e.g., saving a life, relieving pain, curing an infection, etc. In the section on need, I argue that there is no distinction in importance between the inherent needs qua needs. The argument is that the perceived differences in importance

between the ends are actually differences in benefit and these differences might either reflect the quantity of the benefit or the type of the benefit. This is a difficult question to address because in some cases the quantity of the benefit can only be determined with reference to the type of benefit because some types of benefit are generally thought to be more valuable than other types. *Ceteris paribus*, saving a life will always be a greater benefit than saving a finger, but the issue is what is doing the theoretical work? It may simply be that certain types of benefits so often generate a greater quantity of benefit that they are considered more important as types when the real importance comes from the quantity of benefit. But it may also be that the quantity of the benefit is so much greater *because* certain types of benefits are more intrinsically valuable. Part of the difficulty in teasing this out is that quantity and type of benefit are inextricably linked and there is a real danger of falling into a chicken-egg debate.

An additional problem is that there is no theoretical consensus regarding what counts as a “good” for human life. There are three main types of theories of the good for humans: mental state theories (e.g., hedonism), objective list theories, and preference-satisfaction theories. On mental state theories such as hedonism, things are good insofar as they generate pleasurable mental states. Objective list theorists such as Arneson and Nussbaum argue that what is good for a person (and for people generally) is good independent of people’s attitudes towards it. Some of the challenges to such theories have been aired during the discussion of inherent needs, which are rooted in objective list theories of the good. On preference-satisfaction theories, something of value has occurred when your preferences have been satisfied. Like mental state

theories, preference-satisfaction theories of the good are strongly subjective and depend upon the life goals and plans of the individual person.

Fortunately, the present problem does not require solving the problem of human good or adopting any of these theories because at this level of specificity, all of the theories will yield the same results. As Schermer points out,

Most, if not all, theories on well-being agree that [the shape and content of 'the good life'] depends in large part on personal features and on the individual point of view of the person whose life it concerns. For example, if deep personal relationships are a component of well-being, then it depends on the person in question and on her circumstances...what counts as a deep relationship, with whom such a relationship can be established and what needs to be done to establish or maintain such a relationship. It also depends...on this person's own preferences how much deep personal relationships contribute to her well-being, relative to other goods...Even objectivists...do generally believe that on a more concrete level a person's own opinions and preferences matter in determining what enhances her well-being.^{lxxxii}

Nussbaum, for example, lists among her list of capabilities for the good life "bodily health"^{lxxxiii} (as do most, if not all, objective list theorists) but leaves it to the individual to determine the value of various elements of bodily health and the relative importance of these in his or her life. A preference-satisfaction theorist, such as Schermer, can make this move a bit more directly by claiming that the value of a particular medical benefit (and indeed whether it is even a benefit at all) is determined by the person's (perfected) preferences.

Thus, the value of certain types of benefits will be subjective valuations in the sense that the actual value of outcome of a medical intervention is determined by the individual. This is because the value of any benefit that might accrue is tied to the identity and life plans of person who might accrue the benefit and so the same type of benefit may offer a different quantity of benefit or be more important depending upon personal identity and life plans. For example, suppose that two people have the same infection in a leg, one an Olympic sprinter and one a paraplegic. No one denies that losing a limb is a horrible experience, but curing the infection without the amputation

would certainly give greater advantage to the interests of the Olympic athlete since, if her leg were amputated, it would be a major setback of her interests and life plans. The paraplegic, however, would already have life plans that did not involve the use of the leg. Thus, the quantity of the benefit of saving the leg would be greater for the Olympic sprinter than the paraplegic because the type of benefit (saving a leg) is more central to the identity and life plans of the sprinter than to those of the paraplegic and the to lose the leg would be a much greater detriment to the sprinter's interests than to the paraplegic's interests.

The subjective value of a potential benefit also shows itself when the type of benefit is different. Suppose that Chris, a professional ballet dancer, needs surgery that is expected to prevent her from becoming quadriplegic and Dave, a longtime PVS (persistent vegetative state) patient, needs surgery that will save his life. For Chris, the type of potential benefit from the surgery is prevention of quadriplegia and the quantity of that benefit is extremely large since, as an active person who relies on physical activity for her profession, becoming a quadriplegic would be extremely detrimental to her interests. For Dave, the value of continued life in a persistent vegetative state is at least controversial. For many people, biological life in a PVS has little value and so the surgery would only offer a small quantity of benefit. Of course, many people think that all life has intrinsic value and so would argue that the surgery for Dave would be a large benefit. This, however, does not necessarily imply that certain types of benefits (particularly continued life) are more important than others. What this can mean is that there is such a high value placed on life by those people (even if not by Dave) that continued life always yields a large quantity of benefit.

By assessing the type, length, quality and probability of the benefit, one can determine how great the benefit is. Of course, these three factors will not always agree and no one of them trumps any other, but all four factors inform the determination of the greatness of the benefit. A patient could have a high probability of obtaining a minimal quality benefit that will last a long time, a low probability of obtaining a high quality benefit that will not last very long and so on. The benefit to a person cannot really be quantified (even though probabilities are given in percentages, the importance to a patient is not a numerical value) and there is no calculus for determining exactly how great a benefit is. Certainly a benefit that is long-lasting, high quality and has an excellent chance of obtaining is a greater benefit than a short-term, low quality benefit that has minimal chance of obtaining but, in general, the determination will depend on the facts of the particular situation and the reasoned judgment of those making the decisions.

2. Why include potential benefit?

Potential benefit should certainly be considered when determining a patient's claim to a resource. After all, if a resource is given to someone who simply cannot benefit from it then the resource is simply wasted and by strengthening the claims of those who have the greatest potential for benefit, we get the most "bang for our buck" out of a medical resource.. Indeed, few people if any argue against considering potential benefit even if there are smaller disagreements about calculating the extent of the benefit. Even among those who advocate for entirely equal distribution systems, such as a lottery, most

advocate narrowing the pool of potential recipients to those who can benefit from the resource.

3. How will it fit with other considerations?

The importance of benefit as a consideration can vary. Certainly, it should be taken as more or less important depending on the level of certainty there is about the prognosis. If the probabilities are mere guesses and no one is quite sure what will happen, then not much importance can be attached to potential benefit when determining a patient's claim. The more certainty about the prognosis, the more important benefit is in determining who should be given resource. Also, considering potential benefit strengthens a claim proportionally with how great the potential benefit is; greater benefits strengthen a claim more than smaller potential benefits.

There will certainly be a tension between potential benefit and other considerations. Interestingly, accepting a potential benefit criterion could indirectly introduce an age criterion, since length of benefit is one of the factors that determines potential benefit and, all else equal, young people can benefit from a resource longer since they will live longer. Also, because the potential benefit criterion is predominantly efficiency-driven and patient-focused, it will conflict with any consideration that is more equality-driven (such as wait time) or other-focused (such as responsibility for dependents) but will likely be in accord with other efficiency-based considerations. And there will likely be conflict with both need and urgency. Need and benefit are tied together because one can not need something if one cannot benefit from it but this does not mean that need and benefit will always support the same course of

action. Indeed, someone may very easily need something that has little potential benefit. And the tension with urgency comes because those whose situations are more urgent are sometimes significantly less likely to benefit.

Urgency

When a person asserts a claim to a scarce resource because the person “needs it more”¹⁶ or “can’t wait for it”, the person may be making a claim based at least partially upon considerations of urgency. There is little literature that addresses urgency specifically, since urgency is often (and unconsciously) rolled in as part and parcel with benefit or need. In order to assess urgency as a consideration in its own right, it must first be determined what exactly urgency means independently of other considerations before arguing that it is an independently justifiable consideration and discussing how it fits with other considerations.

1. What is urgency, particularly in relation to need and benefit?

Urgency recognizes that there is a limited amount of time to act in some situations; an urgent situation is one that calls for immediate action in order to accomplish a goal before the point in time arrives at which it is no longer possible to accomplish that goal. For example, suppose a woman is bitten by a snake whose venom is fatal unless the antidote is administered within one hour of being bitten. This is an urgent situation because it requires the immediate action of acquiring and administering the antidote in order to accomplish the goal of saving the woman’s life before the hour is up. Once the hour is up, the woman’s life can no longer be saved and that is why the action must be immediate. As such, urgency is a function of time, specifically, of how much time is

¹⁶ Actually, when a person claims that someone “needs it more”, he or she could mean any number of different things. But one thing they may mean is that the person needs it more than someone else because the person has less time, e.g. to live, than someone else. It is this understanding that will be the focus of this section.

left to accomplish one's goal before the time endpoint is reached. Of course, in many situations exactly how much time is available will not be known. Suppose that the woman is bitten but she and her party do not know that the antidote must be administered within an hour to save her life; they may only know that it must be administered within some time period, or that it must be administered "soon". Even if the woman and her party do not think the snake is remotely poisonous, the clock is still ticking whether they know it or not. The fact of not knowing does not make the situation any less urgent.

Urgency is usually discussed as a part of an amalgamation of need, benefit or both concepts and not as a separately justifiable concept in its own right. Understanding the limits of these three concepts would be helped by a discussion of what each brings to the table. Kilner, for example, combines urgency, need (which he considers a factor that justifies considerations, not a consideration in its own right) and one aspect of benefit (continued life) under the heading of "Imminent Death". And when urgency is discussed separately from need and benefit, the meaning of urgency is not always conceptually separated from need or benefit or its relationship to need and benefit is not explained. Winslow, for example, couples urgency with need without either defining one in terms of the other or discussion how they are related, both in his discussion of triage and in his enumeration of the principles for triage. Thus, the relationship between urgency and need and urgency and benefit must be understood.

Such a connection could quite easily lead to the conclusion that urgency is a function of need, benefit or both. After all, urgency (only) represents a limit on how much time one has to satisfy a need or accomplish a benefit. As such, it does not make

sense to try and explain urgency as a separable concept from need or benefit; it only makes sense to talk of an urgent need or an urgent benefit. However, this argument confuses contingent concurrence with conceptual dependence. The connection to benefit and need is not inherent to the concept of urgency but is due to human nature. It would be extraordinarily rare for a person to seek to accomplish something or satisfy a need for something that is purely harmful (even a sadist or a masochist derives the benefit of pleasure from the harm of pain and one who bedevils his enemies derives pleasure from the suffering of those enemies). Suppose, for example, that a man is offered an investment opportunity and he is given only 10 minutes to decide if he wants to buy in. Now, the man knows with 100% certainty that the business will fail and that, should he invest in it, he will suffer substantial financial harm. Nonetheless, though he anticipates no benefit and only harm from investing, the man chooses to buy in anyway. It then becomes a matter of urgency to get ahold of the person in charge of the investment opportunity so that he can buy in. Now, this example is quite farfetched because it is quite unlikely that anyone would seek to do something that they know for a fact will only cause them harm with no corresponding benefit whatsoever. People generally do not seek pure harm. However, the example illustrates the theoretical disconnect between urgency and benefit. It is a matter of urgency to contact the man in charge of the investment opportunity even though making the investment is not a benefit in any way.

Additionally, urgency attaches not merely to the attainment of the goal but also the actions taken to accomplish the goal. In the above example, the time constraint is not merely on the buy in but also on contacting the person in charge of the investment

and arriving at an agreement about the terms of the man's investment. As such, urgency is a factor of the situation in which the need satisfaction, benefit attainment or other goal accomplishment takes place. Thus, there is no urgent need, urgent benefit or even urgent goal but an urgent situation, which encompasses not only the goal but also the actions taken to accomplish the goal.

A situation is not necessarily urgent from its inception, but the question of at what point a situation becomes urgent is a difficult one. A situation that is not urgent may become so and a situation that is currently urgent may have started out not being urgent; immediate action may not be required if one's deadline is in the distant future but as one comes closer and closer to that deadline the situation becomes urgent and increasingly so. Not all situations involving deadlines are cases of urgency since not all deadlines require immediate action to be taken in order that they are met. There is, however, no equation that determines the point at which a situation becomes urgent particularly because urgency is highly dependent upon the context of a specific situation, specifically on what action needs to be taken, how long that action takes, how much time is left until the point past which the goal can no longer be attained is reached and so on. Additionally, urgency is not a threshold concept; that is, a situation can be more or less urgent and as the designated endpoint draws nearer and the goal is not attained. Suppose that a woman is in a car accident that severely injures her leg and she will lose her leg if she does not have surgery within two hours. In such cases, the situation is quite urgent from the moment the woman's leg is injured; surgery is required *soon* to save her leg. In other situations, such as if the woman needs surgery sometime in the next couple of days instead of the next couple of hours, having the

surgery may get put on a back burner because there is plenty of time before the deadline to save her leg is reached. But as more time passes with the goal as yet unattained, more immediate (and possibly more frenzied) action is required and the situation becomes increasingly urgent.

There are many ways to relieve this urgency, though not all are available in every situation. First, one way is simply to take the necessary action to attain the goal; once the woman receives the surgery and her leg is saved, it is no longer a matter of urgency to save her leg. Second, urgency is eliminated when the designated endpoint is reached and the goal is not attained. If the woman does not receive surgery in time, the goal of saving her leg is rendered moot and it is not a matter of urgency to do what cannot be done. A third way of relieving urgency that is not available in all situations is to somehow change the endpoint, or buy oneself more time. It may not be possible to buy more time to save the woman's leg, but in other cases this is certainly an option. If a person severs his finger in a construction accident, putting the severed finger on ice may buy him more time to get to the hospital and get the finger reattached than he would otherwise have had if he had not put the finger on ice. A fourth way of relieving the urgency of a situation may be to change the goal one is trying to attain. Changing a goal may relieve or increase urgency, depending upon the context of the situation. Suppose that the car accident victim has other significant injuries and that the doctors realize that if they focus on saving her leg she may very well die of her other injuries and so they change the goal to saving her life but not her leg. Suppose the actions needed to save her life are not needed as urgently as those needed to save her leg and so the urgency of the situation is relieved somewhat by the shift in goal.

The situation is urgent because the medical facts of the case limit how much time there is to accomplish the goal but even in the clinical setting this is not always the case. Consider that two people are on dialysis and both urgently need a kidney transplant. A man needs the transplant urgently because his last site for an arterio-venous fistula has failed and the woman needs the transplant urgently because she will be fired from her job and lose her health insurance if she has to continue taking time off because of dialysis and its side effects. In the man's case, the urgency comes from the medical facts of the case; he must now receive dialysis through a catheter, which puts him at increased risks of infection and he may even die without the transplant. In the woman's case, the urgency does not come from the medical facts of the situation but from the economic facts of the situation; she will suffer economic collapse if she does not get a transplant soon. The woman's situation is no less urgent because it is not made urgent because of the medical facts of the case but by the socio-economic ones. In both cases, immediate action is required in order to prevent harm to the individuals; the different nature of the harm to each does not make the situation less urgent but affects the benefit that each would receive from the intervention.

Urgency and need are often combined into one concept that is expressed by the idea that one person is "needier" than another or that someone "needs something now". But understanding need in the way discussed in the section on need makes urgency and need conceptually separable. The definition of urgency is that immediate action must be taken in order for a goal to be attained. And since there are no constraints on the selection of the goal, the chosen goal need not be something that is needed. True, it is often the case that the goal to be attained in an urgent situation is the satisfaction of a

need and all of the above examples of urgency are cases in which the satisfaction of a need is urgent. However, just as not all cases of need are cases of urgency (the need for surgery sometime within the next four months, for example), not all cases of urgency involve needs. Suppose that a Jimmy, a 48 year old man, presents to his primary physician with a rare kidney infection. If the infection stays in the kidney, which is its typical course, then the only clinical symptom is that the man's urine turns an alarming shade of chartreuse. If the infection spreads, it can cause flu-like symptoms for two or three weeks and then clear up on its own. There are several treatment options to prevent the spread of the infection, including a variety of antibiotics and surgical removal of the kidney. However, it is Friday and the local hospital's entire surgery department is leaving early the next morning for a conference and a covering surgeon will be available only for emergencies, which Jimmy's infected kidney is not. If they wait until the general surgery team returns, the infection will have already either spread or cleared up, rendering surgical removal of the kidney moot. So if Jimmy and his physicians opt for kidney removal, they will have to do it today. Now, Jimmy does not need the surgery; indeed, given the risks of surgery (and only having one kidney) versus the limited side effects of the drug alternatives and the fact that there is a good chance that the infection would even clear up on its own, surgery is not the best treatment option. But because if the surgery is going to be done it has to be done now, it is a matter of urgency. Thus, while urgent situations can (and maybe often do, especially in the medical context) involve need satisfaction, need and urgency are conceptually and functionally separate concepts.

Urgency is also closely linked to benefit, though these two concepts are also entirely conceptually separate. The example of Jimmy's infected kidney can illustrate this as well. It is not clear that surgery would be beneficial for Jimmy, since, on balance, the risks of surgical intervention would almost certainly outweigh the benefits by a large margin. In a strict sense, Jimmy would receive the benefit of the infection not spreading since the site of the infection had been removed. However, the risks and harms of the surgery so far outweigh that benefit, especially given that it can be achieved through other simple and far less risky means, it is hard to say that he would receive an overall benefit. That being said, there are no theoretical constraints on what that thing to be accomplished can be but what a person seeks to accomplish will almost always be something that he or she sees as a benefit (recall that "prevention of harm" falls under the heading of a benefit). Nearly every urgent situation will likely be one in which immediate action is required in order to obtain some benefit or other simply because the goals that people set tend to be beneficial in some way. Of course, some goals may have both harms and benefits associated with them (the side effects of chemotherapy are harmful but the therapeutic aspects can be beneficial), or may be a harm that will bring about a benefit (amputating a person's leg in order to stop the spread of gangrene, ultimately saving the person's life), but the ultimate benefit in these situations is what the person seeks to accomplish.

There is one final complication to the relationship between need and benefit and urgency: even though urgency is conceptually separate from either need or benefit, it does rely on its relationship with need and benefit for its moral force. If Jimmy were to enter the hospital and declare that it is a matter of urgency that he have his kidney

surgically removed, he would be correct. However, if the surgery is neither needed nor particularly beneficial, it is hard to see how the urgency matters in any way, morally. Thus, urgency can only have an affect on claims that feature need or benefit.

2. *Why consider urgency when evaluating claims?*

There is an important practical reason that could favor an urgency consideration: if a resource is given to the people for whom getting the resource is urgent before it is given to those for whom getting the resource is not urgent then more people will get the resource than if the resource is given to those for whom getting the resource is not urgent before it is given to those for whom getting the resource is urgent. This is because the time may run out for the people whose situation is urgent before the resource is given to them in the time it takes to give it to those whose situation is not urgent. Suppose, for example, that in the above example of the woman in the car accident, there is another person, a man, who is injured and who needs surgery but his surgery is not urgent. Provided he has surgery sometime in the next several days, he will not suffer any ill effects. Now, suppose the hospital only has one surgical team available and will not have another available for three hours. If the surgeons operate on the man first, only he will get he surgery he needs and she will lose her leg. However, if the surgeons operate on the woman first then both the woman and the man will get the surgery they need and recover fully.

The idea that fewer people will die without treatment if the most urgent and severe cases are treated first is compelling indeed and is evident in numerous emergency triage policies. To be clear, triage itself is simply a method of sorting

patients into treatment categories that is seldom based solely upon urgency. Military triage, for example, has in the past prioritized those who can immediately be returned to the fighting even if others are in much more dire straights^{lxxxiii}. Also, Stedman's Concise Medical Dictionary defines triage as "medical screening of patients to determine their relative priority for treatment; the separation of a large number of casualties...into three groups: 1) those who cannot be expected to survive, even with treatment; 2) those who will recover without treatment; 3) the highest priority group, those who will not survive without treatment"^{lxxxiv}, which is a division based solely upon need and benefit. However, treatment policies in emergency rooms across the country that state that more serious and more urgent cases will be seen before others regardless of wait time and old M*A*S*H reruns that display triage of surgical patients in the compound testify to the use of urgency (in combination with benefit) as a criteria for further sorting those who fit in Stedman's third category, just as in the example of the car accident above.

One place where urgency has been given a seminal place is in the distribution of livers for transplant by the United Network for Organ Sharing (UNOS). Of course, needing a new liver and the potential to benefit from a transplant is what gets a person on the transplant list in the first place, but among those on the list the only consideration that takes priority over urgency is that the blood type of the liver is a match to the recipient. Aside from that, urgency is the decisive consideration used in the distribution of livers. UNOS uses a Model for End-Stage Liver Disease (MELD) score for patients

over 12 years old as a determinant of how likely one is to live three months¹⁷. The scores range from 6-40 and are calculated from three lab values: serum creatinine, bilirubin, and INR (an indicator of the liver's ability to make blood clotting factors). The higher the MELD score, the sooner the patient is likely to die and so the situation is more urgent for people with higher MELD scores. Livers are thus distributed to the person among the blood type matches with the highest MELD score. The justification that UNOS offers for implementing a system based predominantly on urgency is just the consequentialist justification of aiding more people and indeed, since the implementation of this system in February 2002, UNOS reports a decrease in the number of people who die while on the waiting list^{lxxxv}.

There are two key problems with this system and they are the problems associated with accepting urgency as a consideration. The first problem is a theoretical problem with the justification of employing urgency as a consideration. The prevailing justification for the use of urgency as a consideration is the consequentialist justification that (*ceteris paribus*) treating the most urgent cases will result in more people being treated overall. And this is true in all but one important case: when the resource that is to be distributed is finite and scarce and once the resource is used no more will be available. Consider the system for the distribution of livers by UNOS. One key reason that UNOS is able to aid more people by implementing an urgency criterion is because transplantable livers, while scarce are constantly coming available and by giving these to the most urgent cases they are able to catch more people before they die on the waiting list. If, for whatever reason, the removal of organs from living or dead human

¹⁷ Children under 12 years old are scored using the Pediatric End-Stage Liver Disease (PELD) model, which adds growth failure and age at listing to the calculation. For simplicity, I will leave out transitions from PELD to MELD and other complications and only discuss the MELD system.

and human-like creatures were to suddenly become illegal and UNOS would only ever have the finite number of livers, say fifteen, it happens to have taken just before the new law were to go into effect, only fifteen people would be able to undergo a transplant whether the livers are given to the most urgent cases or not. In cases where the amount of the resource on hand is all that is likely to be available, the consequentialist justification for urgency does not hold since more people are not aided.

The second problem is the practical problem that, despite the hope that prioritizing people whose situations are urgent will reduce the number of those who are not treated, such a system is likely to be quite inefficient. This is readily apparent in the UNOS liver distribution program. It is true that under the MELD score-based system, fewer people die on the waiting list. However, because priority is given to the highest scores, people generally do not get livers until their situations are quite urgent because they are more seriously ill. And, unfortunately, the sicker one is, the less likely he or she is to survive the rigors of a liver transplant. A study of one year post-transplant survival outcomes by Saab, et al. found that “patient survival was worse with higher MELD scores”^{lxxxvi}. Another study published a year later by Northup and Berg found that, while patient survival outcomes are unrelated to the amount of change in one’s MELD score in the days or weeks prior to transplant, one’s MELD score at transplantation was still the significant indicator of mortality outcomes^{lxxxvii}. Thus, it is true that more people are able to have access to livers but by the time they are badly enough off to get them, their chances of surviving have decreased.

3. Should urgency be accepted as a consideration?

The case for accepting urgency as a consideration is a strong one. In the case of the woman who must have surgery to save her leg after a car accident, we really do think that she should have surgery before the person who can wait and we think this for reasons that are not captured by appealing to benefit or need or anything besides the fact that she needs it *now* and, though he needs it, he does not need it immediately and he will not have a worse outcome for having waited. If one person can wait for the resource without having his or her outcome adversely affected and another cannot, the person who cannot wait should get to go first. And that is what is so compelling about urgency and why it should be accepted here.

And the problems that arise are not insurmountable. The first problem points to the inability of the consequentialist justification to justify giving a resource to the person for whom it is (more) urgent when there is simply no more of the resource. This does not rule out urgency as a consideration but merely points to the fact that urgency cannot be the only consideration because it does not apply in such a situation. If three people need a thing and one of them needs it within an hour, the second needs it within two hours and the third needs it within four hours and there is only one of the thing and there will not be another for several days, then urgency cannot help determine which of the three people should get the thing. But if another thing will come available in three hours, then the decision is between the two people whose situations are more urgent, since the third person can now wait. The scope of urgency as a consideration, then, is limited to situations where the resource may be limited but it has not run out and there is a chance of getting more of that resource.

The problem of inefficiency can also be overcome by acknowledging that other considerations should be employed. In situations where the person whose situation is less urgent *will* be adversely affected by waiting, then other considerations come in to play. Urgency should be checked against, especially, benefit and need in order to prevent the rampant inefficiency that could result from giving priority to those whose situation is the most dire. Urgency will also likely conflict with equality-based considerations, such as responsibility for dependents, since such considerations will blunt efficiency concerns.

Age

The idea that one's age can alter one's claim to a resource is a widespread one. Kilner reports that "88 percent of renal center directors consider age a legitimate consideration" and that "57 percent [of physicians] consider age a very important consideration in deciding which of two patients is to receive the last available bed in the ICU (with a much higher percentage according the criterion at least some importance)"^{lxxxviii}. The general idea behind an age consideration is that being older or younger (depending upon the particular situation) affects one's claim to the resource in question purely in virtue of their age.

1. What does an age criterion look like?

An age consideration is appealing for a number of reasons. It is easy to assess and apply; that is, one can easily determine a person's age and then distribute the scarce resource to the appropriate person. Of course, the closer in age the competitors for the resource are, the less significant the age consideration will be in one's reckoning. Suppose the choice is whether to provide a resource to a 35 year old or to a 36 year old. In this case, age is not going to come into play much, whereas it would if the choice is between, say, a 25 year old and a 75 year old. The strength and importance of an age criterion in making distribution decisions will vary by case.

An age criterion often manifests itself as age limits on particular procedures but introducing an age consideration does not imply that age limits will be instituted for different treatments. If one were to institute age limitations on certain treatments, such

as the understood age cut-off of fifty-five years old for a heart transplant^{xxxxix}, then one would have to justify the age chosen as the cut-off. If the cut-off is fifty-five years, is it really the case that a 54 year-old patient has a significantly better prognosis than a 56 year-old patient? The difficulty with utilizing age limits is that the limit itself is typically arbitrary and one has to justify the choice of one limit instead of another. Of course, accepting an age criterion does not mean that one has to institute age limits on treatments. An age criterion simply states that, *ceteris paribus*, the resource will be distributed according to the competitors' ages. In this way, the age criterion can be relative; one can compare the ages of the patients to each other. One can see patients not as too old or too young for a resource but as older or younger than the other competitors.

A second assumption in discussions on age is that an age consideration favors the distribution of resources to younger patients. However, it is important to keep in mind that an age criterion does not always reduce the claim of those who are older; in some cases, younger people's claims are at issue. For example, a number of researchers advocate excluding the very young from renal dialysis because of concerns about the effect of dialysis on children's physical development and doubts about whether children would comply with the strict diet and other difficulties of those undergoing dialysis^{xc}.

2. *Why consider age when evaluating claims?*

The initial plausibility of an age criterion is readily apparent. The reason most often given for favoring older people over young people are that the very young cannot withstand the rigors of difficult treatments. Reasons given for favoring younger people

over older people are that more life years are saved when the young are saved, the elderly have already lived a great portion of their lives, the quality of life of the young is generally better than the old and there is a series of arguments about greater potential productivity¹⁸ (and the resulting contribution to society) of younger people than of older people. Almost every proponent of an age criterion appeals to one of these justifications.

However, these explanations are not explanations of an age criterion. Applying an age criterion based on these considerations runs into two interconnected problems. The first problem is that an age criterion is not what is being applied; for example, the justification that younger people should get a resource before older people because the young have more life ahead of them than older people is actually a length of benefit consideration. Likewise, the justification that the very young cannot withstand the rigour of difficult treatments is actually a prospect of benefit consideration; the quality of life justification is just that- a quality of life consideration; and the productivity justification is simply a productivity consideration. Instituting an age criterion would thus add a layer of needless complication to the matter.

The second problem is that appealing to other considerations in order to justify the age criterion is unjustified because these other considerations are not age-dependent and do not vary directly with age and so would not justify applying an age criterion. We can all come up with (not-so-outlandish) cases where the older person will be the one with the greater prospect of benefit, where the very young person would be better able to withstand the rigors of a particular treatment better than an older person, where

¹⁸ Kilner lists potential productivity as a justification of age in its own right (op. cit. 79) but he misses that potential productivity is a consideration of its own, like prospect of benefit and length of benefit,

the elderly patient has the better quality of life and so on. Now, it is true that, generally speaking, a younger person will live longer than an older person (thus allowing for greater productivity for society, longer prospective benefits, etc.) but age is only one determinant among many. Consider the justification that younger people are likely to live longer and then suppose that two people are admitted to a hospital, both needing a type O negative blood transfusion. One is a fifteen year old with leukemia and a very poor prognosis; the other is a sixty year-old car accident victim who is in otherwise good health. An age criterion (justified by a concern for length of benefit) would simply be counterproductive here since the car accident victim is likely to live another decade or two, at least, while the girl with leukemia is likely to only live another year at most. If the point of applying an age criterion is to distribute resources to people who are most likely to accrue longer benefits from those resources, then it fails in this case because length of benefit is not dependent upon age.

There is one justification of an age criterion in its own right that has been discussed extensively in the literature: age group or generational equality. This justification does not apply to arguments about weakening the claims of the young; rather, this justification focuses solely on the reduced claims of older people. Now, it seems odd to say that an age criterion would promote equality. It seems *prima facie* likely that an age criterion would be a form of age discrimination and therefore break down equality because it would favor giving resources to the young over the old. Most commentators, however, point out that age discrimination is different from other forms of discrimination based on group membership because, unlike race or gender, we all get to be in the privileged group (the young) and most of us can expect to be in the

underprivileged group (the old)^{xci}. If everyone gets a chance to be in privileged group and most also grow into the disadvantaged group, it is not clear that there is any unfairness. It is important to note that these theories of equality would not justify withholding treatment from the very young, only from the elderly. After all, one cannot argue that everyone has a chance to be in the advantaged group (the young) if the claims of the very young are diminished because of their age.

Indeed, there are a number of arguments from equality that support an age consideration. First, it has been argued that benefits (in this case, medical resources) should be equalized over lifetimes; that is, instead of comparing people at particular times, one should consider the benefits and resources accrued in the totality of that life. Regarding this, Cupit points out that applying an age criterion "may affect when, within a lifetime, benefits come; but it need not affect the level of benefits one person has compared with another"^{xcii}. Such a criterion has the additional practical benefit that "concentrating benefits in the early years of people's lives will tend to equalize lifetime benefits between people who will live to different ages"^{xciii}.

However, this understanding of equal distributions seems to require that the relevant comparison be between age groups and not individuals. Since the concern is with some kind of equal distribution of resources over a lifetime, it makes much more sense to compare individual consumption than the average consumption of an age group. Recall the above example of the leukemia patient and the car accident victim. Suppose that the sixty year-old car accident victim has lived quite a healthy life and has only been hospitalized briefly once before after a construction accident, whereas the leukemia patient has undergone two years of extensive treatments. Now, if one is

concerned with distributing resources equally within whole lives, it seems that the older person should receive the transfusion because he has received fewer resources over the course of his life. While it is true that a disproportionate amount of healthcare resources are consumed by the elderly and that living longer gives one more time to have consumed resources, simply having lived longer is no indication that one will have consumed more resources.

Additionally, simply because the car accident victim belongs to a group (older people), the members of which tend to use more medical resources, is no reason to diminish a particular member's claim to the resources. After all, even if low-income people tend to commit more crimes and if there are two people who could have committed a crime, there is no reason to arrest the person with the lower income simply because she has a lower income and low-income people tend to commit more crimes than higher income people. Nothing in anything thus far explains why "older" or "younger" is a morally relevant kind for equal resource distribution, especially considering there are plenty of cases where individual older people have used fewer medical resources than individual younger people. If the concern is about equalizing resources or welfare (whichever way this is to be interpreted) over a lifetime, then one should compare individuals, not the groups to which those individuals belong.

But there is another way that the argument to equalize benefits over time might be understood: instead of equalizing benefits actually accrued, suppose that what should be equalized is the amount of time that one has had access to a resource, whether that person has used the resource or not. Older people, clearly, will have had more years of access to the resource. There is one practical problem with this assertion. When a new

medical technology comes out, a five-year-old will have had the same number of years of access as the ninety-year-old man. The only person who can claim that she has not had as many years of access to a new technology as another person is a person born after the technology comes out. The same problem can play out a number of ways. Suppose someone is sixty years old but has recently emigrated from country in which he did not have access to even basic medical care. A ten-year-old who was born and raised in the United States, then, would have had access to various resources for a greater number of years than the immigrant. And even in the United States, access to medical care is not guaranteed; some people, in virtue of poverty, geography or whatever simply do not always have access to much beyond basic medical care and sometimes not even that. The point is that one's circumstances, not just one's age, determines one's access to medical care.

It is true, however, that the cases described above probably represent a small number of exceptions; age does generally determine how much access one has had to resources. But there is a more pressing problem: specifically, why does it matter if someone has had access to a medical resource for seventy years if one has not needed the resource until now? Suppose an older gentleman is arrested and at the jail and, for the first time in his life, he requests a criminal lawyer. The detective tells him that he has had access to a lawyer for decades and so he does not get one now. Lawyers are for younger people. Having access to the lawyer for decades does not help the gentleman now. Likewise, having access to medical care for years does not matter if one does not have it when one needs it. Access to resources is only helpful to a person who has to use those resources. This is especially true because medical resources cannot be stored

up or saved for the future like food or money. Having access to money, food or other retainable goods allows one to build up a nest egg against the day when those things are no longer coming in. Conversely, having access to medical resources when one does not need them does not give a person the opportunity to store up such resources. So it is not clear why access to resources over time is something that should be equalized.

A more plausible justification is the “fair innings” argument. There is strong intuitive appeal here because living longer is *ceteris paribus* of value. On one understanding of this statement, if it is valuable to live more years, then the person who would live the longest after the resource is given should receive it. This is simply the length of benefit consideration again. Another reading of this statement is that the resources should be given to the young in order to equalize people’s opportunities to live beyond their youth or live a normal length life. The idea is to attempt to reduce the impact of losses in the natural lottery (or simple bad luck) by prioritizing the young; it should be noted that this does strictly prioritize the young over the old. Suppose two patients, one who is 20 years old and one who is 50 years old both need a new cancer drug and the prognosis for both is the same. With the drug, each is expected to live five more years but without the drug each will die in a matter of weeks. Because production has not gotten fully underway, there is not enough of the drug for both patients. The 50 year-old has only had 50 years of life already and the 20 year-old has only had 20 and so to give the extra five years to the 50 year-old would be to give more years to the person who already has more, increasing the inequality of years lived. In terms of life years, since the 20 year old has fewer and the 50 year old has more, then the 20 year old is the least well off in terms of life years. Following the “fair innings” argument, the 20

year-old should get the drug since the extra five years represent 25% more life for the 20 year-old and only 10% more life for the 50 year-old.

But why does the difference in percentage matter so much? If a bag of potato chips says "Now with 15% More", you get more chips. But in this case, both the 25% and the 10% will only ever be five years in absolute value; the extra 15% does not get you more years. The years are not longer for the young person than the old person. Giving five more years to an older person over a younger person is also not like giving an extra \$100 to a rich person over a poor one. What about being younger makes the two years more valuable, or what about being older makes the two years less valuable? One reason that more years of life are valuable is so that we have more time for life projects, relationships, accomplishing goals and so on. A person who is older may (or may not) be farther along in these projects and indeed an older person may have undertaken more relationships and projects than a younger person. To reduce this complicated picture of life to a person's age is a vast oversimplification.

Or, another reason that a person might value life is if life is intrinsically valuable. If this is the case, then it is still not clear why treating people as equals would require that those five years be distributed to the younger person. If life is valuable in and of itself independent of life experiences, then it is equally valuable for older person and the younger person. The Rawlsian might argue that because the older person has more years than the younger person, the younger person is less well off with regard to life years. And it is by definition true that older people have lived more life years than younger people. But the difference that the 20 year-old gets 25% more life does not equalize or improve his or her opportunity to live to a ripe old age since he or she will

only live to be 25 years old. The new cancer drug is not a cure; the 20 year old will not have an opportunity to live any older than 25.

3. Should age be a consideration?

I strongly suspect that the appeal of applying an age criterion is because of its connection with so many other intuitively plausible considerations such as length of benefit, productivity or social contribution, quality of life and so on. It is also a nice bright line that can be drawn. When the age criterion is analyzed in its own right, however, it is difficult to justify. Considering age when it is a determinant in other considerations, such as length of benefit or likelihood of benefit, is perfectly appropriate because it does affect those things. But that does not justify an independent age criterion. It may be that looking at other considerations that go to a totality of a person's life leads to younger people tending to receive a greater share of the resources, but a person's claim should not be diminished because of age.

Ability to Pay

One constant in all health care is that no matter what the treatment in question, it costs money. Even when the resource in question is donated, as are blood products and organs, there are still costs associated with the utilization of the donated resource, such as physicians' and nurses' time, sterile equipment, anti-rejection drugs of organ transplants, heart-lung machines that pump blood and so on. And the money to pay for such interventions has to come from somewhere. Unfortunately, the large cost of most medical interventions (especially life-saving interventions) is much more than what most people can afford to pay out of pocket; with the enormous cost of medical treatment, it is not just the poor who are unable to pay for care. Increasingly, higher income families are faced with bills they are unable to pay. Many people rely on health insurance, but a 2003 study found that 35% of people ages 19-64 were either uninsured or underinsured (had insurance insufficient to protect patients from amassing catastrophic medical bills)^{xciv}. If a patient cannot pay for his or her treatment, then the cost of treatment must be either paid for by taxpayers via government programs, be borne by the hospital or the patient must go without. The question then arises, when one must decide between patients, should a patient's being able to pay (either out of pocket or through adequate insurance coverage) or not for the treatment in question affect his or her claim to the resource?

1. What does the ability to pay criterion encompass?

In the strict sense, ability to pay is simply that- one's ability to pay for one's medical expenses, whether by paying out of pocket or by paying for medical insurance (including Medicare). However, discussions of this consideration often range beyond this more strict understanding of ability to pay and may encompass any expenditure a patient may make in obtaining a limited health resource^{xcv}. Often, ability to pay is confused with other pecuniary activities such as monetary donations to healthcare institutions generally, for awareness campaigns and/or medical research, for organizing blood drives or advertising for organ donors or one might simply bribe the doctor or allocator. And all of these are ways that monetary expenditure might influence one's access to a particular resource in different ways. However, all of these are examples of considerations entirely different from one's ability to pay one's bills. The case of giving money to fund awareness campaigns and research is an example of past (and possibly continuing) contributions. Equipment and monetary donations to specific hospitals are also examples of past (and possibly continuing) contributions unless there are strings attached to the gift, in which case it is likely a contractual issue. And by funding blood drives and advertising for donors, a patient increases his or her chances of getting a resource either by finding donors to donate specifically to that patient or by increasing the amount of the resource available.

They are also examples of expenditures over and above the simple paying of bills and, as such, are completely different issues. In the case of ability to pay, the issue is that healthcare costs money and someone has to pay; if it is not the patient, then it has to be the hospital or, ultimately, taxpayers via government funds. In the other above cases, the issue is not one of who pays but of whether or not additional contributions or

efforts can strengthen one's claim to a resource. If a person does not make these additional expenditures but pays for his or her care, no one else is left holding the bag. Thus, the ability to pay consideration does not encompass all monetary expenditures but only those expenditures made to cover the cost of one's own care. These expenditures may take the form of simply paying cash out of pocket (including cash that comes from donations from friends, family and community/charity groups) or through insurance programs. Those without the means to pay out of pocket or who are underinsured and cannot cover the expenses their insurance does not cover are not able to pay.

2. Why accept or reject an ability to pay criterion?

There are two issues that arise with an ability to pay consideration. First, should ability to pay affect a patient's claim to a resource and, second, if so, does one's ability to pay strengthen or weaken the patient's claim? The answer to this latter question may seem obvious in the current climate of cash-strapped medical facilities and increasing healthcare costs, but there are arguments on both sides of that issue. However, the former question must first be resolved.

There are, of course, numerous arguments regarding the validity of an ability to pay criterion but the individual arguments generally coalesce into a few main arguments on either side of the issue. The arguments for rejecting an ability to pay criterion tend to be person-oriented in nature, claiming that a person's value is not determined by his or her bankroll and that health and healthcare are so intrinsically necessary in life that it is inappropriate to withhold medical treatment because of one's inability to pay. Wealthy people are not more entitled to life or to be accorded greater respect and

dignity simply because of their wealth because it is humans qua humans that have equal intrinsic value and that are deserving of respect and accorded dignity, not wealthy humans or poor humans. Depriving people of needed medical treatments because of their financial status, then, inappropriately devalues the less wealthy because of their lack of wealth. These sentiments have a strong pull and have been crafted into legislation such as the Emergency Medical Treatment and Active Labor Act (EMTALA), which requires Medicare-accepting hospitals to provide emergency and/or stabilizing care to patients regardless of their ability to pay.

Of course, the leap from “people are inherently equal” to policies like EMTALA, which ensure the very basic minimum of healthcare to everyone, requires a bit more explanation. Unsurprisingly, most studies of monetary impact on health find that those without insurance (and are thus more likely to do without healthcare) have worse overall health outcomes^{xvii}. And, with the exception of cutting short a person’s life, nothing limits a person’s life prospects as much as having poor health since at least some level of good health is instrumental in pursuing the good life, whatever that may be. Access to at least a minimum level of healthcare This does not entail that everyone is entitled to those things that are necessary to achieve their visions of the good life but that they should not be cut off from the pursuit itself. However, this line of argument is open to the objection that it goes too far. It entails not only that people have a right to a basic minimum of healthcare but also that they have a right to have losses in the natural lottery offset using whatever amount of healthcare is necessary to preserve their lives and bring them to a certain level of functional health.

There are, of course, other arguments in support of a right to a basic decent minimum of healthcare, but arguing whether or not people have such a right is beside the point of the present project. There are practical realities to consider. Even accepting the idea that human beings are equally intrinsically valuable qua human beings and, as such, should have access to (at least a certain level of) medical treatments without regard to ability to pay, the world is not an ideal one. The reality of the matter is that healthcare costs money and there is not an infinite supply of money. Certainly, giving one person a scarce resource means it is not available for the others competing for the resource but the potential problem is that by distributing scarce resources without regard to a patient's ability to pay could affect the care and treatment of people other than those competing for the resource since any treatment that a patient receives that he or she does not pay for contributes to this financial problem. If medical facilities treat all patients without an eye to the economics of the situation, then the hospitals and the government (through programs and subsidies) will have to eat the costs of the care for those who cannot pay. And the result of hospitals and governments bearing the costs of so much expensive care is compromised care for everyone (since less money means less up-to-date facilities, fewer doctors and nurses, and so forth) or an overall lack of access to medical facilities in places where the financial outlay versus income is untenable. As much as we may value human beings qua human beings, the current cost of medical treatments makes giving free medical treatment to everyone who cannot afford it financially impossible. And, since money (or lack thereof) is often (at least partially) behind a scarcity of medical resource, it makes perfect sense to distribute resources according to who can pay for them.

This practical concern is sometimes coupled with a more person-oriented, Nozickean, appeal to freedom of choice^{xcvii}. People choose what to spend their money on and have the freedom to buy medical insurance or save money for medical needs. Those who have chosen not to spend their money on medical goods have made their beds, so to speak. This argument freedom argument is flawed because, in order to be true, one has to make several questionable assumptions. The level of freedom (specifically of choice) and the amount of (presumably monetary) resources one must have to have that high level of freedom are unrealistically high. The presumption is that everyone has a real option to be covered medically, whether through purchasing medical insurance, saving sufficient funds to cover oneself medically, or by taking a job with great benefits. Some people choose not to go this route. But for the choices a person makes, everyone could have bought insurance or saved against a future catastrophic health problem.

But this is simply not the case. Certainly, in the case of any given individual, he or she could have worked hard and gone to college and majored in a field (such as engineering or pre-medicine) or learned a trade (such as a mechanic or electrician) that offers a good prospect of a high salary and a job with good benefits. But even this does not take into consideration the realities of many people's family, social or economic situation, or even an individual's talents, from the outset. If unfavorable, these areas of a person's life can put up legitimate barriers to education and jobs with good benefits. And even if all individuals can choose their paths in life despite possible barriers from one's family, social class, economic status or individual talents, it is not the case that everyone can obtain the financial resources or good job necessary to have the level of

freedom necessary to make such choices that the argument asserts. After all, even if *anyone* can be a doctor, it does not follow that *everyone* can. Someone has to grow the food, get it to the store or restaurant, manufacture the laundry detergent, teach the children, etc. In order to support a culture in which professionals exist, there has to be an entire support network that frees the professional class from doing the work their family needs done, such as growing and harvesting food, teaching children, etc^{xcviii}. And in order for those who perform these tasks to have the level of (financial) resources to make the kind of freedom the argument assumes possible, products such as food would have to cost exponentially more than they do and all prices would rise drastically. And even wealthy people may be underinsured in the event of catastrophic illness. The actual level of freedom all people can possess combined with the exorbitantly high cost of medical treatment makes this argument unworkable in this context¹⁹.

So it comes down to whether or not the concern for the value of people qua people trumps the practical realities of the situation. The practical concern is that in the absence of major health care reform hospitals will have to cut back on services and staffing to stay solvent which would result in less or compromised care for everyone. It is because of this impact on others that ability to pay should be considered. When a patient does not pay for health care and receives resources, not only are those resources no longer available to others, which is generally the outcome when a resource is used,

¹⁹ This kind of argument has been much more successfully employed as an objection to single-tiered health care systems such as Canada's. See, for example, Krohmal B. Access and ability to pay: The ethics of a tiered health care system. *Archives of Internal Medicine*. 167: 2007. Pp. 433-437 and Engelhardt HT. Why a two-tier system of health care delivery is morally unavoidable. In Strosberg M, et al. Rationing America's medical care: The Oregon plan and beyond. The Brookings Institution; 1992: 196-207.

but also care is compromised a bit more, or other patients will pay more for their insurance premiums to cover the difference to maintain the level of care. The point is that not only does a no-pay patient reduce the amount of resources available by using resources, but by not paying for them, that patient also reduces the level of care for everyone or causes others (insurance companies, employers, taxpayers) to have to pay more for the level of care to be maintained. This is a kind of double hit to those who either find lesser care for themselves or have to pay extra, since the pay patients have not only lost the competition for the resource in question but then also have to pay for it, either with greater monetary expenditure or with compromised or less care. Thus, not only is it more efficient to consider one's ability to pay, but making some patients take a double hit is also inconsistent with treating people as equals.

There is an important argument against this line of reasoning that should be mentioned. Returning to the issue of a right to a basic decent minimum of health care, the argument is that if a certain level of care is guaranteed to everyone, costs would be kept down because everyone would have access to primary and preventative care, earlier diagnosis, earlier intervention, etc. and all without using the emergency room as a primary care clinic. It would be cheaper and more efficient to offer the basic decent minimum of care. Though this argument is not generally employed to address the particular problem at issue here, it implies that the argument about compromised care due to free riders on the system would no longer be a problem^{xcix}. There is thankfully no need to debate the economics of the situation, though, because, once again, this argument misses the point. If everyone is guaranteed a basic decent minimum of health care, then there is some entity (e.g., the state, Medicare, the British National Health

Service, etc.) that is paying for the care. If it is guaranteed, then it is paid for and ability to pay is a non-issue because someone is paying for the resource. The argument from the basic decent minimum does not address the current reality of the situation which is that people in the United States are generally not guaranteed a basic decent minimum of health care.

3. How does not specifically considering ability to pay affect a patient's claim?

Considering ability to pay does not, however, leave the poor and uninsured entirely without access to health care. The key justification for considering one's ability to pay is the impact that a patient not paying has on others, so a no-pay patient's claim is only weakened to the extent that not paying actually has a detrimental effect on others. Not all treatments have the same cost or impact on hospital budgets, or on the availability of resources for others. And many charities provide some money for indigent care. The point is that not being able to pay does not bar someone from receiving a health care resources; being able to pay is not a necessary condition for obtaining health care or scarce resources.

This does, however, raise a related issue. If the justification for considering ability to pay is that failure to pay (ultimately) results in compromised care for everyone, then it seems that someone who is willing to pay more than his fair share in return for a strengthening of his or her own claim, (ultimately) raising the level of care for others, should be able to make such a deal. In some cases, this is fairly easy to accept: consider a wealthy dialysis patient who offers to pay for an additional dialysis

machine and the staff to run it if he or she can use the machine at his or her convenience. Others clearly benefit from the greater availability of dialysis and no one is really made worse off by the deal. It is simply a good deal. More problematic are people who simply offer to pay more for their treatments in return for special consideration. The best answer to this is that, just as not being able to pay only weakens a claim to the extent that not paying would have a detrimental effect on others, paying extra should only strengthen a claim to the extent that it has a beneficial effect on others. In some cases, this beneficial effect will be more pronounced or more clear (as in the dialysis example) but in some cases it will be merely a drop in the bucket and difficult to quantify what beneficial effect it actually confers.

Considering ability to pay certainly opens up potential conflicts with such considerations as need and urgency. Because those who lack the funds to pay for health care often put off seeing a physician or are diagnosed later, they are more likely to have more serious conditions. Additionally, considering ability to pay as a separate criterion makes it count double, in a sense, since one's ability to pay affects not only the initial treatment but also all associated medicines, treatments and follow-up care including travel to and from appointments, parking, time off work and so on. People who can afford all of these peripheral expenses are more likely to realize the full benefit of a treatment; people who cannot afford these things are less likely to benefit from treatment. The ability to pay criterion is also likely to dovetail with a conservation criterion insofar as the impact on those others is to deprive them of health care or treatment they would have had if the no-pay patient could pay and this can set up a competing claims situation.

Responsibility for Dependents

The idea that having responsibility for dependents can increase a person's claim to a resource is different from other considerations. Other considerations are concerned with particular patients and are grounded in medical facts about the patient (e.g., the urgency of the patient's situation) or about a patient's own actions and goals (e.g., past donations). But this consideration involves concern for people other than patients; the concern in this case is for the people who are dependent upon the patients.

1. What does it mean to be responsible for dependents?

Though there are various arguments supporting a dependency consideration, most have at their heart the realization that patients are not isolated and complete entities unto themselves; patients exist in a complex web of relations and what impacts individual patients has a kind of ripple effect of impact on others. In one sense, this is trivially true since, if a patient dies, close friends and family grieve, uncompleted work may have to be shifted onto others, employees may have to find new jobs and so on. But to be dependent means that one relies on another for some form or level of support, sustenance or care and there must be some sense in which only that person can supply that kind of support, sustenance or care. For those who are dependent on the patient, the impact of a patient's death or disability is especially pronounced because poor outcomes for the patient result in a serious downgrade in the quality of life for those who are dependent upon the patient.

The parent-child relationship is the paradigm of this consideration and for good reason. Minor children are, to varying degrees, physically, psychologically, financially and possibly spiritually dependent upon their parents. Very young children cannot feed or clothe themselves and they certainly cannot get jobs to pay for things they need. The relationship between a parent and child is the central relationship in children's lives.

But it seems that the reason that the parent-child relationship is the paradigm case is not because of the people entering the relationship but because of the many modes of dependence at work in the relationship. If children were able to fend for themselves and the culture were such that children were raised by the community group and not by parents, the specific parent-child relationship would be devoid of dependency. It may still be special, or have meaning, but it is the modes of dependency that are operative in the relationship that make it the paradigm dependency relationship. Thus, since it is modes of dependency that matter in dependency relationships, then any relationship in which the dependency exists matter for evaluating claims. It does not make sense, as some do, to limit the dependency consideration to only the parent-child relationship.

There are numerous modes of dependency, including financial, physical and psychological. But the congregants of a small church may be spiritually dependent upon the church's longtime pastor and the lives and safety of some people may be dependent upon a certain politician's ability to maintain a delicate truce between two warring factions. The question is whether all of these different modes of dependency matter for evaluating claims; to determine this, they should be checked against the justification for considering responsibility for dependents in the first place. Considering responsibility for dependents is justified because of the serious and detrimental impact

losing the person upon whom a person is dependent has on the interests of that dependent. Modes of dependency that matter morally are those that would seriously harm the interests of the dependents if they would no longer be fulfilled.

Physical dependence clearly meets this, since if one is physically dependent on another, then the dependent depends upon another for the very conditions of life, such as food, shelter and security. Elderly, incapacitated parents may be physically dependent upon a child who cares for them, as they are not able to care for themselves. Should the child no longer be able to care for the parents, they may be sent to a nursing facility where the level of care cannot meet that of the personal care they had received from the son or daughter. The other modes of dependence mentioned are murkier. In each, there are clear cases where a dependent's interests would be severely harmed by losing the person on whom he or she is dependent. An older employee who has worked for the same family business for his entire working life might be financially dependent upon his employers and a loss of financial security affects so many aspects of one's life and enables a person to maintain a certain quality of life. And, in cases such as the one with the politician whose diplomacy holds together a fragile peace, it is clear that the very lives of numerous people are at stake.

But there are cases that seem counterintuitive. A person might be financially dependent in upon a patient because the dependent is blackmailing the patient. Psychological dependence and spiritual dependence also admit numerous of these types of cases. People do have unhealthy dependence relationships, which are chronicled not only in psychology literature but also in many books and movies. Spiritual dependence, in which people depend upon someone for their spiritual well-being, can fall under this

latter, unhealthy category. But there are also clearer cases; it may be the case that a particular group of worshippers is dependent upon a particular leader because she is able to reach them as others cannot or, more practically, may be the only spiritual leader who speaks the language of the worshippers. These difficult cases are still cases of dependence, so another criteria is needed to determine if a particular case of dependence is relevant to claims. What the problem cases have in common is that the dependence relationship itself is harmful to one or all of the people in the relationship. In the case of the blackmailer, the patient is harmed financially. In the case of the unhealthy psychological and spiritual dependence relationships, one or all of the people in the relationship can be harmed psychologically (such as when an adult child remains psychologically dependent upon his parent's approval a la *Psycho*) or spiritually (such as when a worshipper begins worshipping the leader). Thus, in order for a patient's responsibility for dependents to strengthen his or her claim to a resource, the dependent must meet the criteria for being dependent and also the dependency relationship must not be a harmful to the patient or the dependent(s).

Finally, the degree of dependence also matters. Dependence is not an all or nothing concept; there is a continuum of how dependent a person can be. The greater the degree of dependence, the more important dependence becomes when evaluating claims. Degree refers to both how many dependents are affected as well as how serious the harm to their interests is. Clearly, if one small business owner has five employees and another has fifteen, all other things being equal the patient with fifteen employees is depended upon to a higher degree than the patient with five employees simply because more people's interests are at stake. Determining the seriousness of the harm done to a

person's interests is not as straightforward. It involves an assessment of both what kind of harm is done and also the intensity of the impact of that harm. Harms to physical well-being will almost always be more serious than, say, financial harms simply because of the primacy of physical well-being. Food, shelter and physical security are necessary for the fulfillment of other, higher-order interests and thus have an impact on almost every aspect of one's life. Essentially, the greater the affect of losing the person on whom one is dependent is on more areas of one's life, the higher the degree of dependence.

2. What modes and degrees of dependency are morally significant?

There are numerous specific arguments put forth as to why dependency should be considered. However, as Winslow argues, the justifications for considering dependency are at root all consequentialist in nature since by considering dependents, decision-makers seek to maximize the well-being of all involved^c. These consequentialist arguments can generally be divided into two types, society-focused and person-focused. The society-focused arguments emphasize the benefit to society derived from a particular person and translate into a focus on the role that the patient plays in a dependency relationship. Society certainly benefits from minor children being raised, jobs being created and elderly parents being cared for by others. If the person with dependents is no longer able to provide for them, society must bear the responsibility of providing for the dependents; by saving the person with dependents, society is saved the burden of providing for those dependents. Minor children do not become wards of the state, Medicaid is saved expensive nursing home care and people

are kept off the unemployment rolls. This society-focused justification cannot be the entire justification because, in focusing on a person's role, it ignores the relationship between individuals in the dependency relationship. From a societal standpoint, as long as someone fulfills the role of parent, caregiver or business owner, the efficiency is maintained.

Suppose a woman owns a small, family-run business with several employees, one of whom is a 53-year-old man who has worked his whole life for the company. If the woman dies and the business folds, the man's pension would be at risk and he would likely have difficulty finding another job at the same wage level, given his age. He may never actually seek financial assistance from society (in the form of government programs), but his financial well-being is clearly at stake. He may have to take a job that pays less and work at it for more years than he otherwise would have had to to stabilize his retirement funds. This outcome is not problematic from a societal standpoint because society does not have to support the employee at any point. But the employee suffers a large blow to his financial well-being that represents a serious downgrade in his quality of life. From his standpoint, the outcome is certainly problematic. Focusing solely on society and the role the patient plays in the life of the dependent completely ignores the impact of patient care decisions on the dependents themselves. Indeed, from this society-focused perspective, a minor child's losing a parent is not problematic as long as there is a godparent or other relative willing to raise the child.

None of this is meant to deny that society does benefit from considering a patient's responsibility to his or her dependents in making decisions about who receives

a resource, nor is it meant to deny that these are good reasons to support a dependency consideration. The argument is rather that society-focused justifications miss the importance of the connections between people, which are provided by person-focused reasons. Together, these two types of reasons provide the justification for a dependency consideration. Recall that, in order to be dependent there must be a sense in which only the person upon whom one is dependent can supply that particular kind or level of support, sustenance or care. The sense in which only the particular person can do so is found in the particular relationships between people and a person-focused justification focuses on this relationship. Consider the minor child who loses a parent. Even if there is someone available to step in the parental role, the child will still experience psychological trauma and harm because in losing his or her parent, the child experiences the loss of that particular person and the parent-child relationship. The child may not suffer financially or physically in being raised by someone else but the psychological harm of losing a parent certainly represents a major downgrade in his or her quality of life. Likewise, the man in the above example who lost his job suffered the job he lost offered a certain level of financial security that he cannot find elsewhere. That which causes a downgrade in the quality of life for a dependent after the loss of person upon whom he or she is dependent does not result from losing the person in that role as parent or employer but rather result from losing a particular person or relationship.

And in these relationships, losing the person upon whom they are dependent represents a serious downgrade in the quality of life of the dependents. In the case of the employee, he loses his financial security, which in turn affects his other life

prospects. In the case of the minor child, he or she suffers psychological as well as financial harms. An elderly parent may suffer physical and psychological harm if he or she has to be placed in a nursing home after the loss of a caretaker child. These harms are more than grief. While grief is certainly suffering, the harms a dependent suffers are the result of a loss of financial, psychological, physical and so on support. And this is morally significant because, in losing the person upon who one is dependent, the dependent suffers real harms to his or her interests. Since such harms to others' interests can be the outcome of allocation decisions, they should be considered when making those decisions.

The most prevalent reason offered against considering dependents is the concern that the interests of dependents will be considered as at least equal to those of other patients. Kilner points out, "Whereas most people would agree that [dependency] relationships are quite important, the priority of these considerations over the very lives of patients is more debatable. Children indeed experience a significant loss when a parent dies; but the greater loss is that of a patient who must die if the parent is selected"^{ci}. Also operative in this concern is physician's obligation as a fiduciary of the patient since, while people other than patients may have a stake in the well-being of the patient, the interests of patients should come first. Considering dependents is especially problematic if the consequences of a patient not being treated are that the patient suffers serious disability or death which are, in many cases, much more serious consequences than those suffered by dependents at the loss of the person upon whom they depend. However, this criticism misses the point when the issue is distributing scarce resources because, no matter who receives the resource, someone will not. The question is

whether or not it is, *ceteris paribus*, morally significant that the harms the untreated patient suffers would be compounded by the harms his or her dependents suffer. Or, in cases where the patient is the dependent, the question is whether or not the possibility of imposing responsibility on a caretaker is morally significant and should factor in. The concern that the interests of non-patients being considered as on par or more important than those of patients is simply unfounded in scarcity cases.

Two related objections concern perfectionism and good parenting. The first objection is that allowing responsibility for dependents to increase a patient's claim to a resource is a form of perfectionism that values parents, business owners and others who have dependents more than those who do not. This represents a form of discrimination against those whose idea of a good life does not include having children (or who have already raised their children) or being in a position in which others depend upon them. The second related objection is that considering responsibility for dependents penalizes those parents who work to make their children independent and stable and rewards parents who raise needy and dependent children. Taken together, it seems that considering a patient's responsibility for dependents would encourage people to become parents (and bad ones at that) and find ways to make others dependent.

There are several responses to this. First, in response to the perfectionism objection, there are already numerous cases in society where parents, small business owners and so on are given special allowances, such as tax deductions and incentives for hiring more people. These are justified because it is generally good for society overall, in the case of child tax credits or deductions, that society be perpetuated and that children are not raised as wards of the state. In the case of business owners, it is

good for there to be jobs for people, as fewer people will then need public assistance, or not need as much public assistance. And, to some extent, the non-parent, non-business owning section of the population pays for this with taxes that are somewhat higher than they would be without the tax breaks and incentives for parents and business owners. Admittedly, paying somewhat higher taxes is not exactly analogous to suffering severe disability or death for lack of a particular resource but it is true that it is better for society as a whole if parents raise their children, businesses provide jobs and so on. But it is not only the societal benefit that matters. Since the driving justification for considering responsibility for dependents is the concern for the interests of all those affected by treatment decisions, this is not really a perfectionist consideration. The concern is not about encouraging people to adopt certain lifestyles or make particular choices, but about the interests and well-being of those affected by treatment decisions.

Besides, if the goal of considering responsibility for dependents were to encourage certain life choices, the results would surely be a mixed bag, as the second objection illustrates. Certainly, more people might seek careers such as “the only physician for two hundred miles” or “small business owner with numerous older employees” but parents also might think twice about encouraging little Bobby to overcome his separation anxiety. This objection does seem to overstate the impact that considering responsibility for dependents would have on people’s behavior. After all, there is a much greater chance that someone who is obese or is a smoker will have serious health problems from that than that a person will be in a situation where a scarce resource must be distributed and yet people continue unhealthy habits. But, of course, the second objection is not concerned about influencing (as the first objection seems to

be) but about people who have raised independent and stable children getting a raw deal where people who raise needy and unstable children being rewarded for it. This is a bullet worth biting, however, especially if it is tempered by the kind and degree of dependence considered.

3. How does responsibility for dependents fit in with other considerations?

Responsibility for dependents is not inherently tied to other considerations the way that, e.g. benefit and urgency are tied. As such, whether or not it agrees with other considerations or not is not a function of the considerations themselves but of the facts of the case. When a patient has responsibility for dependents, his or her claim will be strengthened but by how much will depend on how many dependents the patient has, the degree of dependence of those dependents and so on.

Desert

The idea that people should get what they deserve is a prevalent one that has spawned an enormous discussion in the justice literature. This is an intuitively powerful assertion since “to say that someone deserves something is to say that there is certain sort of propriety in his having it”^{cii}. Or, a person may be *undeserving*, in which case there is a certain propriety in his or her *not* having the thing in question. And there are numerous reasons that one might deserve (or not deserve) a particular medical resource, the main ones being: past contributions (of any kind), character, responsibility for one’s condition and compensation. But, while the idea that people should get what they deserve is intuitively plausible, whether and what role it should play in patient selection decisions is not so clear. Consider the following scenario: during a blood shortage, two people need blood transfusions and there is only enough blood to transfuse one of them. One of the people has been a blood donor for years and has donated gallons of blood while the other has only donated sporadically, if at all. One might argue that the donor deserves the transfusion in virtue of his past contributions of blood. But what about having given blood generates the donor’s desert of the current transfusion? And even if the donor does deserve the blood transfusion, does that desert mean that the donor should be given priority over the non-donor?

1. *What constitutes desert?*

There is very little consensus about what, exactly, it means to say that something is deserved. It is widely accepted that a desert claim is different from an entitlement

claim. Being entitled to something means that a person has met the sufficient conditions for having a right to that thing, such as when a competitor correctly spells the most words in a spelling bee. Then, she or he has met the sufficient condition (correctly spelling the most words) for winning the bee and has a right to the medal or scholarship or whatever the prize is for winning the bee. The winner is then entitled to the prize. But being entitled to something does not imply anything about desert; a person might be entitled to something but not deserve it and one may deserve something but not be entitled to it. For example, suppose a CEO's salary is \$250 million but during her leadership the company is run into the ground because of her lack of vision and poor performance. The CEO may be contractually entitled to the \$250 million but it would be hard to argue that she deserves it. Conversely, suppose that a hardworking and productive employee of the company has worked there for decades and makes a pittance; the employee may deserve more money but he is not entitled to it.

There is also general agreement about the basic structure of desert claims. Desert consists in a three-place relationship between the subject, the thing deserved and a desert basis (the reason the subject deserves the thing deserved). Thus, desert is of the form "P deserves x because of y" where P is the subject, x is the thing deserved and y is the desert basis. But, beyond these basic points, everything else, from the subject of desert to the maelstrom of disagreements surrounding desert bases, is contested. And, unfortunately, it is not the case that there are a few general standout theories around which ideas about desert coalesce. Instead, a person's theory of desert is a patchwork quilt made up of the positions he or she takes on numerous issues, ranging from free will/determinism to the nature of justice. It is not within the scope of this project to

engage all of these debates nor to articulate and defend a full theory of desert. Instead, in what follows I will present my working theory of desert and defend those parts that are especially pertinent in determining whether or not desert should play a role in patient selection decisions.

Because the present problem is the question of who should get a scarce medical resource, the question of who should be the subject of desert and the question of what is deserved are not at issue. The subject will always be the person claiming the resource; a person is the paradigm example of the desert subject. The question of whether or not animals or inanimate objects can be subjects of desert does not arise in this context, although whether or not animals are the subjects of desert may arise in research ethics or veterinary ethics. And the thing that is putatively deserved is the medical resource at issue. Some might argue that medical resources are not the kind of things that can be deserved. But this seems false. Other things that people need for wellness or survival are often said to be deserved. Indeed, the claim that someone deserves even life itself is not uncommon. And medical resources meet Feinberg's (and others') requirement in that they are "affective in character"; people desire and seek them and so they are generally looked upon with favor^{ciii}. So there seems to be no reason to exclude medical resources as things that can be deserved based simply on the nature of medical resources.

The pertinent questions, then, are questions about the desert bases. The desert bases are the justifications for desert and, as such, there are numerous views about what these bases can be. Like with desert in general, there are a few broad strokes of consensus on the desert bases. First, the basis for a person's deserving something must

be something about that person^{civ}. The allegedly deserving person cannot deserve something because of a quality of someone or something else; in a group math project, one teammate cannot deserve a good grade because of another teammate's hard work (though he may be entitled to it). Also, like things deserved, the desert basis must be something toward which we take appraisive attitudes^{cv}. The hardworking student may deserve the high grade because of her excellent work ethic, which is generally looked upon favorably, and the other student may deserve a low grade because of his inattentiveness and laziness, which are generally disfavored. Further, the quality of the deserving person must also be related somehow to the thing deserved. The hardworking student may deserve the high grade because of her strong math skills but she would not deserve a high grade on a math because of her lovely singing voice, which has nothing to do with math. A desert base must be an appraisable quality of the deserving person that is somehow relevant to the thing deserved. However, beyond this broad sketch, there is little agreement about what constitutes a desert basis.

One larger view of desert bases, institutionalism, states that what a person deserves is entirely dependent on the goals of the institution in which the desert claims arise²⁰. People thus deserve what they do because they forward the goals of the institutions that control the things deserved. For example, consider the Bowl Championship Series (BCS) in college football, which was instituted with the goal of determining the best team in college football. To this end, the BCS ranks teams and the two highest ranked teams play in a championship game. Since the goal of the BCS is to determine the champion, only the best team deserves to be the champion and only the

²⁰ Another version of institutionalism holds that what a person deserves is entirely dependent on the *rules* of the institution but this quickly collapses desert into entitlement. See Olsaretti, *op cit.*, p. 9.

two best teams deserve to be in the championship game. And, since the BCS ranking system does not necessarily pick the two unarguably best teams to play in the championship series, arguments that another team has been overlooked or underrated, or that the best team has simply suffered bad luck, make sense and go directly to the goal of the BCS. Thus, one can (and people often do) still make the intuitively plausible claim that some team other than the top two BCS-ranked teams deserves to play in the championship game.

There are a few difficulties with institutional accounts generally. First, Sher points out that institutional accounts of desert severely limit the notion of desert^{cvi}. Goal-based institutional desert by definition does not admit any desert claim that is not grounded in the goals of the institution. Returning to the BCS example, individual players and coaches cannot deserve anything in the BCS, only teams. And a team cannot deserve anything other than being in the championship game or being the champion. One cannot say that a particularly hard-working or sportsmanlike team deserves to win or that an arrogant, lazy player does not. An account of desert that does not allow for such desert claims limits the notion of desert to the point of being counterintuitive²¹.

But this may not be the case. Desert claims often arise in large and complex institutions that may not have a clearly expressed goal or that may have multiple goals (which may or may not be clearly expressed themselves) that may conflict. But the goals of more complicated institutions such as “society” and “healthcare” are not so clear-cut and are undoubtedly multifaceted. Additionally, all of these institutions (including the BCS) are embedded within larger societal institutions and rarely arise as

²¹ Sher (op cit., p. 15) also makes this point.

isolated and independent entities. The hardworking team may not deserve to be the champion because it is not the best but maybe being hardworking promotes the goals of society or of college athletics generally and so the team deserves to win vis-à-vis society or college athletics. Given the interrelatedness of institutions and their goals, it seems that the notion of desert is not so circumscribed as it may initially seem to be.

But this points to a new problem for an institutional account of desert. A proponent of this kind of desert theory would have to work out not only what the goals of society and healthcare are or should be but also how the goals of healthcare should or do fit in with the goals of society. This creates two serious problems. First is the problem of identifying the goals of the institutions. In identifying goals, one will have to strike a balance between identifying goals that are too broad and vague to offer any guidance and identifying goals that are too narrow to avoid inappropriate essentialism (even if multiple goals are identified). This is especially true of the larger, more complex institutions such as “society” and “healthcare”. And, since most, if not all, of the smaller, more focused institutions are embedded somehow in the larger, more complicated institutions, the problem of identifying the goal(s) of the larger institution is pervasive. The second problem is determining how all these goals, once identified, relate to one another. This complicates matters immensely. What if goals conflict? Which goals would take precedence? The goals of the most proximate institution or the most overarching? What if the desert claim arises within overlapping institutions? Without such an analysis that answers these and other such questions, a person’s desert claims could not be properly evaluated.

Of course, one possible response to this is to reject that all of the overarching institutions are irrelevant and only those which immediately give rise to the desert claims (that is, those that control the thing deserved) are relevant to desert claims. But there are two problems with this as well. First, Sher's initial criticism about counterintuitively circumscribing desert claims stands. Second, what reason is there to limit desert claims to the immediate institution given the fact that those institutions themselves arise within other institutions and so on? Taking this view (and biting the bullet with regard to Sher's criticism) simply ignores the fact of the interdependence and interrelatedness of institutions. To ignore this complexity and privilege the proximate institution without an argument as to why makes this a flawed approach.

Once the interdependence and interrelatedness of institutions is acknowledged, it is not clear that there would be any serious differences in practice between institutional accounts of desert and pre-institutional accounts (which hold that desert is independent of institutions) regarding what counts as desert. There is one serious exception. On an institutional account of desert, considerations of desert cannot shape the institutions because those institutions determine desert. This is not a damning criticism, per se, since one holding such a view might see this as perfectly acceptable. Rawls^{cvi}, for example, who does have an institutional theory of desert, is clearly invested in the idea that there is no desert outside of institutions because if it is the case that there is desert that is not generated within an institution, then his two principles of justice as fairness are clearly not the whole story. However, this problem is not especially relevant to this project because, even if an institutional account of desert were operative, healthcare as an institution is embedded within larger institutions (such as "government" and

“society”) and so even justice in healthcare can be constrained by desert because of the desert claims in these larger institutions. Since I do not believe there would be a practical difference between institutional accounts (understood with institutional interdependence and interrelatedness) and pre-institutional accounts and because delving into all the theoretical analysis necessary for an institutional account would be beyond the scope of this project, I will make my arguments from a pre-institutional view. Parallel justifications can certainly be offered from an institutional view.

A pre-institutional account of desert must find some other way to identify the morally appraisable quality of the deserving person and how that is properly related to the thing deserved. Given the complexity of desert claims, it is unlikely that any single principle will be able to ground all desert claims. Two of the more comprehensive and potentially helpful pre-institutional theories are those of Feinberg and Sher. Neither directly addresses desert of medical resources, though both have something to offer. Feinberg argues that there are different desert bases for different categories of “modes of treatment” (the things deserved). There is no single set of desert bases that can be applied to any mode of treatment because not all desert bases are relevant to all modes of treatment. Instead, he discusses five categories of modes of treatment (awards of prizes, assignments of grades, rewards and punishments, praise and blame and compensation, reparation and liability^{cviii}) and sets out appropriate desert bases for each mode of treatment. The appropriate bases for each treatment are appropriate for a variety of reasons and relevant to the desert bases in a variety of ways. In the case of prizes, desert is tied to the point of the competition for the prize, which is not unlike the institutional account above^{cix}. But in the case of compensation for injury, desert is tied

to atonement and “functions not only to repair the damage but ‘restore the moral equilibrium’”^{cx}.

However, Feinberg’s theory is not immediately helpful for the current project for two reasons. First, medical resources do not fit comfortably into any of Feinberg’s categories since it cannot properly be understood as a prize, grade, reward, informal response or always (or even usually) as compensation. This is not a major issue, as Feinberg does not claim that his categories are complete and adding medical treatment/resources as a category would be more of a friendly amendment to than a criticism of Feinberg’s approach. But the second problem is that, while he offers relevant desert bases for the various modes of treatment, he offers no explanation for exactly why it is that the particular desert bases are appropriate for those modes of treatment. For example, if an institutional approach is appropriate for determining the desert bases for competitive prizes, why is it not an appropriate basis for desert of praise or blame? Though his claims are intuitively plausible, the lack of a theoretical justification for his arguments makes it impossible to extrapolate his views into any other modes of treatment, such as medical resources.

Sher takes a different tack and focuses on the desert bases themselves and discusses what about desert bases makes them justify a person’s desert of a thing. Ideally, there would be a single elegant principle underlying all desert claims but, after unsuccessfully attempting to derive all cases of desert from the single principle of autonomous action, Sher concludes that different desert bases will have different values grounding them. This, he claims, makes sense; “because the notion of desert has probably evolved through a series of analogical expressions, there are unlikely to be any

strict necessary and sufficient conditions for its application”^{cxix}. Thus, the value of acting autonomously will ground some desert claims while the fact of being wronged or made to suffer will ground others and so on. In many ways, this is an improvement over Feinberg’s theory, since it provides theoretical justifications for why the particular desert bases ground desert claims and grounds the desert bases themselves in the values we find in various things such as a person’s autonomous action or his or her effort.

However, this theory is also not immediately helpful to the current project. Though it would seem easier to apply the justified desert bases to medical resources. But it is not that simple. Consider Sher’s discussion of grounding desert in autonomous action. Since we value acting autonomously, then people deserve the reasonably predictable (good or bad) consequences of those autonomous actions. But even this must be circumscribed since this would generate many and outrageous desert claims. Sher notes at least four cases where one does not deserve the predictable consequences of one’s free choices: when the consequences are “1) very easily acquired. 2) the disastrous results of merely careless acts. 3) the spoils of wrongful acts. [and] 4) the harmful effects of self-sacrificing acts”^{cxii}. This shows that the value of acting autonomously cannot simply justify a desert basis; the context of the situation is relevant as is a certain proportionality between the thing deserved and the desert basis. Thus, individual cases still have to be individually interrogated to determine if the value of the desert base applies in the particular situation.

Unfortunately, then, there is no “plug and chug” theory of desert that would help here. In light of this, the approach I will take will be a kind of hybrid of Sher’s and Feinberg’s approaches. Like Feinberg, I will start with the thing deserved and discuss

four possible broad categories of desert bases commonly asserted in the medical context that are qualities of the putatively deserving patient. In doing so, I will see if each desert base is appropriately connected to the thing deserved. However, unlike Feinberg but following Sher, I will interrogate these desert bases to determine what about them justifies the desert claim; that is, I will try to establish what morally appraisable value grounds the desert bases. The four potential desert bases are character, past contributions, responsibility for condition and compensation. Of course, all patients deserve some things, such as respect and care and there is a sense in which all deserve some medical resources—all simply in virtue of their humanity and suffering. The desert bases discussed below are those that would not generate claims true of all patients in the situation but that are above and beyond the general desert claims that could be made by all patients.

2. What could justify a desert consideration?

Character or Moral Virtue

One prevalent claim is that someone deserves a treatment because he or she is a wonderful person. One's character, then, is asserted a basis for deserving treatment. People with good characters are deserving while people with bad characters are not deserving (or, more severely, are undeserving). And, at least at first glance, this seems like a plausible claim. One's character is the quintessential morally appraisable quality of a person. But the connection between having a good character and medical resources is somewhat shakier. It is difficult to go from good people deserving good things to a good person deserving that specific thing. It is clear that virtuous people do

deserve some things, such as praise and, possibly, good citizenship awards, but these things are related to virtuous characters (good citizens have virtuous characters, we praise people for things we value, such as good characters) in ways that medical resources are not. However, there is a connection between the virtuous character and medical treatment if the claim is that that people with good characters deserve those things that make it possible to have a good life, even if they do not necessarily deserve everything that would make that life good. Medical resources fall into this category since receiving treatment promotes good health.

But there are some problems with this, even aside from the less than ironclad connection to the thing deserved. There is certainly a practical problem associated with this and that is the problem of judging a person's character. I am not asserting the relativist position that value is in the eye of the beholder, since there are certainly some virtues that valuable (honesty, fairness, kindness, etc.) and some qualities that are base (such as hatred, cruelty, dishonesty, etc.). There is little doubt that different people value different characters traits and some character traits can be valuable in some contexts and disvalued in others and even valued in some people and disvalued in others. But part of having a good character is being able to recognize what is appropriate and when, being appropriately kind, appropriately generous and so on. No, the problem is one of properly judging a patient's character. This is also not a question about how hospital personnel can accurately assess the character of, say, an unconscious patient or a patient they do not know well, though that is an interesting question. This is the broader question of how to identify those people of good character generally. No one is wholly good or wholly bad and almost everyone is a mix of saint and sinner.

Despite this, we can all think of people we consider particularly good or particularly bad. But we judge this based upon people's actions. If one's character is simply the sum of his or her actions, then the desert basis is actually one of past contributions, be they good contributions or bad contributions. If we are simply judging the net worth of a patient's actions and calling that "character", then we can move on to a discussion of contributions. However, this is not what most people think of when they think of character. Instead, the issue is more of personality, of one's heart and soul. And how do we judge that?

But these practical problems do not address the issue of whether possessing a good moral character is a basis for a claim of deserving medical resources. Sher argues that moral virtue can ground desert claims because the virtuous are worth more as persons than the non-virtuous or the vicious because the virtuous seek the right kind of value in the right kind of way and thus the objects of a virtuous person's endeavor have greater value. Thus, the success of their efforts and the satisfaction of their desires are simply worth more than that of an ordinary person^{cxiii}. Thus, virtuous people deserve the medical resources because the medical resources would promote the health of the virtuous person, which would satisfy their (more worthy) desires and allow them to continue seeking higher value in their lives.

But one need not accept the perfectionist claim about the worth of virtuous people to accept that the virtuous do indeed deserve the medical resource that would promote their health and well-being. After all, there is a value in good things happening to good people and that value is in the sense that there is kind of order to the world in which working hard and being virtuous can result in a good life. There is a kind of

fittingness between being good and getting good in the same way that there is a kind of fittingness between being the fastest runner and winning the race. Circumstances may intervene (even good people get sick and many an excellent runner has tripped during a race) but the notion of desert is what captures that fittingness. And since health is a prerequisite for many of the goods in life, it makes sense that the virtuous person would deserve those things necessary for a good life.

So if good people deserve the medical resource, do bad not deserve it, or deserve not to get it? There seems to be no reason to assume that if character counts for the good, it should not count for the bad. After all, the same arguments about worth or fittingness can be applied to vicious people as well as virtuous ones; it is, after all, equally fitting that a bad person gets what is coming to him or her. But, as I stated above, people deserve certain things, such as care and consideration, simply in virtue of their humanity and suffering. Because of this, bad people may not deserve to get a particular resource, but they do not deserve to not get the resource.

Personal Responsibility

The idea that a person's being responsible for his or her own condition (or for making it worse by not complying with doctors orders) makes it so that he or she deserves not to be given a resource over someone who is not responsible for his or her own condition.

This would mean that people who attempt suicide, accidentally overdose on illegal drugs, go into diabetic comas for not following their diets and so on are *undeserving* of being given scarce resources. Like the character issue, there are certainly practical problems associated with this claim as well. Establishing a smoking gun causal link between a person's actions and his or her health is often difficult since connections

between the two are often statistically linked. And it is certainly an open question to what extent an addiction (such as smoking) or mental illness (such as depression) mitigates responsibility for one's actions. However, as above, these problems do not get at the heart of the matter, which is the question of whether or not personal responsibility for a condition can justify a claim of undesert.

This potential desert basis also seems to fit the profile of an acceptable desert basis. A patient's own actions are certainly qualities of the (putatively undeserving) person that are morally appraisable. And, unlike the connection between character and medical resources, the connection between a patient's actions and medical resources is clear, since the intentional actions are what created the situation that made the patient seek the medical resources. The connection to the person is not simply that he or she has acted in some way to bring about the condition from which he or she suffers. If this were the case, then the undeserving would include those who lose control of cars and wreck them and those who eat things to which they are unknowingly allergic and have a reaction. The cases that are at issue are the ones where a person's intentional actions have resulted in a reasonably foreseeable consequence. If the actions were not intentional or if the consequence were unforeseeable, the person would not be morally responsible for his or her condition.

The question then becomes how such a desert basis is grounded. Again, Sher offers a possible justification for this kind of desert basis. He argues that people deserve the expected consequences of their own free acts. The idea that the desert basis has to be something within one's own control is widespread, as even Rawls maintains that only things that are under a person's control can ground desert. But certainly,

people do not deserve *all* of the expected consequences of their acts; if this were the case then people would deserve innumerable benign things, such as for their tires to wear down when they drive their cars, as well as some fairly serious things normally not thought to be deserved, such as being mugged when walking down the dangerous street on which one lives. Sher argues that expected consequences are deserved when they inherit value from “an agent’s genuine exercise of autonomy”^{cxiv}. We value the expression of freedom in making autonomous choices and it is this that confers value on the person realizing the consequences of his or her own free choice^{cxv}. The action that makes a person responsible for his or her condition and the value of his or her free choice of that action is the reason for deserving to not be treated. However, recall that Sher discusses exceptions to this general argument, since the context of the situation can alter one’s desert claim. In discussing the exception for disproportionately bad consequences, he specifically states that, even for predictable consequences, “we would balk at the claim that...a heavy smoker deserves to get lung cancer” because it is “unduly harsh”^{cxvi}. This makes sense for moments of stupidity but it seems difficult to argue that, if we really do value autonomous actions, a person who consistently abuses his or her body knowing what can result does not deserve the consequences of that action because it is so severe a consequence. It is also hard to characterize many of these actions, such as heavy smoking or attempting suicide, as a merely careless acts. Thus, it seems perfectly plausible that personal responsibility can be a basis for undesert.

However, there is one complication. The foreseeable consequences of abusing one’s body are the conditions that result. Not being treated is not the expected

consequence of any of the actions that bring about a medical condition. The claim, then, has to be that the subject deserves the condition that he or she brought about *and* that deserving the condition makes the patient deserve not to be treated. To deserve the condition means that there is a certain propriety in that person having the condition but it is not clear that a patient should not be treated because of this. After all, there is a disconnect between deserving the foreseeable consequences of one's actions and not deserving treatment (which is not foreseeable). Couple this with the general desert of care and consideration because of patients' humanity and suffering leads to the conclusion that, like the person of bad character, the person who is responsible for his or her own condition may not deserve the treatment, but he or she does not deserve not to be treated.

Past Contributions

There are numerous contributions that a person might make that could potentially ground that person's desert of medical treatment. Generally, though, these contributions can be divided into two categories: contributions to society and in-kind contributions. Contributions to society include philanthropic projects, scientific advancements, community involvement and so on. In-kind contributions include (but are not limited to) things like blood (as in the donor case above), organs and donations of medical equipment and other monetary donations to health organizations. The intuition is that people who have given to society deserve to get something back in their time of need. These are different claims for an important reason. While both a person's past contributions to society and past in-kind contributions are morally appraisable qualities of that person, there is no clear connection between past contributions to

society and the medical resources. Volunteering at the local food pantry or giving money to the United Way (or other charity) are certainly commendable activities, but these things have nothing to do with medical resources. Such actions may reflect upon a person's character, but if that is the claim then it is the person's character that will ground a desert claim, not the person's actions.

Past in-kind contributions, on the other hand, are certainly connected because, by making the contribution, the subject has helped alleviate past scarcity of the same resource that is now putatively deserved by the subject. In the donor example above, the donor has contributed numerous units of blood to the general supply in the past and now he needs the same resource of which he has contributed so much of over the years. The question is what might ground this desert claim. An institutional argument would work well here, since by donating blood (or organs, or medical equipment, or money for more hospital beds) the person has clearly furthered the goals of healthcare (however they may be articulated) by making more medical resources available to others. Thus, by furthering the goals of healthcare, one then deserves what healthcare can distribute: medical resources. But one need not appeal to furthering the goals of an institution to justify the in-kind donor's desert of resources. Consider the blood donor. Certainly, if he is an autologous donor, who stores his own blood for a future surgery or other use, he deserves to get his blood back since it is his. But the donor in the example has given his blood to the general public for whoever can use it. Because he has given blood and helped to ensure blood would be there when people need it, he deserves that it will be there for him when he needs it. It is because of his helping others in similar medical situations that he deserves the blood. The situation with donations of money and

medical equipment is parallel, but the situation with some organs is a bit different since many organs are not donated until death. In such cases, willingness to participate in organ donation programs (by indicating donor status on a driver's license, for example) shows the commitment to helping alleviate scarcity of organs and to helping those in a desperate situation.

Compensation

The final potential desert base is compensation. Compensatory desert claims arise when the subject of the desert has been wronged by the person administering his or her medical care. This includes cases of medical malpractice and medical mistakes, such as when a nurse administers an incorrect medicine or when a surgeon leaves a sponge inside of a patient. The desert base is the fact of being wronged by the relevant people. Compensation does not ground desert claims in instances where one has simply incurred a harm (such as getting hit by a rogue meteor); it only grounds desert claims where one claims to deserve some recompense from the person or institution that has done him or her wrong.

In cases of compensatory desert, it is the fact of having been medically wronged that is the morally appraisable quality of the person and it is because the person has been wronged by some medical error that he or she is in his or her present condition. Thus, the thing deserved serves to right the wrong done or at least improve the situation of the person who was wronged. Of course, in some cases, medical intervention will be unable to completely (or at all) right the wrong done to the patient. This is indeed something about the person but it is a different connection than the ones discussed above. The connection to the subject in all of the putative desert bases has been

something that the subject is or has done and so has been something that is, at least partially, within the subject's control. But, though most desert bases will turn out to be something that is to some extent within the subject's control, it is not necessary that they be. Some of the more basic desert claims (especially those shared by all patients mentioned above) are based in the fact of humanity or the ability to suffer, neither of which is within a subject's control.

What is it about the fact of being wronged that generates the claim of desert? Sher, again, argues that the value of diachronic fairness justifies the claim of deserved compensation for wrongs done. Diachronic fairness, "which demands the offsetting of earlier lapses from independent standards"^{cxvii} relates to the value in treating people fairly and correcting mistakes when they are made. Negligence, carelessness and mistakes generally will happen, but these do represent a lapse from the quality standards of medicine and, as such, should be rectified. Certainly, a person will always deserve that wrongs against them be alleviated, but when the wrong has been done within the very institution that distributes the competed-for resources, the connection between the wrong and the thing deserved are particularly strong. Thus, because fairness demands that such a lapse be rectified, the patient deserves the resources necessary to do so.

3. How does considering this limited form of desert fit in with other considerations?

The above discussion yields the following desert considerations: virtuous people, people who have made in-kind donations and those who are wronged are all deserving of (at least some kinds) of medical resources. The question now is about the moral

force of these desert claims. That is, does deserving a resource strengthen a patient's claim to that resource?

Though it is clear that virtuous people deserve good things and the pre-requisites to those good things, I am not convinced that there is any obligation to see that they get them. Clearly, having desert as part of a claim does not ensure that the deserving person will get the resource because desert is not the only consideration. Others' situations may be more urgent or others may be able to benefit more. Of course, desert may still strengthen claims even if there is no particular person obliged to fulfill that desert claim. After all, desert simply means that there is a certain propriety to the person getting what he or she deserves. But given the already strained connection between the desert basis and the thing deserved as well as the practical difficulties that are warrant for serious concerns, I am convinced that a person's character should not factor into decisions about who gets the resource.

The cases of compensation and in-kind donation are different. While the justifications for including desert because of in-kind donations as a consideration is not quite as strong as the reasons for including compensatory desert there are still solid reasons for including it. After all, those who have made in-kind donations have given of themselves (often literally) in to alleviate scarcity and to provide for others when they are in need. To not make similar resources available to the donor when and if he or she needs them would not only be ironic but it would also be a violation of that person's willingness to help make sure there is enough of what others need. Thus, desert because of in-kind donation should be considered when evaluating patients' claims.

In the case of compensation, there is an obligation to see that the person gets what he or she deserves since the value that undergirds compensatory desert is not fully realized until the wrong has been righted and the person given what he or she deserves. And, “since the standards that pertain to compensation forbid the infliction of certain sorts of harms, any deviations from them are best rectified by precisely the persons who inflicted the harm. Thus, it is also unsurprising that those persons bear the primary obligation to compensate”^{cxviii}. In the medical context, it is not only the nurse who administers the wrong medication that bears the obligation, but since he or she acts as an agent of the hospital and since he or she is not able to offer twenty-four hour intensive care, the hospital and its staff also have the obligation to ensure that the desert subject gets what he or she deserves. Deserving a resource as a matter of compensation will strengthen the claim of a person deserving a resource.

Consideration of desert from compensation and in-kind donations will not intrinsically clash with other considerations such as benefit, urgency and need. Certainly, a person who deserves a particular resource may be competing with those who more urgently need or would obtain a greater benefit from that same resource and there is potential for conflict there because of the importance of righting the wrong done to the deserving patient.

Conservation of Resources

Those who use conspicuously large amounts of resources are often singled out as utility monsters- those who have consumed and consumed resources regardless of the situation of others. Because of this, there is the idea that requiring more of the resource lessens one's claim to the resource. Following Winslow, I will refer to the idea that requiring more of a resource lessens one's claim to that resource, as conservation^{cxix}.

1. What does a conservation consideration encompass?

In many cases where the supply of medical resources do not meet the demand, the resource in question cannot be effectively divided or shared amongst patients to ease the scarcity. In these cases, there is no way to "spread the wealth" since dividing the resource would make it completely ineffective at resolving the patient's problem. Dividing a transplantable kidney between two people would be pointless, since dividing the kidney in half renders the kidney useless since half a kidney does not help either person. However, other resources could be divided among several patients, such as blood for transfusions. In these latter cases, some people will require more of the resource and some will require less; if patients only require small amounts of a limited resource, then more patients overall can be helped. But in many situations, a handful of patients require significantly larger amounts of the resource such that their receiving the large amounts precludes the resource's availability to others. Consider the following scenario put forth by Philippa Foot:

- 1) We are about to give a patient who needs it to save his life a massive dose of a certain drug in short supply. There arrive, however, five other patients each of whom could be saved by one-

fifth of that dose. We say with regret that we cannot spare our whole supply of drug for a single patient... We feel bound to let one man die rather than many if that is our only choice^{cxix}.

Although Foot introduces this scenario in an entirely different context, it is a paradigm case for considering conservation.

2. *Why consider conservation when determining claims?*

As Winslow points out, conservation is a strategy for maximizing the usefulness of the resource^{cxxi}. By giving the resource to the five people who require less of it than the one person who would require all of it, five lives are saved by the same amount of the resource that would otherwise have only saved one. And most would agree with Foot that it is simply common sense that, all else being equal, we should save the five lives instead of the one. Indeed, all would have to be *vastly* unequal for most to think it appropriate to save the one instead of the five.

Taurek challenges this intuition.^{cxixii} He argues that, though there may be other reasons for saving the five over the one or the one over the five, if all else truly is equal, then the numbers do not matter and the proper thing to do is to flip a coin to decide whether the one lives or the five live. Taurek's objection is two-fold: first, he objects to counting the aggregate loss of the five people because it objectifies the loss suffered by the individual. He states that "for each of the six persons it is no doubt a terrible thing to die...but should any one of these five lose his life, his loss is no greater to him because, as it happens, four others...lose their lives as well...Five individuals each losing his life does not add up to anyone's experiencing a loss five times greater than the loss suffered by any one of the five."^{cxixiii} Second, because the profundity of the loss

is equal, all six people should have an equal chance of receiving the drug and living. Thus, the roll of a six-sided die should decide the matter of who gets the drug²².

But while it is true that, when all else is equal, each individual will suffer the same loss, it is difficult to understand how aggregating these losses somehow dehumanizes those who lose their lives. On the contrary, it is dehumanizing to understand human life from the purely self-centered point of view required of Taurek's position. By his account, what matters is only the loss to an individual person of that individual person's life. But others, including society generally, have an interest in those people's lives. Taurek does acknowledge the relationships between people and that others will experience loss when a person dies, but it is not the same as the loss experienced by the individual who dies. This point is well taken, but what is not so clear is why this latter form of loss is the only one that is morally relevant. Certainly, absent any special obligations or connections to the one individual, the loss of the five people is a greater aggregate loss, even if it is not a greater loss to the five individuals who have lost their lives. If all that matters is the perspective of those who actually lose their lives, then losing over 2300 people at Pearl Harbor on December 7, 1941 cannot be counted a greater loss than the loss of one person in a car accident. From the perspective of those who died at Pearl Harbor and Darla Perez, it is the same amount of

²² Taurek actually says that it should be decided by the flip of a coin, but flipping a coin gives the one person a 50% chance and the other five together a 50% chance, which gives the one person a greater than equal chance of getting the drug compared to the other five. For each of the six to have an equal chance, they should each have a 1/6 chance, so I have changed it to the roll of a six-sided die. Of course, if the roll of the die comes up in favor of one of the five, then they will all get the drug and this may be what Taurek wants to equalize. Nothing in his argument really hinges on this, however- the point is that since the loss is equal, the chance to avoid it should be equal as well.

loss. But to claim that because it is the same from that one perspective makes it the same, full stop, is simply absurd²³.

But Taurek is right to question what exactly is going on when the intuition of choosing the many over the few is qualified with a “*ceteris paribus*” and to seek justification for the intuition. Does the first person requiring more of the resource than the others really have anything to do with it? Consider the above scenario with a few modifications:

2) We are about to give a patient who needs it to save his life 10mg—the entire supply—of a certain rare drug. There arrive, however, five other patients, who each need 7mg of the drug to survive.

In this case, the 10mg of the drug will only save one patient no matter which patient is ultimately given the dose since giving any of the six patients the dose he or she requires will preclude all of the others from receiving the dose they require. Do we still feel bound to give the drug to someone who requires less of it? All else being equal, giving the drug to the person who needs more of it does not seem to be the miscarriage of justice it might be in the first situation; thus, conservation cannot simply be about using more of a resource.

Winslow explains this by positing that the issue is not that one person requires *more* of the resource but that the person requires a *disproportionate* amount of the resource. It is thus disproportionality that is at the root of conservation. Winslow defines a disproportionate amount as an amount sufficiently large to save at least two other people^{xxxiv}. Thus, in the first scenario, the amount is disproportionate because giving the drug to the person who requires the larger dose results in five people dying,

²³ Others also object to Taurek’s position and for a variety of reasons. For extended discussion, see Kamm F. *Morality, mortality, volume 1: Death and who to save from it*. Oxford University Press, Oxford. 1993: pp. 75-98.

while only one will die if the drug is given to the five people. In the second scenario, five people will die no matter who gets the drug and giving it to the person who requires the larger amount does not change this and, thus, is not disproportionate.

But there are problems with understanding disproportionality this way.

Consider a third scenario:

3) We are about to give a patient in excruciating pain 10mg—the entire supply—of a certain pain drug that is in short supply. The 10mg of the drug will not entirely relieve his pain and he will still be in moderate, but tolerable, discomfort. There arrive, however, five other patients, each in moderate discomfort and each needs 2mg of the drug for pain relief.

Understanding in disproportionality this way reduces a conservation consideration to a simple count of how many people benefit and this certainly is not right. If the point is to maximize the usefulness of a resource, simply counting the number of people who get some benefit from it will not necessarily maximize the usefulness of a resource. Giving one person even a disproportionate (on Winslow's definition) amount of the resource can realize a greater usefulness than simply distributing it over a greater number of people, as the third scenario shows is possible. But a more complex calculation of usefulness to maximize will inevitably include other considerations such as benefit, need, etc. in order to assess the usefulness of the resource in a given distribution, which could lead to double-counting or over-emphasizing these considerations. And while conservation is one strategy to maximize usefulness, usefulness maximization is not the same thing as conservation, which is giving priority to those who need less of a resource.

Additionally, in the third scenario, the man in excruciating pain could quite reasonably argue that giving him the entire supply would not be disproportionate- it would be entirely proportional to his pain. And it is not clear how Winslow would respond to this. He could revise his definition of disproportional to mean that an

amount is disproportional if giving someone that amount leads to a non-maximized distribution. With this move, disproportionality is no longer doing the theoretical work and is replaced with utility maximization. This is not necessarily a bad thing, as it gets straight to the point of why even consider conservation in the first place-for utility maximization. But, again, utility maximization is not the same thing as conservation and the idea of conservation is dropped in favor of utility maximization.

However, as is alluded to above, there are problems with adding utility maximization as a consideration. Aside from the narrow issue of double-counting some considerations, determining a utility maximization and what all goes into that is an issue that is at least as complex and context-dependent as determining what a person is due. Since utility maximization (efficiency) at least partially justifies some of the considerations, including benefit and others that would have to play into utility maximization, a vicious circle can develop. Fortunately, this problem can be avoided entirely because there is another way to account for the strong intuitions for each scenario. Rather than think about these scenarios in terms of quantity of the resource, disproportionality, or utility maximization, a better idea is to think about it in terms of competing claims.

In what has been discussed thus far, the cases considered have all been cases where only one person can have the resource; there may be two, three or more people competing for the resource, but in each case only one person could actually have the resource, so the strength of each person's claim is only compared to the individual claims of the others. But when the resource is divisible and more than one person can use the resource, each person's claim is compared to the combined claims of the group

of people who have claims as if they were a single claim. In the cases where everyone lays claim to the same amount of the resource, one person's getting the resource does prevent the others from getting it, but only one of the others would have gotten it. However, when one person's getting the resource prevents others from getting it, all (or several) of whom would have gotten it, then those claims are combined.

In Scenario 1, the first patient is in competition with five others and has to compete with the combined claims of five other people because if the first person gets the drug, then five people who would have gotten it otherwise will not get it. Assuming that each of the six claimants has the same claim, then the claims of the five people combined are five times the claim of the first person. Thus, because the combined claims are stronger than the one person's individual claim, the five should get the drug. In Scenario 2, only one of the people will get the drug so each individual claim is compared with the individual claims of the others. Since only one person will get the drug no matter who that one person is, then only the individual claims are considered and the person with the strongest claim should get the drug. In Scenario 3, there is not currently enough information to determine who's claim is the strongest, but it is at least possible that a person in excruciating pain has a stronger claim to the pain drug than the other five people in moderate pain combined. Understanding the problem as one of competing claims provides a framework for evaluating such situations.

3. How does this fit with the larger framework?

The upshot of all of this is that requiring a large amount of a resource does not in and of itself weaken a person's claim to that resource and thus should not be considered.

However, because all competing claims are considered, it will likely often work out that the sheer number of competing claims will offset even a strong claim but this is not because requiring more of the resource weakens the claim but because the cumulative effect of the several claims against the one.

Past Resource Use

Another potential consideration that evokes the utility monster is past resource use. The concern with past resource use is the idea that “everyone should get their firsts before anyone gets seconds”. Just like all of the members of a kindergarten class should get a first cupcake before any of them get a second, the thought is that everyone who needs a kidney, for example, should get one before anyone gets a second one. With kidneys, of course, the stakes are much higher and there is also a bit of the idea that the person who has already gotten a kidney has already had his or her chance. What is actually behind this intuition must be sorted out.

1. What is the concern with past resource use?

This issue arises most frequently in the discussions of repeat transplants in patients for whom a first transplant failed and who need a second transplant. However, this is not the only time the issue arises. It also appears as concern about giving even more resources to those who have already used a large amount of resources over the course of their lifetimes. In this case, there may be one particular resource at issue, such as giving a blood transfusion to someone who has already gone through copious amounts of blood products. Or the concern may be about resource use generally, such as expending resources on someone who has a long history of various medical problems and associated resource use.

The main concern with past resource use is that giving more medical resources to one person over the course of his or her lifetime at the expense of others' lives or

health would result in a distribution that fails to treat people as equals. Again, the issue is not simply that the person has gotten “more” of a resource; the amount of a resource (or of resources generally) that a person uses has to be such that others are deprived of the resources. The idea is that it is unfair for one person to get “seconds” before others have had their “firsts”.²⁴ Consider the following scenario:

Three patients who require a kidney transplant are all a match to the same kidney. One patient, Alex, receives the kidney but, unfortunately, the transplant fails and Alex requires another kidney transplant. A new kidney is identified that is a match to Alex, but this time there is a second patient, Billy.

If all of the players in this scenario were contemporaries and the question was whether or not to give Alex two kidneys while three others receive none then it would be a matter of determining the strength of the patients’ claims. But how does one, over time, account for claims that were overridden in the past? In much of the literature, the question that this scenario generates is “is it fair?” and the answer depends solely on how one unpacks the “fairness”.

2. *Why consider past resource use?*

In many cases, particularly in news stories, “fairness” is not unpacked any more than by using examples such as “pieces of the pie” or the “firsts” and “seconds” language used above. Ubel, et al. offer a brief discussion of the fairness question and use just such language: “A more commonsense view of justice dictates that we all deserve an equal slice of the healthcare pie. That is, all else equal, we should not be giving out scarce pieces of pie to those who have already had some, while others await their first piece”^{cxxv}. They maintain that this is the case whether the issue is

²⁴ An argument similar to this is sometimes used to try to justify an age criterion but this argument is not addressed in that section because an age criterion would not necessarily help equalize resource use between people’s lifetimes.

retransplantation or simply having used large amounts of resources in the past for various health problems or where the patient has gone through a large amount of a specific resource, such as blood product. Ubel, et al. answer this question in the context of retransplantation and conclude that it is inappropriate to deny Alex a second graft because of fairness concerns because doing so focuses the issue of fairness far too narrowly on a single organ and does not account for larger distribution patterns. The sum total of health care resources distributed to individual patients should be examined, not simply a single organ (or two)^{cxixvi}. But this response sidesteps the issue entirely. In the outset, Ubel, et al. frame the question as “all else equal”^{cxixvii} but then answer it with the assumption that all else is *not* equal; access and use of healthcare over the lifetimes of the patients are assumed to be unequal. They never answer the original question: all else being equal, does Alex’s previous transplant matter? Further, they claim that looking solely at one specific organ is too narrow and does not account for health care resource distribution more broadly but do not say whether or not accounting for a broader distribution would matter. If one person has had greater access to or usage of resources, would this matter? They seem to imply that it would, but they do not provide an argument either way.

Veatch also frames the question of the fairness of retransplant in terms of the “pieces of pie” analogy but he offers an answer to the question. Veatch argues that it is easy to say that no one should get a second piece of pie until everyone has had one because no one *needs* pie. A kidney is a different matter entirely.^{cxixviii} We are interested in treating equals equally and Alex and Billy are equal with relation to their need for the kidney. Assuming then, as Veatch does, that “‘fair shares’ are proportional

to need”^{cxix}, giving Alex the second kidney would be giving her a fair share. This diffuses the question because if the second graft is a fair share for the Alex, then the question of whether or not it is fair to give a patient a second (or third) transplant, or additional blood products during a shortage, is answered “yes”. The problem with this answer, while somewhat intuitive and satisfying, is that it does not explain why need and urgency are the only arbiters of fairness. One arguing the other side of the issue need only come back with “but past resource use is also an important element of fairness” and Veatch’s argument would not be able to address this objection because he does not explain why fair shares are proportional to need (and urgency)²⁵.

One important point about past resource use echoes the arguments in conservation and the resulting procedural point about competing claims. Veatch argues that this is not a reason to deny Alex the second kidney because each kidney can only ever help one patient, regardless of who that patient is^{cxix}. And that is true but it is also only part of the story in most cases. Understanding this argument this way presupposes that past resource use will be ignored. If resource use through time is considered, then Alex’s previous kidney transplant matters because if the current kidney is given to Alex, then two kidneys will have gone to help one person. One kidney may only be able to help one person, but sometimes people require more than one kidney. If Alex gets the kidney instead of Billy, then only one person is helped instead of two and the finite number of organs are distributed to fewer people. This is also true of other resources, such as blood products or ICU beds; if people are able to use large amounts of these resources, fewer people will have access to them. It is this latter concern that, I suspect,

²⁵ Kilner, in a similar move, also appeals to need (and urgency) to explain why past resource use should not weaken a patient’s claim to a resource. His argument also suffers from the same problem.

drives much of the concern over “slices” of the health care “pie”. If people have open access to an infinite number of slices of pie, no one will care who has had firsts, seconds or even thirds. It is when having seconds makes it so others cannot have firsts that the problem arises.

And it is this same sentiment that drives the intuition in the conservation case, that, all else being equal, it is better for one to die than for five to die. And the part about “all else being equal” is what those who claim that treating people with equal (and equally urgent) needs as equals requires ignoring past resource use miss. If all else truly is equal, then the need, urgency, potential benefit and all of the other considerations that take rights and such into account are equal in the case. The only thing that is not equal is past resource use and when the only difference is a difference that presents the choice of saving more or saving fewer, the choice has to be saving more.

3. How does past resource use fit in with other considerations?

Past resource use then does weaken a patient’s claim to a resource. How much the claim is weakened is extremely context dependent and depends on the nature of the resource in question, the number of people concerned, the actual amount of the resource(s) consumed to date, the real scarcity of the resource and so on. But even without knowing the specific circumstances, it is clear that past resource use will likely conflict most with considerations such as benefit or need since past resource use is a restriction that weakens the claims of those who may be in need or who might greatly benefit from a resource.

Queuing

Queuing is frequently invoked and intuitively compelling, since we have all learned since childhood to take turns, wait your turn and do not cut in line. However, despite the frequent appeals to queuing, rarely are any of them justified beyond an unexplained reference to their being required by equity or justice. Further, few if any of these justifications deal with the problem of there not being equal access to the healthcare line at all. The relevant questions are, then, why is this set of concepts so strongly linked to equality and justice and also whether their reflection of equity holds true in the medical setting.

1. What does the queuing consideration encompass?

This, at least, is fairly straightforward. Queuing refers to a family of concepts that are all intrinsically linked to each other including waiting time and first come, first served (FCFS). The idea in all of these is that the person who has gotten there first and has thus been waiting longer should have a greater claim to the resource. It is important to note that even though queuing is generally thought of as a procedural consideration (and would thus not fit into this discussion of substantive considerations), it has substantive elements as well. It is these substantive elements that will be the focus of the discussion here.

2. *What is the moral justification for FCFS generally?*

Writers in fields as disparate as operations research, psychology, philosophy and queuing theory all cite some version of FCFS as the just procedure for handling queues.

We learn from a young age that it is not acceptable to cut in line or jump the queue altogether and we feel that we have been wronged if someone does jump the queue ahead of us. This is because the idea of first come, first served is rooted in egalitarianism; it is “in harmony with the basic principle of human equality”^{xxxix}.

Larson, for example, discusses queue theory with reference to social justice, “as measured by adherence to (or violation of) first in, first out”^{xxxix} and further states that “queuing theorists and social scientists have long believed that first come, first served (FCFS) is the socially just queue discipline”^{xxxix}. Unfortunately, he does not explain *why* it is so considered and he is not alone. Very little explanation or justification is ever offered for why FCFS, and consequently waiting time (since the person who had gotten there first is the person who has been waiting the longest), seems to be such an important feature of justice.

Winslow^{xxxix}, who offers a more extensive discussion of the issue than most others, discusses several possibilities for justifying FCFS. One of those possibilities is also the most popular justification among those who discuss the issue at all; most seem to agree that the importance of FCFS is grounded in equality, i.e., that FCFS is the proper way of treating equals equally. FCFS is widely held to embody fairness and equality. Unfortunately, the most widely cited justification of FCFS is also the least explained. The quote at the beginning of this section from Larson is essentially all that he says by way of justification. And Brady, in his study of people waiting (sometimes

more than a week) in line to purchase tickets to *Star Wars: The Phantom Menace*, simply states, “Presumably, people sense a kind of fairness about queues”^{cxxxv}. And a host of people (including some cited by Winslow) simply write elaborate examples of people forming lines in situations where line jumping would be somewhat frowned upon by most and go little farther. The fairness of FCFS and its promotion of equality are, apparently, meant to be self-evident from these examples. And they are compelling. In situations where all other things are equal, we really do think that people who jump lines should be punished (sometimes severely). But why this is still needs to be teased out.

One idea that is frequently mentioned in conjunction with FCFS and equality is that, with FCFS, people’s wait times will be equal, so no one will have to wait any longer than anyone else. But this can only be true in highly idealized lines. Consider, for example, a line at the bank with only one teller window open. In order for everyone to wait the same period of time, every person’s interaction with the teller must be the same length and one person must join the line just as the person at the front of the line leaves it. And there is no way for the wait to be the same for everyone during initial line formation. Thus, FCFS does not do anything to equalize wait times. At most, it limits the length of time the longest waiting person must wait compared to a system where people may jump the line. Or, more precisely, it ensures that no person will wait longer than a person who arrives later. But more likely it does not even do this since in the healthcare world the access to the line is radically unequal. And the problem again is what the significance is of arriving first. After all, if wait times are unequal, why should someone who arrives first be accorded the shortest wait?

Another, more promising, possibility that Winslow mentions is that the relevant form of equality in FCFS is equality of opportunity. All people, Childress maintains, are equal in their humanity- that is, everyone is equal with respect to personal dignity^{xxxxvi}. And this is not a new sentiment. In everyday life, people are generally considered equals although rarely are any two people truly equal with regard to intelligence, talents, education, wealth, etc. The idea is that, qua human beings, people are equal with respect to their individual human dignity- that they are fundamentally equal. Thus, Childress argues, “The individual’s personal and transcendent dignity...can be protected and witnessed to by a recognition of his equal right to be saved. Such a right is best preserved by procedures which establish equality of opportunity”^{xxxxvii}. The procedures that best serve this purpose are those that rely on randomness or chance. When flipping a coin, both heads and tails have an equal opportunity to come up and when drawing lots, each person has an equal opportunity of drawing the desired lot. Childress explains that FCFS is a form of “natural chance”^{xxxxviii} that does promote equality of opportunity over time. Although it is not random, a person’s place in line is determined by chance; that person could have joined the line at some other time when the line was longer or shorter. Taking people in the order in which they joined the line then preserves the equal opportunity all have to receive treatment.

On Childress’s account, simply being at the head of the line is not what is morally significant. Instead, what is morally significant is that, by utilizing FCFS, people have an equal opportunity to obtain whatever it is that they are waiting in line for and the principle of treating equals equally is maintained. And Childress’s explanation

maps onto general intuitions about equality, fairness and waiting in line. Reactions to line jumping tend to be of the “what do you think makes you so much better that you don’t have to wait like the rest of us” variety. The thinking is that by jumping the line, the line jumper asserts that he or she is somehow “better” than the others in line, or that he or she is “too good” to wait in line. The issue is not so much that this person goes before other people; it is that by going before the other people, the line jumper shortens his or her wait at the expense of others. He or she makes the other people in line wait longer and spend more of their time waiting than they otherwise would have. And because we take all people to be fundamentally equal in personal dignity and humanity, usurping FCFS essentially treats equals unequally, violating the basic principle of ethics to treat equals equally.

But how does such an application map onto healthcare? Though FCFS is intuitively compelling, its application in the healthcare setting is problematic for a number of reasons. Practically, the idea that line formation comes about through natural chance is a suspect one. If everyone had equal access to healthcare, the idea would not be so problematic but, in reality, people do not have equal access to healthcare. As a population, people who live in rural areas, the poor and uninsured and certain ethnic populations often do not have the same access to care that insured white (sub)urbanites do. The Institute on Medicine’s Committee on the Consequences of Uninsurance (IOMCCU) reports that those without insurance (who are disproportionately poor and from racial or ethnic minority populations^{cxix}) “generally have reduced access to care”; they “are less likely to have any physician visit within a year, have fewer visits annually, and are less likely to have a regular source of care”^{cxl}.

The barriers to access do not end once an uninsured person has seen a physician, however. IOMCCU further reports that the uninsured are also less likely to receive treatments deemed necessary by their physicians or to receive routine care for chronic conditions^{cxli}. These barriers to access are associated with worse health outcomes overall^{cxlii}. With such substantial barriers to joining the line, one's position in line can hardly be considered a case of natural chance among equals.

One approach with the potential to avoid this problem is to take Fried's position that being at the head of the line for a physician's services creates a doctor-patient relationship between the physician and the person at the head of the line (presumably because the person at the head of the line has a face-to-face encounter with the doctor before any of the other people in the line)^{cxliii}. Once there is a physician-patient relationship with this first patient, the physician would be guilty of abandoning the first-in-line patient were he or she to treat someone farther down the line or put the farther-down patient's interests ahead of the first-in-line patient. But why this is the case is not entirely clear; broadly, this does not explain why there is moral significance to being at the head of the line. If people farther back in line have seen the physician on previous visits, then there is a pre-existing physician-patient relationship with them- shouldn't then they be seen first? And if everyone in the line has a relationship with the physician, why should FCFS hold?

And even if no one in the line has a pre-existing relationship with the physician, the core problem still exists. The problem is that concern over the physician-patient relationship does not justify FCFS; it can only justify treating people with whom the physician has a relationship over those with whom he or she does not. Why, for

example, does the person at the head of the line have an expectation of a relationship when that people farther back do not? Only if we presume FCFS does the person at the front of the line see the physician first (and thus establish a physician-patient relationship prior to the others) but the presumption of FCFS does not justify its use. The physician does not have to approach the front of the line. If the physician approaches the line and pulls out someone from the middle to treat, then that person has a physician-patient relationship with the physician, not the person who is in front of the line. By the reasoning of Fried's argument, at the point that the physician approaches the line, the physician's obligation to any one person in the line is equal to his or her obligation to any other person in the line. But once a patient has been identified, from whichever section of the line the patient is pulled, that patient has the physician-patient relationship and thus takes priority. Nothing in Fried's argument justifies FCFS.

Additionally, FCFS is remarkably inefficient since more people are likely to suffer harm or die while waiting in line. This is not the case in lines for movie tickets or bank tellers. If emergency rooms were to adopt strict FCFS as a triage measure, a person having a heart attack could die in the waiting room while the doctors and nurses set broken fingers, see people suffering from colds and suture cuts. In discussing casualty treatment on American Civil War battlefields, Winslow quotes Walt Whitman's description: "The men, whatever their condition, lie there and patiently wait till their turn comes to be taken up"^{cxliiv}. Certainly, even with the dubious value of medical treatment at the time, men died waiting for care while those who could have waited received care. And the physician has a professional obligation to act as a fiduciary of his or her patients and consider their best interests primarily. To let people

die in line who could be saved while others who could wait are taken care of is certainly not in the best interests of most patients.

Of course, inefficiency in itself is not a sufficient reason to reject a consideration, for as Veatch points out, distributive justice must balance efficiency with human rights and equality. A frequently proffered partial solution to the problem of inefficiency that is operative if not explicit in most FCFS accounts is to limit who can join the line in some way, such as to those who can benefit from the resource or to those who will die without it instead of allowing just anyone to join. Childress^{cxlv} clearly has something like this in mind because the examples of FCFS he uses are examples where the line has already been limited to those who need the treatment in question. But once a person's condition becomes morally relevant to line-joining or line formation, it is no longer wholly about fundamental human equality. It is about equality among those of a certain condition²⁶ or treatment as equals. And in order for that to obtain, much more than FCFS must be considered.

But these problematic attempts to solve the problems associated with FCFS point to a more fundamental problem with Childress's account specifically and the exclusive use of FCFS generally. If the line is limited to only those who would benefit, the Civil War problem still exists; certainly many of the wounded soldiers who could have waited to see the surgeon presumably benefit from seeing the surgeon. Those lines would not have changed much. The fundamental equality is preserved but it costs numerous lives and, in this sense, undermines its own justification. Since people die or suffer harm while waiting for others who could wait are treated, equal respect for the

²⁶ This is also the case to a certain extent when the line is limited to those who can benefit from the resource in question.

lives of those involved is denied. If people really are fundamentally equal then there should be equal respect for the value of their lives. Having people wait in line regardless of their situation and, in short, treating them equally, fails to give equal respect to the lives of those in the line.

And this is the central problem with Childress's account: he chooses as his "relevant equality" the fundamental equality of all human beings regardless of their situation. In doing so, he essentially advocates equal treatment instead of treatment as equals. Childress clearly does not support giving everyone the same treatment, regardless of condition. But if everyone is equal in everything that is considered relevant (i.e., their personal dignity and fundamental human equality), then there is no reason to treat anyone differently from anyone else. And this is what Childress points to as a virtue of his account and why he advocates natural chance. But acknowledging differences in condition and situation is what allows us to treat people as equals instead of simply giving them equal treatment. By having them wait in line as if their conditions were the same for the sake of fundamental equality does fail to treat people as equals in important ways, especially when the very lives of some people are at stake. Using FCFS, it is possible, indeed probable, that people with more urgent conditions who could be saved are allowed to die in line while those who might have waited receive treatment. By failing to acknowledge their differences of condition, the individuals in line are not accorded an equal opportunity to receive treatment or to be saved.

But acknowledging a person's situation does not eliminate concern for the fundamental equality of people²⁷. Instead, it becomes one consideration among others because personal dignity is a part of each person's (human) condition. But because it is equal (by definition) in each person, it can neither directly strengthen nor weaken a person's claim to a resource relative to another person's claim and so the operative considerations must be those that differentiate one person's condition and situation from another's. However, there will be many times when people's claims to a particular resource are similarly strong. In this case, FCFS is often justified as a kind of tiebreaker. Veatch advocates using FCFS (as determined by wait time) only as a tiebreaker among those with similar claims to a resource^{exlvi}.

However, using FCFS only as a tiebreaker minimizes the importance of the concern for basic human equality; even if such a concern does not directly affect a claim, it can indirectly affect a person's claim in terms of wait time. In the case of organ donation, patients with certain blood types or from certain racial or ethnic groups are less likely to receive organs due to the shortage of matching donor organs. Patients in these groups usually face longer wait times than patients from other blood groups and backgrounds. And, some patients may simply have a longer wait because a match for them simply does not come up. Because we are concerned to treat these people as equals and with respect to their personal dignity as humans, the fact of their having longer wait times does strengthen their claim to the resource. This is because the concern for the equality of personal dignity is tied to a concern for equality of opportunity. Clearly, those with longer wait times face diminished opportunity to

²⁷ Supporters of a lottery system also point to the fundamental equality of people as the justification for using a pure lottery system to distribute goods. The difficulties with lottery systems and the comparison of a lottery system to the claims system I propose are discussed in the last chapter.

receive the resource. Considering wait time in determining the strength of claims to some degree offsets the inequality of opportunity afforded those with longer wait times.

3. How will wait time as a consideration work with the other considerations?

Although some writers advocate using wait time only as a tiebreaker, it can strengthen the claim to the extent that the claim of a person with a long wait time may override the otherwise stronger claim of a person who has not waited as long. How much wait time strengthens a person's claim to a resource will depend on the length of time spent waiting and also on the magnitude of the disparity between the claims in question (before wait time is factored in). When a person has spent much longer waiting and the magnitude of the disparity in claims is small, wait time can offset the disparity in claims. However, the greater the magnitude of the disparity to be overcome and the less the difference in wait time, the smaller the impact of wait time. Wait time is dependent in this way on the other considerations because, as was discussed above, giving too much weight to it causes us to treat people equally, instead of as equals.

Since wait time is a consideration based in concern for equality (like concern for dependents), it will likely conflict with efficiency-based considerations, such as benefit and urgency, though the conflict is not inevitable. In many cases, a patient will have deteriorated as he or she waits for treatment and because of the deterioration the situation will be more urgent.

“Squatter’s Rights”

Though this consideration does involve a possible right, it is included as part of the claims section because it is not a clear cut and legally defined right as are those discussed in the previous chapter.

In making distribution decisions, the prevailing mental image is that of an unused resource and a group of claimants with competing claims. The person who then has the greatest claim to the resource avails him or herself of the waiting resource. Once the resource is “claimed” it is no longer available. This is certainly accurate when the resource in question is something like a drug dose that is not reusable. But many medical resources are reusable. Is this picture accurate, or should it be, with regard to reusable resources? The picture assumes that the person who is initially given access to the resource should have ongoing access to the resource that is not consistently reevaluated. The question is whether the picture is an accurate one.

1. What is a squatter’s right to a resource?

Though the idea of squatter’s rights in healthcare seems fairly straightforward, there are a few conceptual issues that must be addressed. First, who counts as a squatter and what counts as “squatting” must be clarified. The legal understanding of a squatter as someone who is using another’s property without permission does not accurately map onto what actually happens in health care institutions but, for the sake of simplicity, I will use the term anyway and I discuss the issues regarding property issues below. Here, the term “squatter” refers to the person who has initially been given access to a

resource and for whom continued use of that resource is medically indicated. In most cases, the squatter is the person who is “using” a resource, such as the person occupying an ICU bed or the person receiving dialysis. The complication comes in determining what “to use” or “a use” means. There are some clear examples of a resource being used: the person lying in the ICU bed is using that bed, a patient plugged into a dialysis machine is using that machine and a patient with an LVAD is using that LVAD.

However, this picture of healthcare delivery is far too simple. People in ICU beds go for tests, sit in chairs beside the bed and use potty chairs; they are not always in the bed. Does each time the patient returns to bed count as a new use? Or is the patient always using the bed, even when he or she is not in it? Or does each new day count as a new use, whether or not the patient has at any point left the bed?

What counts as a use will almost always depend on the resource itself. What counts as using or a use of a bed might be different than what counts as using or a use of hemodialysis treatment. In what follows, I will consider a “use” of a resource to cover the entire time period that the resource is unavailable according to standard practice. There are times when a resource might be physically available to be used by another person but, according to standard practice the resource would not be seen as available. Consider the ICU bed. Once a patient is assigned a bed, the bed is generally considered unavailable to others until the patient has been transferred or discharged. Thus, it is not a new “use” every time a patient returns to bed or starts a new hospital day. Admittedly, this sounds question-begging because determining that a resource is “unavailable” assumes that a squatter has rights. However, by saying that a resource is

unavailable, I simply mean that the resource would not normally be assigned to anyone else if there is no shortage of resources to contend with.

To better illustrate this, consider hemodialysis (HD). HD is what people generally think of when they think of “dialysis”. It is a procedure in which a patient is hooked up to a machine that filters the patient’s blood. It is usually administered several times a week for several hours at a time. A patient receiving HD uses the machine during his or her treatments but in between treatments the machine is available for others to use. Thus, even though an HD patient may be engaged in a treatment regimen, he or she is not always using the machine. Each individual treatment is considered a new use of a resource. This is a bit different from how most people think about HD treatment. Ceasing HD treatments is usually referred to as a withdrawing of dialysis, not a withholding; calling it a “withdrawal” instead of a “withholding” makes it sound like the patient is using the machine and it is being taken away, not that the patient is between treatments and not using the machine. However, even if a patient is not actively using the HD machine, the withdrawal terminology can still make sense if what is meant is that the patient is stopping the treatment regimen. The treatment *plan* or *order* for HD is withdrawn, but the *individual* treatments are withheld²⁸. Given this understanding, an HD patient is not a squatter on the HD machine except when he or she is actually receiving treatment.

By this account, squatters’ rights can only apply to “withdrawings” and not “withholdings”. With this understanding in mind, I now turn to the arguments for and against considering squatters’ rights in resource allocation decisions.

²⁸ Unless, of course, the patient is in the middle of a treatment when it is stopped; then it is rightly called a “withdrawing”.

2. *What would justify squatters' rights to a resource?*

There are a number of arguments both for and against considering squatters' rights, some of which are tied up in much larger issues. The most notable of these is the concern that withdrawing treatment for any reason is impermissible because it would be killing the patient. Of course, this is an extreme position as most accept that treatment might be withdrawn if doing so accords with the patient's wishes but there are many groups that hold the more moderate and defensible position that withdrawing indicated treatment against a patient's wishes is impermissible. This argument frequently appears in debates about withholding or withdrawing medically inappropriate (so-called "futile") treatments and, as vehement as some are against the withdrawal of a medically inappropriate treatment against a patient or surrogate's wishes, the intuitions are even stronger against withdrawing treatment from someone who can clearly benefit from the treatment. The reason is, quite simply, that withdrawing indicated treatments against a patient's wishes for any reason is willfully harming, or even killing, the patient and to do so is morally unacceptable.

This raises the issue of the possible moral valencing of doing and allowing. Suppose, for example, that Albert is using a hospital's only ECMO machine (extra-corporeal mechanical oxygenation, akin to a heart-lung machine) and removing him from the machine will certainly kill him. Betty then arrives by ambulance and she has an (otherwise) greater claim to the ECMO machine than Albert. On this argument, the machine cannot be withdrawn from Albert for Betty's sake because to withdraw the machine kills Albert while Betty simply dies for lack of resources. Killing Albert is

morally impermissible and so there is nothing we can do for Betty²⁹. There is a large literature surrounding this issue and I do not think it would be productive to turn this into a protracted discussion of the issues raised by that literature. Suffice it to say here that my take on this is that there are numerous cases in which it is morally wrong to cause something to happen but not to allow it to happen but there are also cases where it would be equally morally unacceptable to cause something to happen as to allow it to happen, cases where it would be morally acceptable to both cause and allow something to happen and maybe even cases where it would be morally acceptable to cause something to happen but not to allow it to happen. The moral acceptability of an action or non-action rests not with whether it can be classified as a “doing” or an “allowing” but on the context of the situation. The argument should be not about the fact of withdrawing or withholding the resource but instead should be about the rightness or wrongness of withdrawing the treatment from this specific patient or withholding it from that specific patient. It is not clear why it is always (or even generally) morally worse to harm the patient by withdrawing the treatment in order to give it to another patient with a stronger claim than it is to allow the patient with the stronger claim to be harmed by withholding the treatment in favor of a patient with a lesser claim who happens to be using the resource currently.

Other arguments in favor of squatter’s rights fare little better. One such argument is similar to the one put forth by Charles Fried when he argues in favor of “first come, first served” but would apply here as well since, presumably, the patient

²⁹ I realize that there are numerous ways that the actions and inactions involved in the Albert and Betty case can be conceptualized and only on some of these will what I have written be the case. On other understandings, this might not be a case of killing versus letting die or of doing versus allowing. However, I have conceptualized the (in)actions in this way to illustrate the issue that arises- that of killing versus letting die, doing versus allowing- and not to argue that this is the correct conceptualization.

who is using the resource did indeed come first. This does not mean that queuing or “first come, first served” are an argument in favor of squatters’ rights, though they might be easily conflated, but instead that an argument that purports to support the one might also support the other. The idea is that the squatter has an ongoing relationship with the physician caring for him or her. Once in this relationship, the physician has an obligation to act as a fiduciary of the patient and act in the patient’s best interests. Withdrawing a beneficial treatment from a patient would not be in the patient’s best interests and would therefore be a breach of the fiduciary duty. To do so then is not only in violation of a physician’s obligations to his or her patient, but they have detrimental effects on that specific patient’s trust in his or her physician and patients’ trust in the medical profession generally.

There are two serious flaws in this argument. The first is inherent in Freid’s argument that the obligations of the physician-patient relationship support allowing the squatter to continue using the resource. It is certainly not the case that the squatter always has a relationship with a physician and the second person does not. Realistically, since the second person is seeking an ICU bed, he or she has probably already been evaluated by a physician who has determined that ICU care is indicated. And what if the physician for the squatter changes? Physicians do go on vacation or sign off of cases and often the new physician has not ever seen the patient before. These complications are not meant to show that the squatter is not in a physician-patient relationship or that the squatter’s physician does not have a fiduciary duty to the squatter. The complications show that it is likely that the second patient likely does have a physician, with whom he does have a relationship and who has a fiduciary

obligation to him as well. Also, physician-patient relationships and interactions in the hospital are much more complicated than the model Freid assumes.

Even accepting that simplistic model of the physician-patient relationship in hospital settings does not yield any support of considering squatters' rights. Rather, Freid has offered a defense of why the patient who is already using the resource should be allowed to continue to do so without reference to squatters' rights. The argument uses reasons of professionalism and consequences for trust to support squatters' rights, but these reasons have nothing to do with the patient being a squatter. The physician's obligation to his or her patient and the personal and public trust in the medical profession are principles in their own right that have little to do with being a squatter. A more direct argument from fiduciary duty and the consequence of losing trust is much less problematic than having to justify squatters' rights along the way.

Of course, there is another way of understanding the relationship issue that would support squatters' rights and that is to posit an implicit promise to the patient that once treatment is begun, it will be seen through to the end. Many patients and their families certainly think this but patients and families have many beliefs about what they think they are entitled to, including the right to demand treatments of various sorts, but this is not the case. The question is not whether or not patients and families think there is such a promise but whether there is such a promise. Freid tried to ground the promise in the physician-patient relationship but is there a broader promise, between the medical institution and the patient or some other such relationship? The problem with assuming such a promise is showing that it is there. Yes, hospitals and individual physicians work to save everyone but, generally, they all recognize the necessity of triage and the

realization that not everyone will be able to be treated as much as they might require because of limitations in the amount of a resource. Even the Texas legislature recognizes this in the Texas Advance Directives Act, which states that the act “may not be construed to require the provision of life-sustaining treatment that cannot be provided to a patient without denying the same treatment to another patient”^{cxlvii}. This explicitly denies any such promise and recognizes the difficult decisions that must sometimes be made. The argument

that very few of the rights that Bjorkman and Hansson list would be rights that a patient has to a medical resource that he or she is simply using. However, while this theory of property rights interestingly informs their discussion of ownership in biological specimens, it would be at best circular and at worst question begging in the current discussion because the present question is whether or not any form of property right will grant a patient the right to continued use of the medical resource at issue. The “bundle of rights” idea assumes that we know what rights a person has to an object and then determines the property relation from there.

More helpfully, Locke famously argues a natural rights theory of property that starts from the idea that resources are owned by all in the community. A resource becomes the exclusive property of one member of that community when that member mixes his or her labors with the resource, thus adding value to it; by cultivating a piece of land or sculpting some mud into a piece of art. The owner has invested work and added value to the resource and so becomes his or her exclusive property because of this investment^{cxlix}. There are numerous challenges to this theory but the more relevant challenges are those that arise when this theory is applied to the problem at hand. Certainly, when a patient uses a medical resource such as a dialysis machine, the patient certainly in some way mixes with the machine; after all, it processes his or her blood. However, there are two problems with using Locke’s theory to justify a patient’s right to continue using a dialysis. First, it is not obvious that simply using something means that the patient has mixed his or her labors with the thing. It is especially difficult to make the case that use equals labor mixing in the case of say, an ICU bed that a patient simply lays on. Further, even if use did equate to labor mixing, using a medical

resource does not generally add value to that resource. So use of a medical resource would not be the kind of investment and improvement in a thing that Locke seems to have in mind.

This bears some closer scrutiny, however, given the connection between Locke's theory of property rights and legal rulings on land squatting, or adverse possession. This usually applies to land or real estate; if a squatter uses land owned by another person as if the squatter were the owner without the owner's permission, then after some amount of time, the squatter acquires rightful ownership of the land. The squatter cannot simply occupy the land or walk on it; the squatter must actually improve the land somehow by, at the very least, mowing or clearing the land. Now, the patient-squatter would clearly not have a claim to actual title of the medical resource. As was pointed out before, the patient-squatter has not actually improved anything. But a more interesting issue is the point about the owner's permission. Those squatters on healthcare resources are doing so with the (sometimes reluctant) permission of the healthcare institution. The better analogy than that of patient-as-squatter would be more along the lines of a renter, but there is difficulty with this as well. Renters have rights in virtue of a variety of laws governing the renter-landlord relationship but more immediately in virtue of the contract they enter into. Though there are laws governing the relationship between the patient and the healthcare distributor, there is no contract analogous to that signed by the renter that clearly defines the scope of treatment. Indeed, the inpatient does not rent the ICU bed or the dialysis equipment from the hospital in the same way that a tenant rents a living from a landlord. The patient does pay for the use of the resource, but the use is at the discretion of the physicians in

charge of the resource. Given these problems, squatters' rights to medical resources cannot be justified by appeal to property rights.

There is one objection to considering squatters' rights that should be mentioned: the idea of "taking turns". The idea here is similar to the signs hanging in the cardio rooms of most gyms that limit people's time on the equipment to 20 or 30 minutes when others are waiting. The idea is that those who are already on the equipment working out should not monopolize the machines and should take turns. Similarly, a patient who is using an ICU bed when someone else comes in who requires the bed should yield to the new patient because the squatter has already had a turn with the bed. This argument also appeals to a strong intuition: the idea of taking turns that has been ingrained in us all since we were small children. This should not be confused with a concern for past resource use, which is a concern about amounts of resources consumed by an individual that is discussed in a separate section. Instead, it is a concern about everyone having the opportunity to use a resource.

However, the cardio room analogy is not perfect and may mask an important objection to this argument: the squatters' turn might not be up. In order to make an argument about taking turns, what counts as a "turn" has to be defined. In baseball, a turn is defined by strikes, outs and innings. In the cardio room, a turn is defined by the number of minutes on the equipment that has been determined by the management. How is a turn decided in medical resource allocation? And is a turn the same for everyone using a particular resource? Further, just because a person is using a resource, it does not mean that he or she has had a turn; the squatter might be in the middle of his or her turn, like the person who has only been on the treadmill for 5 minutes. The

concern about people having the opportunity to use a resource is a valid one, but access is not the only concern, especially since access does not really matter if the patient cannot benefit because his or her access is rescinded before the benefit can accrue.

3. *What it means to not consider squatters' rights.*

The strongest objection to considering squatters' rights is that there is no good justification in support of them, other than intuitions that may have more to do with "first come, first served" or beliefs in entitlements that do not exist. Of course, if hospitals and physicians removed people from treatments every time someone else came along, then it is likely that very little of the benefit would accrue to everyone since no patient would be able to finish his or her treatment. Of course, this has little to do with squatters' rights and more to do with benefit and efficiency. And it is by no means certain that resources would be used inefficiently, squatters' rights or no. After all, if the people who are already receiving treatment have a greater claim all things considered, then they will certainly continue to receive treatment. Those who do not have sufficiently strong claims will receive alternate treatment, just as if they arrived at the same time as the patients who have recently arrived.

Thus, the picture described at the beginning of this section is an inaccurate one. When using a reusable resource, a patient's claim to that resource should be reevaluated as circumstances change and evaluated against newly arriving claims if there is not enough of the resource to go around.

Immigration Status

The basic idea is that priority (at the very least) should be given to American citizens (or at least those who are in the country legally) when considering who should be given a medical resource in America. This consideration is almost always used as a reason against providing medical resources to illegal immigrants and it is sometimes difficult to separate the issues of distributive justice from the tempest of rhetoric and spleen that is the immigration debate. But, while some reasons for considering immigration status can certainly be written off as irrationally xenophobic, there are some rational arguments that might justify some form of this consideration.

1. What would an immigration status consideration entail?

As potential considerations go, defining one's immigration status is fairly straightforward. And it is fairly easy to determine who counts as an American citizen. However, the nation is not so easily divided into citizens and non-citizens given the spectrum of residency situations. The extremes are certainly citizens on one end and undocumented immigrants on the other but between these two situations there are permanent residents, asylees, people with a rainbow of visas and so on. Certainly most of the vitriol about non-citizens and health care is directed at undocumented immigrants but there is also some concern about, for example, medical tourism and its associated resource use. Without understanding why it is that American citizens should be given priority, however, drawing lines between any of these groups would be arbitrary. Whether or not immigration status affects the claims of which groups directly depends

upon the justification provided for prioritizing some groups over others. Different justifications will encompass different immigration statuses. Thus, the issue of which groups receive priority under this consideration will have to be put off until a justification is found that would ground this consideration.

2. Why accept an immigration status consideration?

Probably the most prevalent argument in support of an immigration status consideration is also a red herring. And that is that the issue is about money and, specifically, money spent on undocumented immigrants. In discussions of health care for undocumented immigrants, there is a ubiquitous portrait of the destitute undocumented immigrant who works odd jobs, does not pay taxes and has had some medical misfortune befall him and now requires extensive costly medical intervention. Or, the undocumented immigrant is a poverty-stricken woman (who also does not pay taxes) having a child who will be a U.S. citizen, thus anchoring the family in America. In both of these portraits, the undocumented immigrants have contributed little if anything to the community in which they live and are using costly medical resources. The argument that accompanies this portrait is that undocumented immigrants cost taxpayers (who are presumably American citizens) billions of dollars per year in medical care alone. With some hospitals barely staying open because of the strain of uncompensated care, excluding treatment from those whose mere presence in the country is a violation of U.S. law seems to be a good resource management plan. Under this justification, having undocumented immigrant status would weaken one's claim to medical resources while those who are in the

country legally are accorded the same status as citizens vis-à-vis the strength of their claims to a resource.

But there are several problems with this argument, including problems with both the explicit and the implicit assumptions that undergird the argument. For starters, although solid numbers are hard to pin down because of the nature of the study population, estimates of the percentage of illegal immigrants who file some form of income tax (including payroll taxes) are between 50-55%, with some estimates as high as 75%^{cl}. Additionally, even those who do not file income tax pay sales taxes on all of the goods they buy and also pay property taxes through the rent that they pay to landlords^{cli}. Further, several recent studies challenge the picture of rampant health resource overuse by illegal immigrants. These studies show that undocumented Latinos (who make up roughly 80% of the undocumented population in the United States) have a lower rate of use of health services than documented and citizen Latinos^{clii} and there is also some evidence to suggest that undocumented immigrants spend less on health care than native citizens^{cliii}. And even in places like California, which has the highest undocumented immigrant population in the United States and spends an estimated \$9-\$10 billion on uncompensated care for illegal immigrants, a Congressional Budget Office Report states that the amount of money spent is not a large portion of the state health care budget, nor is it disproportional to the size of the immigrant population in the state. The large amount of money California spends on uncompensated care for illegal immigrants constitutes less than 10% of the state's health care budget, which is proportional with the estimates that roughly 8% of California's population is undocumented^{cliv}.

Of course, even if it is proportional, \$9-\$10 billion from one state is still an enormous sum of money. And even using generous estimates, the Congressional Budget Office Report concludes that the government (mostly on the state and local levels) does not take in enough in taxes and other contributions to the economy to offset what they spend on health care and other services, such as law enforcement and education, for illegal immigrants^{clv}. So even if the portrayal of the undocumented immigrant is unjustly harsh, the fact remains that someone has to pay for services for the illegal immigrants who do not pay for themselves. But if the issue is that undocumented immigrants are simply not paying for themselves, then the question is one of ability to pay, not immigration status. Presumably, then, if the undocumented immigrants paid for the medical services and there was no uncompensated care attributable to them, this would be a non-issue. And, as was also the case with using age as a shorthand for potential benefit, using immigration status as a shorthand for ability to pay is unjustified targeting of a particular population. After all, there are plenty of American citizens who also receive uncompensated care and many surely are a greater burden on the health care system, pay fewer taxes and contribute less economically to the community than some illegal immigrants. It is true that the average illegal immigrant family is poorer than the average native-born family or legal immigrant family and less likely to be insured^{clvi} but there are individuals that buck that trend. It simply does not make sense to say that a certain group will be excluded simply because many people in that group are unable to pay; no one asserts that people who live in a particularly poor ZIP code should be denied care because many of the people in that ZIP code are unable to pay for treatments and thus contribute to the shortages.

But this does not have to be understood as an ability to pay issue. Even with resources that are not (directly) paid for, such as organs or blood products, there are arguments in favor of prioritizing citizens over non-citizens. The argument that grounds such reasoning is the most popular argument for prioritizing citizens after ability to pay arguments: community membership. And though the argument from community membership is often a reflection of zealous nationalism or xenophobia, the most prominent discussion around community membership in the literature on organ transplantation is that the relevant community membership is that of the “giving community”. The argument is “that since foreigners are not members of the community which gives organs, it would be unfair to allow them to receive organs”^{clvii}. This can be extended beyond the organ donation debate to encompass a health care giving community, in which undocumented immigrants are “free riders” on American health resources. However, in neither the organ debate nor in the broader health care debate does this argument hold up. Davis and Goldberg, et al. challenge this argument both on the grounds that American citizens comprise the relevant community and also that foreign nationals are not members of a “giving” community. First, Goldberg, et al. challenge the idea that foreign nationals are not members of the giving community by pointing out that American citizens receive 96.2% of the organs but only donate 94.8%. Clearly, Americans do donate the vast majority of organs transplanted in the United States but they do not donate all of them^{clviii}. Others are apparently giving to the giving community.

Davis points out that defining the giving community as American citizens is untenable since not all Americans are willing or able to donate organs and, among

Americans there are some families and religious groups that are opposed to donation (even if they are not opposed to receiving a transplant)^{clix}. Goldberg, et al. point out that this disparity applies to certain racial groups as well^{clx}. Because some Jewish and Muslim sects and blacks donate in proportionately small numbers, should these groups be excluded from the giving community? The question becomes why include all and only American citizens (and legal residents) in the giving community when there are so many groups within America that will not or do not give? The other part of this argument is that there may be those who are willing to donate in other countries but do not have the chance. Clearly then, willingness and ability to donate, to give, does not put a person in the giving community and, by defining the giving community as American citizens and legal residents only, a giving community is not decided by who actually gives or is willing or able to give. And this is why the idea that equating American citizens and legal residents falls apart.

However, the concern about community membership can be understood a different way which is often crudely expressed as “taking care of our own first”. The argument is this: governments and government entities are primarily institutions of the people, by the people and for the people. Because of this, government and government entities have a special obligation to their own citizens to consider their interests over and above the interests of people from other countries. Curbing the use of health care resources by non-citizens protects the interests of American citizens by making sure that as many medical resources are available to citizens as possible. If there were a surplus of medical resources for American citizens, then providing compensated care for undocumented immigrants with that surplus would be acceptable since no American

would be deprived of the resource by giving it to a non-citizen. But America does not have a surplus and since hospital budgets are strained and many Americans go without basic health care, then what medical resources the U.S. does have should go to American citizens. Reducing uncompensated care for non-citizens makes funds available to pay for care for indigent citizens. Or, even if more money is not spent on care for poor Americans, then hospitals will receive some relief and those that may have closed otherwise will be able to stay open, thus providing access to care generally. Resources that would have gone to non-citizens are available for American citizens. In short, because not everyone can receive indicated health care, what resources are available should be given to citizens because of the special obligations of a government to its own people.

But what exactly this special obligation entails is fairly confusing. The governments themselves offer little theoretical help and do not even present a cohesive position. All hospitals that receive federal funds are required by the Emergency Medical Treatment and Active Labor Act (EMTALA) to evaluate everyone who comes to the emergency room and treat those with emergent conditions (including active labor) regardless of immigration status. But then, in an attempt to discourage illegal immigration, the federal legislature passed the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), which broadly denies public benefits (including Medicaid) to nearly all undocumented immigrants. This dramatically curtails federal spending on undocumented immigrants but PRWORA also includes language that allows individual states to pass laws that provide public benefits for undocumented immigrants, thus shifting the financial burden to the state and local

level and, increasingly, to the hospitals themselves³⁰. In Texas, for example, after then-Attorney General of Texas John Cornyn issued a non-binding opinion that PRWORA “prohibits [public hospital districts] from providing free or discounted non-emergency health care to undocumented aliens, even if they reside within the district’s boundaries”^{clxi}, the Texas legislature passed a law permitting, but not requiring^{clxii}, public hospitals to provide non-emergency care to undocumented immigrants. Essentially, despite some federal programs³¹, the decision about whether to provide non-emergency health care to undocumented immigrants, and the burden for doing so, has been passed from the federal government to the states and, at least in Texas, from the state to local government.

But inconsistency in legislative acts is hardly an objection to the theoretical point that governments have special obligations to their citizens with regard to health care. More to the theoretical point, the special obligation can only extend to government entities and programs. The special obligations due citizens over non-citizens can (at least partially) justify federal legislation like PRWORA and other programs that limit what the government will reimburse for non-citizen medical resource use and also UNOS’s restrictions on transplanting organs into foreign nationals and non-resident aliens³². What the special obligations argument cannot justify is making sure all entities in the health care system follow the same priorities regarding immigration status because the special obligation to prioritize citizens and their interests is a government

³⁰ Jones, et al. note that at Harris County (Texas) Hospital District’s Ben Taub Hospital, only about 25% of the \$128 million spent on undocumented immigrants was reimbursed by state or federal funds. See Jones J, McCullough L, and Richman B. My brother’s keeper: Uncompensated care for illegal immigrants. *Journal of Vascular Surgery*. 2006; 44(3); 679-682.

³¹ Such as Medicare’s Disproportionate Share (DiSH) Payments and the \$250 million allotted by the Medicare Modernization Act (2003) to compensate hospitals for care to illegal immigrants. These payments nowhere near offset the expenses incurred by hospitals.

³² UNOS was chosen as the OPTN required by the National Organ Transplant Act (1984).

obligation, not an individual obligation. At most, a government's special obligations can extend to government facilities (such as public hospitals, who might then have policies that bind their employees and those who practice there) but not into the greater medical community. This is the most that an argument from the special obligations of a government to its citizens can do.

3. What is the effect of not directly considering immigration status?

Since all that can be justified in immigration status is for governments to consider their own citizens first, bedside patient selection decisions should not directly consider immigration status. All that can be considered is the impact of those government priorities on other considerations and on the possibilities open to the patient given these restrictions, should they choose to restrict programs and reimbursement to citizens and legal residents. I strongly suspect that the thrust of most concerns about foreign nationals using American health resources is a concern about paying for those resources. It is an interesting side note that there are very few complaints about legal immigrants receiving care or about illegal immigrants receiving care that they pay for, the debate over organs notwithstanding. This concern is addressed by considering a person's ability to pay, though it may play a greater role since a greater number of people will have claims and may not be able to pay if governments and government programs will not reimburse hospitals for no-pay undocumented immigrants. Also, program restrictions will impact the potential benefits available to non-citizens.

Chapter 4: A Theory of Distributive Justice

The set of considerations that I have accepted as affecting a patient's claim to a resource are: need, potential benefit, urgency, past resource use, queuing, a very limited form of desert, responsibility for dependents and a narrow form of ability to pay. But simply identifying these elements, combined with rights from Chapter 2, does not really generate any action-guidance on the issue. Thus, the work of this chapter is to explain how these considerations fit together as a patient's claim and how claims fit with rights to provide guidance to those trying to determine the just course of action. After working through those issues, I will apply the resulting theory to two prismatic cases to demonstrate how this understanding of justice plays out and how it fits in with a larger pluralistic theory for making medical decisions.

Structure

The sections on each of the accepted considerations in the previous chapter contain a brief discussion about whether the consideration would strengthen or weaken a patient's claim to a resource. A bit needs to be said, however, about how this is, i.e., about the nature of the considerations. The considerations are facts about a person's condition or situation within a certain context that *ceteris paribus* generate some kind of duty that they be given (or denied, depending on the consideration) the resource. There are two important elements to this that need to be teased out: the *ceteris paribus* clause and context-dependence. First, the *ceteris paribus* clause does not mean that all considerations have equal weight in all cases; it merely indicates whether the

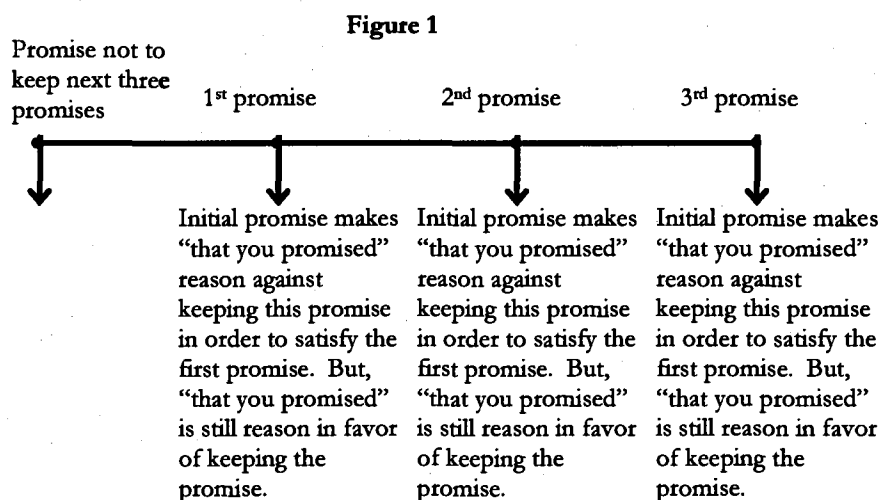
consideration is a reason the person should get the resource (or a reason the person should not get the resource) in this context. To say that a person who needs a resource should, *ceteris paribus*, get that resource simply means that a person's needing a resource is always a reason in favor of giving that resource to the person in the appropriate context. Second, the considerations accepted from the previous chapter are context dependent, which means that in a certain context (medical scarcity) each consideration is a reason that a person should be given a resource, *ceteris paribus*. As such, they are not meant to be the sole arbiters of people's claims to a resource in every distributive situation. The role of the BCS for example, is to distribute the NCAA college football championship each year. It would be difficult to argue that a school's or team's potential to benefit from being a champion should matter or that the fact that a team has been a champion in the past should count against its being a champion this year.

In Dancy's terms, this makes the considerations "contributory principles"^{33clxiii} to which he objects. A person who accepts contributory principles is a generalist (one who believes that "the rationality of moral thought and judgement depends on a suitable provision of moral principles"^{clxiv} and generalists who accept contributory principles suppose, "qua generalist, that a feature that makes a difference in one case will make the same sort of difference in every case, and that there will be a contributory principle specifying its regular contribution"^{clxv}). The "regular contribution" is simply the idea that the fact that a patient, for example, needs a resource will always count in favor of his or her getting the resource. As a particularist (one who believes that there are no

³³ Dancy's seminal work on the topic is his 2001 book but the Stanford Encyclopedia entry is a more recent and clear statement of his objection to contributory principles and so much of what follows will be taken from that account. I will pull examples and clarification from the earlier work, where appropriate, however.

principles but instead morally relevant reasons can count either for or against a course of action in different circumstances), Dancy agrees that there are many relevant facts about the situation that, taken together, determine what the right (or just) thing to do is. However, he objects that particularists “merely want to say that the matter is not regular in the way that [generalists] suppose”^{clxvi}. On this account, the fact that a patient needs a resource might count in favor of a patient getting a resource or count against a patient getting a resource, depending on the circumstances.

Dancy offers three arguments against contributory principles. First, he suggests possible counterexamples to individual contributory principles, such as fidelity. On the generalist account, that one has promised to do Ψ is always a reason in favor of Ψ ing but Dancy imagines a situation in which promising to Ψ is a reason against Ψ ing, such as if one has promised not to keep his or her next three promises^{clxvii}. Since in that case, promising to Ψ is a reason against Ψ ing, promising to Ψ is not always a reason to Ψ and the generalist position does not hold. But this should be thought through more carefully. On Dancy’s account, the earlier promise not to keep the next three promises makes the subsequent three promisings reasons to not keep the promise. But this does not in any way demonstrate that there is no longer any reason at all in favor of keeping the subsequent three promises. That one has promised in all four promisings might still be a reason in favor of keeping those promises (see Figure 1).



The point about a promise being a contributory principle is that it makes “that you promised” always *ceteris paribus* a reason to do whatever it is that you promised. That “that you promised” might also be a reason against is entirely beside the point.

Of course, the particularist might reply that that is beside the point; the point is that the first promise to not keep the next three promises makes the three subsequent promises reasons against keeping the promise and so “that one promised” can be a reason both for and against Ψ ing- it is not regular in the way the generalist says. But if this is the case, then in each of the three subsequent promisings, promising is both a reason for Ψ ing and a reason against Ψ ing. That a reason can be in the same instance a reason for and a reason against Ψ ing is, to say the least, quite awkward. It is much simpler to take the path open to the generalist and claim that, in each promising, that one has promised to Ψ is a reason in favor of Ψ ing but that circumstances are such that the importance of the first promise outweighs the importance of keeping the three

subsequent promises (or, conversely, the importance of one or more of the three subsequent promises outweighs the importance of keeping the first promise).

Dancy's second objection is "to ask *why* we should suppose that a feature that counts in favour in one case must count the same way wherever it appears"^{clxviii} (italics mine) and, as a second question, how can we tell^{clxix}? The standard answer from generalists is that it is a standard method in analytic philosophy and is often applied not only to moral reasons but also to reasons in general, explanations and so on. This follows the scientific method in which theories are developed via generalization of principles^{clxx}. In this case, the answer to Dancy's first objection above shows the resilience to counterexamples. Without assuming a world completely different from the one we actually inhabit, I cannot think of a situation in which, for example, "that a person has a right to Ψ " is not a reason in favor of allowing the person to Ψ . Now, that might be outweighed, and the overall correct action might be to not- Ψ , but being outweighed does not mean that it is a reason against. Incidentally, the answer that Dancy thinks is appropriate but not open to the generalist is that different cases will have different features and in some cases the features will indicate that the reason in question should favor the action while in other cases be against it because of different features of the case^{clxxi}. I think that Dancy's thought that this answer is not available to the generalist rests on a misunderstanding of contributory principles (or, at least, rests on an understanding of contributory principles that is different from this project). As is discussed above, contributory principles include the *ceteris paribus* clause; all other things being equal, the contributory principles counts in favor of (or against, depending on the principle) giving the resource to this person. In the cases where the situation is

radically different, all other things are *not* equal. Recall from above that the BCS will have a different set of contributory principles than medical distributions because it is a completely different distributive situation. What the generalist says is, *ceteris paribus* (i.e., in similar distribution situations) this contributory principle will count in favor of this distribution. If the distribution situation is different, all other things are not equal. In this way, the answer Dancy gives is open to the generalist.

Dancy's final objection (related to the second objection) is broadly that the generalist account of relevance (that is part of the epistemology of contributory principles) assumes that all contributory principles are stand-alone entities and, as such, cannot make sense of interactions between different reasons. On Dancy's view, the generalist account of relevance "understands a feature as relevant here if and only if, *in any case where it is the only relevant feature it would decide the issue*"^{clxxii} (italics his) and he concedes that "if this account of particular relevance were defensible, we would indeed have some reason to suppose that what is relevant here would be relevant in every other situation"^{clxxiii}. Dancy attributes this account to Ross^{clxxiv} but it is not clear why he interprets Ross as saying that relevance is determined by what would be the case if it was the *only* relevant feature. If, as above, Ross is understood as saying that a feature is relevant if, *ceteris paribus*, it decides the issue, then relevance is preserved as is a connection between individual principles because "all other things being equal" recognizes the presence of other things. For example, Dancy points out that "the definition is trying to characterize something that a feature can do in concert with others by appeal to something that can only be done in concert with others... [this is] no better than trying to characterize the contribution made by a football player to his side's

victory by talking only about how things would have been had he been the only player on the field^{clxxv}. But by reading the relevance account as all other things being equal, it is more like characterizing the contribution made by a single player when the other twenty-one players are equally matched and that one player makes all the difference. If he is a superstar, the team wins; if he is no better than the towel boy, the team loses. And, if the other players are not equally matched, this one player's contribution still matters though he may be outplayed.

In none of Dancy's objections do I see sufficient reason to understand the considerations as anything other than contributory principles that, *ceteris paribus*, provide reasons that regularly strengthen (or weaken, depending on the consideration) a patient's claim to the resource in question. Therefore, the next step in determining which patient has the strongest claim to a resource is to determine which patients have a claim to the resource in the first place. Broome argues that because things are being distributed to qualified candidates, the distribution amongst the candidates should be a just one. And this is quite helpful in explaining this particular theory because it explains how patients have claims to the medical resources without having claims to all and anything that would make them better; that is, the claim can only be made on things that are being distributed such that they should be distributed justly. For example, suppose that Fred suffers from kidney failure and is a candidate for transplant. Because UNOS and transplant centers are in the business of distributing cadaveric organs, Fred has a claim on those organs. He does not, however, have a claim on his coworker Beth's kidney no matter how perfectly it may match. This is because Beth's kidney is not being distributed.

However, applying the idea of claims in this particular theory requires a bit more explanation. Consider Broome's original example: "It seems implausible that anyone has a right to a research grant from, say, the Ford Foundation. But if the Ford Foundation decides to distribute research grants, it should surely deal fairly with the applicants"^{clxxvi}. In this case, it is only grant applicants who can have claims on the Ford Foundation but who are the equivalent of the applicants for medical care? Surely, not every person has a claim (however small) to cadaveric kidneys, so how is the field narrowed? In the case of kidney transplantation, it is fairly easy to answer that the people on the transplant list are the ones with claims, but this misses the point. The problem is to explain why certain people have claims, not necessarily to identify those who do. In the case of the Ford Foundation, the applicants have a claim because they have applied; the group is thus self-selecting. But medical resource distribution is not as clean as this as the relationship between distributing institutions and recipient groups is much more complex.

Even though the kidney transplant list example generally misses the point, pushing it one step farther is instructive. The question becomes not who has a claim to the cadaveric kidneys but how a patient gets on the transplant list. Those who are on the transplant list are, putting it quite simply, those who would benefit from a kidney transplant. They have a condition where their kidneys do not work properly and a kidney transplant would (presumably) solve that problem. This explanation holds when extended to other medical situations as well. If a patient has a virus, he or she does not have a claim to antibiotics, since they will surely not help. Thus, what makes a patient part of the group that has a claim on a particular resource is that the patient has the

potential to benefit from the resource. The reason that medical resources are distributed at all is for the sake of benefitting people and so it makes sense that the people who have the potential to benefit from those distributed resources constitute the group of people who have a claim. Potential benefit, in this tier, is all or nothing since if a patient can benefit at all, then he or she has a claim. The amount of the potential benefit only plays into the second tier where the strength of these claims is determined³⁴.

Potential benefit, then, is unique among the other considerations for the double role it plays. First, it is the criterion for entry into the group of people who have a claim to a medical resource and, second, it is a consideration that affects the strength of that claim. This creates a two-tier system where the first tier is entry into the distribution group (the group of people who will be considered to receive the resource) and the second tier is where the relative strength of patient's claims is determined. There are two important points that should be made about this first tier before turning to the mechanics of the second tier. First, it should be noted that entry into the first tier is not solely determined by whether or not a person has a claim to the medical resource. Again, recall from Chapter 2 that rights and claims are separate aspects of a person's entitlement. A person may have a right to a medical resource because he or she own the resource, has entered into a contract for that resource or has some other legal right to the resource. Since rights are not absolute, a person's having a right to the resource does not automatically preclude the resource from being available to others but having the right certainly gives a patient an entry into the distribution group.

³⁴ Note that this statement about claim creation only applies to the type of general medical distribution I have been discussing. If, for example, a hospital can only afford to perform three charity care bone marrow transplants per month and establishes a committee to determine which of the candidates should receive the charity care transplants, then a patient's ability to pay will also be a claim-creating consideration because only those patients who cannot pay would be eligible for charity care.

Second, some might argue that some other consideration should be in the first tier, most notably need. However, this is unnecessarily narrow for two reasons. First, recall that the understanding of need I adopt is a strict understanding: a person needs X in order to Ψ if and only if there are no other alternatives to X that would allow the person to Ψ and he or she cannot Ψ without X. Given this, no one would have any claim to any resource that he or she does not strictly need. Most medical resources are distributed to people who do not strictly need them. In many cases, even patients in kidney failure do not strictly need a kidney transplant because of the availability of dialysis. Usually when someone argues for distribution based on need, they construe need much more broadly. Secondly, as a practical point in this particular context, it is unlikely that there is anyone who will need a medical resource who will not benefit from it. While it is theoretically possible that someone can need X for the sake of some Ψ that is not in any way beneficial, it is hard to see this happening in the medical context.

In the second tier, the strength of the entitlements of those in the distribution group is determined. However, there is no magic wand to wave to automatically sort the competitors for the resource and determine the strongest entitlement and so there must be some mechanism for doing so. One possible strategy is to take QALYs as a model and develop a mathematical calculation that takes into account all of the considerations to determine a patient's claim as well as any rights a patient may have to determine which patient has the strongest overall entitlement. There are some advantages to this approach, not least of all the ease of use of such a model; it offers an opportunity for plug-and-chug ethics. Additionally, the more automated a system is, the

less likely it is to be sabotaged by human error (except of course, for any human error in developing the model). Despite these attractions, this is not the best approach. First, it would be extremely difficult to create a mathematical model that would be sensitive to particular contexts and situations in which the weights of the various considerations and rights differ from other contexts. Additionally, and more problematically, any equation created would require input from a human operator and any output will only be as good as the input that comes from a human operator. Thus, any equation or calculation will likely not be particularly context sensitive and will also be only an added layer of complication on top of a decision maker's reasoned judgment.

Instead, I will rely on reasoned (and clinical) judgment to assess the entitlements of the members of the distribution group. There are some points to bear in mind, however, while assessing people's claims. First, a methodological point about competing claims is introduced in the section on conservation. If a resource is divisible such that different people can use greater or smaller amounts of it, then several weaker claims (or entitlements) combined can override a stronger claim (or entitlement) if all of those with weaker claims could use the resource if the person with the stronger claim does not get it. Thus, claims (or entitlements) are not always considered singly but can be considered as groups if the entire group could use the resource.

Second, although this is certainly controversial, there is no a priori hierarchy among the considerations or among claims and rights. One might argue for a simple priority in the sense that rights always trump claims and, within claims, need always trumps past resource use, which always trumps ability to pay and so on. Another, more appealing, hierarchy option is to make subsets of considerations always trump other

subsets. Indeed, there are some who emphasize medical criteria in medical decision making, including those who think that “medical criteria” such as need, benefit and urgency should be the only criteria for decision making^{clxxvii}. Such a hierarchy might have rights as the primary subset, medical considerations (need, potential benefit and urgency) as the second tier and all the other considerations as the third tier. However, that would render the entitlement determination completely unresponsive to situational context. There are certainly cases where the fact that one patient cannot pay for a resource will be a more important feature of a case than the patient’s need for the resource. Also, the whole reason that one patient’s right to a resource does not make that resource completely unavailable to others (who do not have such rights) is that rights are not absolute and can be overridden by claims.

This does not mean that all rights and considerations are given completely equal status. Certainly, a claim would have to be especially strong to overcome another person’s right to a resource since the nature of a right versus the nature of a claim makes the right a relatively strong reason to give the resource to the person with the right to it. This is especially true considering many people who have rights to resources will also have a claim to the resource in virtue of being able to benefit from it. Additionally, the scope of this project is limited to medical contexts and so because the medical facts of the situation are central to the context of the situation, they are especially important in determining the strength of a patient’s claim. However, this has more to do with the fact that the context of the situation will always be medical than with anything inherent in those particular considerations. Having more a priori *importance* does not equate to an a priori *hierarchy*.

A third issue is the problem of accounting for future claims. In many cases, the resource in question will be sufficient to satisfy all current claims to the resource but it can be anticipated that others will have claims in the future and that the supply of the resource is not sufficient to satisfy those claims as well. Consider the following example:

General Hospital (GH) is a large public urban hospital in a very cold region. It stocks a supply of a special drug that reverses the effects of frostbite. Currently, the city that GH is in is suffering a severe cold snap and it is anticipated to last for another five or six days. Each day, several people are brought in with frostbite ranging from minor to severe enough to require amputation without the frostbite drug. GH has enough to cover everyone who has already presented with frostbite but if it treats all cases of frostbite with the drug, it will run out before the cold snap is over.

If all of the cold snap's frostbite victims presented at the same time, a straightforward determination of their entitlements would settle the issue of who receives the drug. But because the patients present over time, some who would have had much stronger claims to the frostbite drug might go without while those who would have had much weaker claims are treated with the drug. The question is whether and how these potential future claims should be weighed.

One option is to argue that future claims should be given the same weight as current claims; after all the suffering of people tomorrow is just as serious as the suffering of people today. But this is problematic because it is not certain that there will be people with stronger entitlements to the frostbite drug later in the week. The cold snap might end, or maybe the most severe cases will have already presented. This uncertainty should certainly be accounted for. Another option is to completely disregard future claims, since they are not actual, but potential, claims to the resource. It is interesting to note that this move to disregard the potential in favor of the actual is most often made in the literature on the morality of abortion^{clxxviii}. And this makes

some sense, since the suffering of a patient here and now is much more compelling than the possible suffering of *possible* future patients whose claim to the resource is *uncertain*. However, this approach is needlessly strong, especially since there will be varying degrees of certainty in different cases and “uncertain” does not mean “will not occur”.

A better solution to the problem of future claims is a middle ground that is context dependent. The future potential claims of people should be discounted according to the likelihood of there being future patients, how many future patients there might be, whether the dose the actual patient requires would be sufficient to relieve their suffering, how many of them would be helped by the drug, the likelihood of the drug supply being replenished and other contextual factors. In the frostbite case, GH might choose to only use the frostbite drug on patients who have strong claims anyway, such as cases that would cause facial disfigurement or require amputation, since it can be fairly certain to see more severe cases over the next several days. Thus, like most of the literature supports, the potential future claims should be discounted, but not entirely disregarded.

Finally, during the discussion of queuing, the issue of tiebreakers is mentioned. What happens when, after due contemplation, the entitlements are equal among all competitors for the resource? In the queuing section, the idea of wait time as a tiebreaker was entertained and rejected but there are other possible procedural tiebreakers, the most discussed of which to hold a lottery. Now, there are many problems with this approach as a stand-alone arbiter of just distribution in and of itself, especially in the healthcare setting, and these will be discussed in the next chapter.

However, many of these problems for lottery systems as a just distribution system do not really hold for lottery systems as a tiebreaker; as such, if the entitlements of competitors are roughly equal, it seems to make sense that a lottery system could be implemented as a procedural element to break these ties and determine the just distribution of a resource. However, this would be a mistake. The reason is that justice is but one appeal used to determine the correct course of action and not all appeals have to “side” with a particular course of action. That justice is equivocal as to which course of action to take, even if the question is primarily one of distribution of a resource, is not problematic. It simply means that other appeals that are not equivocal on the issue will determine the correct course of action. Now, once all appeals are considered and if all of the appeals are, on balance, equivocal, a tiebreaker might be appropriate at that level. But a tiebreaker would only be appropriate in a scheme for distributive justice if distributive justice were the *only* thing determining the best course of action.

The central element in all of this, and the primary justification for leaving the ultimate determination of a person’s entitlement to a decision maker’s reasoned judgment is that the facts of the particular situation are crucial in determining the relative strengths and weaknesses of patient’s claims. Decision makers should first determine who is in the distribution group by assessing who has rights to the resource in question or who could benefit from it. Then, he or she should evaluate each competitor’s entitlement by weighing the considerations given the facts of the case to determine the person’s claim relative to other competitors and also determining each competitor’s rights. This, combined with the procedural points about competing claims and dealing with future

claims, should guide decision makers in determining which patient(s) should receive the resource.

Illustrative Cases

Finally, I will discuss two cases in order to demonstrate how this theory operates and also fits with a larger pluralist theory of decision making. In reviewing the cases, I will first determine what a just distribution would be and then discuss how the appeal to justice would fit in with the other appeals to determine the best course of action.

Case 1: *Mr. O is a 66 year old black male who arrives in the emergency room with myocardial infarction. The emergency room physician thinks that if he can keep the oxygen flowing to Mr. O's brain during the immediate crisis, he could survive with minimal neurological damage and so he hooks Mr. O to the hospital's only heart lung machine. Unfortunately, over the next several days, it becomes apparent that the damage is worse than initially thought and that Mr. O will not regain consciousness. The physicians meet with Mr. O's family who understand the situation and say that Mr. O would not want to be kept alive and they agree that there should be no escalation in treatment and that Mr. O should not be resuscitated if he should go into cardiac or respiratory arrest. They further agree that the best thing to do is to withdraw the heart-lung machine allow Mr. O to die.*

However, the family has consulted a shaman, who has determined that the optimal time for Mr. O's spirit to leave his body and enter the spirit plane would be eight days hence. They will not agree to withdraw the treatment before then, though they have no objection to the DNR order. In the meantime, Mr. O is monopolizing the heart lung machine. Several surgeries have already been postponed and, if Mr. O remains on the heart-lung machine, five more cardiac bypass surgeries will have to be postponed. Also, Mr. O is going through copious amounts of blood products, which are always in short supply. The question is whether the heart-lung machine should be withdrawn from Mr. O before the eight days are up.

The first step in evaluating justice is determining whether or not Mr. O is a member of the distribution group. Mr. O does not have any apparent rights to the heart-lung

machine or to the blood products since he does not own the heart-lung machine or the blood products, nor does he have any contractual rights. Regarding claims, the question is whether or not Mr. O has the potential to benefit from the heart-lung machine and blood products. It seems clear that he does; even if continued biological life is not a benefit for Mr. O, surviving until the optimal time for his spirit to enter the spirit plane certainly would be. Thus, Mr. O is a member of the distribution group. The question then becomes who else is a member of the distribution group. The clear candidates are the five surgical patients whose surgeries have to be postponed and anyone whose claim for blood products will not be satisfied because of the large amount of blood that Mr. O is using. Regarding the blood products, Mr. O will not completely deplete the supply. Some patients may get O- blood instead of their exact type if they are the same type as Mr. O. Also, physicians will likely hold off on giving blood products to patients who are borderline in whether or not they would benefit from them. Thus, it is not clear that there is any patients who have a claim to the blood products whose claim will not be satisfied. The surgical candidates are another matter. They may not have a right to their surgeries, but they certainly have a claim. After all, they would not have scheduled surgeries if the surgeries do not have the potential to benefit them. Thus, the distribution group includes Mr. O and the five surgical patients and each of them have claims but not rights to the heart-lung machine.

In evaluating the six patients' claims, each patient's need, potential benefit, urgency, responsibility for dependents, past resource use, queuing, desert and ability to pay. Suppose that all of the patients either have insurance or Medicare and so can pay for their treatments and that all have average medical histories and so past resource use

roughly evens out for them all. One of the surgical patients has a son in his sophomore year of college that he supports financially but there are no other responsibilities for dependents. None of the surgical patients have been waiting an especially long time for the surgery but all of their surgeries were scheduled before Mr. O was admitted to the hospital. There are no issues of compensatory desert (since none of the patients is having surgery to correct a prior error), though Mr. O and two of the surgical patients have been regular blood donors.

Mr. O clearly needs the heart-lung machine in order to preserve his life. The need for the surgical patients is less clear. Some of their conditions might be managed by medical means and diet and exercise, though this probably is not true for all of them. Suppose that two of them actually need the surgery and for the other three, other surgical techniques that do not require the heart lung machine or medical management would suffice. But what do the surgical patients need the surgery for? Certainly prevention of heart attacks, which can be life-saving but possibly might also be an issue for quality of life and morbidity, since some people who survive heart attacks have significantly reduced quality of life, especially if there is some anoxic brain injury or some other such complication.

This is what the surgery is needed for, but it also gets into the idea of what the potential for benefit is. The surgical patients then, anticipate significant benefit from the surgeries. Of course, there are also risks; there can be unexpected complications in surgery or after, or the surgery simply may not work. However, cardiac bypass surgery is fairly commonplace and the benefits are well-documented. In Mr. O's case, one potential benefit is that he will live for another eight days. This benefit is fairly likely to

accrue but the quantity of the benefit is questionable since Mr. O will not regain consciousness and his family maintains that he would not want to be kept alive this way. The more important benefit for Mr. O is that living the extra eight days allows his spirit to enter the spirit plane at the most opportune time. This is a significant benefit but it clearly is not imperative, since Mr. O's family does not insist that everything (or, indeed, anything additional) should be done to keep him alive until this time.

Regarding urgency, Mr. O's case is more urgent than any of the surgical patients since his need is immediate; he will die without the machine. The surgical patients will still accrue the benefits of the surgery if their surgeries take place several days later than planned. However, it is the case that patients who need bypass surgeries are in some ways a ticking bomb. Of course, if their physicians believed them to be in imminent danger, the patients would be in for emergency surgery, not for planned surgery. Thus, postponing the surgeries for a week or ten days carries some small but real risk that the benefit of the surgery will not accrue.

Past resource use, desert and ability to pay are all pretty even and so do not support a particular course of action. Since one of the surgical patients has a son who is financially dependent on him, responsibility for dependents favors withdrawing treatment from Mr. O in favor of the surgical patients but the dependence is not severe and there is only one dependent in question so this consideration will not be especially important. Queuing would weakly favor the surgical patients but since no one has been waiting very long and will not have to wait appreciably longer either way, queuing is not a particularly important consideration here. Need likewise supports the surgical patients since two surgical patients need the resource, but urgency strongly favors

keeping Mr. O on the heart-lung machine because he will die immediately without it while the surgical patients can wait. Benefit would also strongly favor the surgical patients, because the benefit they have the potential to accrue is much greater than the benefit Mr. O has the potential to accrue. And, bearing in mind that the combined claims of the surgical patients weigh against Mr. O's claim, it seems that the just course of action is to withdraw the treatment from Mr. O so that the heart-lung machine will be available for the other five surgeries. But though the surgical patients' claim is stronger than Mr. O's it is not a great deal stronger given the strength of the urgency consideration and the immediacy of the benefit he accrues.

But just because withdrawing treatment from Mr. O is the just course of action does not mean that it is the best course of action, all things considered. There are appeals other than justice that may have more importance. For example, the consequences of withdrawing treatment from Mr. O could be serious. In Texas, there is a process set out in the Texas Advance Directives Act that physicians must go through to withdraw treatment from the patient against the wishes of the patient or the patient's legal surrogate in order to be protected from liability for the patient's death.

Withdrawing treatment against a patient or surrogate's wishes without going through the process is not illegal; however, physicians who do so are not protected from liability. The process takes, at a minimum, 12 days. So physicians (or a hospital's risk managers) may be reluctant to withdraw treatment from Mr. O because of a concern about litigation, even if the actual risk of this happening is small. Also, the consequences of withdrawing treatment from Mr. O are much more severe (he loses his life, such as it is, and his spirit does not enter the spirit plane at an optimal time, which

causes his family much grief) than the consequences of a couple of days of surgery for the other patients. More importantly, compassion for the family's and Mr. O's situation would support following the family's wishes and waiting the eight days. Because of these appeals, one could argue that even if the just course of action is to withdraw treatment from Mr. O immediately, the overall best course of action is to wait the eight days before doing so.

Of course, this is a judgment call about which reasonable people can (and did) disagree. It is also the case that if any of the surgical patients had needed surgery emergently (and could not have been transferred to another hospital for treatment) or were more immediately facing dire clinical outcomes without the surgery, then the surgical patients' claim would be much stronger relative to Mr. O's and the appeal to justice would be much more compelling in the overall picture. Additionally, had Mr. O or any of the surgical patients had a right to the heart-lung machine, through ownership or through some sort of contract, then it would require a very strong claim to overcome this right. Thus, even small differences in the facts of the case can dramatically change the final judgment about the best course of action.

Case 2: *In 1962, the arteriovenous shunt, which allowed kidney dialysis to be a chronic treatment for kidney failure, had only recently been developed and there was only one outpatient clinic in the country. The Seattle Artificial Kidney Center did not have enough treatment slots available for everyone, or even most of the people, who needed this life-saving treatment. To decide who would receive the treatment, the Center formed the Admissions and Policy Committee that was comprised of community members (including a minister, lawyer, businessman, homemaker and a labor leader) and two physicians^{clxxxix}. Those that the committee chose to receive the dialysis would likely live while those that were not chosen would die, likely within a couple of weeks.*

Suppose that it is 1962 and there is only one treatment slot currently available. The members of the committee have to decide between the following two people³⁵:

Mrs. A: Mrs. A is 32 year old widow with two young school age children. She works as a secretary to support her family and her sister watches the children while she is at work. Her family lives in the area but her parents are frail and her sister has to care for her ailing in-laws. She does not have health insurance and cannot pay for her treatment, should she receive it. She had been reasonably healthy until she caught a severe case of the flu that caused severe dehydration and, ultimately, kidney failure.

Mr. B: Mr. B is a 40 year old married man with three teenaged children and a large extended family that is very close. His wife stays home with the children and he assembles widgets at a factory. He has health insurance through his job that would pay for the treatment. He has also been reasonably healthy until he suffered from acute appendicitis that required an appendectomy. The surgeon botched the procedure, which, among other complications, led to sepsis and, ultimately, kidney failure.

Neither Mrs. A nor Mr. B has any rights to the dialysis treatments. Both need the dialysis, without which they will die and in both cases, the need is equally urgent.

Regarding the potential for benefit, they are both likely to live the same amount of time with the dialysis and neither has any comorbid conditions that would make them less likely to benefit from the dialysis. However, Mr. B has a large support network to help him get to treatments and to allow him to rest after the treatments. Mrs. A has no such support network. As such, Mr. B is slightly more likely to benefit from the treatment since he will be able to better focus on his own health. Additionally, they have both been waiting about the same amount of time. Mr. B's claim, however, is significantly strengthened by the compensatory desert consideration. Mr. B would not need dialysis had his appendectomy not been botched in the first place.

Both Mrs. A and Mr. B have financial responsibility for their children. Mr. B has more children than Mrs. A, but his children are older and more able to fend for themselves. In addition, Mr. B's large and close family would certainly step in and care

³⁵ The information about the Admissions and Policy Committee is factual. The patient profiles are entirely fictional.

for his children, just as they will for him. And, while no one can replace a lost parent, Mr. B's family can fill some of the emotional needs of his children after his death while Mrs. A's children are emotionally dependent on her. Her family, while they would certainly do what they could for the children, does not have the financial or emotional resources to provide for them adequately. And so even though Mr. B has more children and he is the breadwinner for his family, he has family who will step in and take care of his children both financially and emotionally. Mrs. A has a greater responsibility for her dependents since their financial and emotional well-being rests almost exclusively with her.

However, Mr. B can pay for his treatment, while Mrs. A cannot. Mrs. A's inability to pay for the treatment does not directly cause dialysis to be unavailable to anyone else, but providing dialysis free of charge does have an impact on the Center's coffers and the Center needs money to be able to increase the number of treatment slots available. So, while there is not a one-to-one correlation between Mrs. A's free treatment and some other patient not receiving treatment, her not paying does contribute to others not receiving treatment. Her not paying does not prevent forever an additional treatment slot being opened, however, at most it delays it a bit. Therefore, her inability to pay will only weaken her claim proportionally with the delay in opening an additional slot that her inability to pay contributes to. Thus, though this weakens her claim, it is not weakened much.

This is a difficult judgment to make since the claims are quite even and no rights are involved. Mr. B's claim is strengthened somewhat by his ability to pay for the dialysis and his marginally better potential for benefit. However, it is especially

strengthened by considering compensatory desert. Mrs. A's claim is slightly weakened by her inability to pay but she has a significant responsibility for her dependent children. In this case, I would argue that Mr. B should receive the dialysis since the compensatory desert consideration is something that is owed directly to the patient as a result of the initial botched surgery and the primary relationship in medicine is with the patient. Additionally, Mrs. A's children will be cared for even though they will indeed suffer a significant setback in their interests with the death of their mother; the children are not being condemned to death by the death of their mother. And, in this case, this is important because the other appeals all tend to be a wash and not strongly support one competitor over another. The consequences on both sides are serious and irreversible, the virtues all apply equally to both patients, and so on. In this case, justice is the deciding appeal.

Endnotes

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- ⁱ Winslow 1982, pp. 46-59.
- ⁱⁱ Hume 1902, pp. 183.
- ⁱⁱⁱ Winslow op cit., pp. 47.
- ^{iv} Hume, op cit., pp. 186.
- ^v Ibid., p. 187.
- ^{vi} Winslow, op cit., p. 52.
- ^{vii} Vlastos 1962, p. 53.
- ^{viii} Ibid., p. 54
- ^{ix} Ibid., pp. 59-60
- ^x Winslow, op cit., p. 55.
- ^{xi} Anscombe, G. E. M., discussed in Winslow, op cit. p. 58.
- ^{xii} Ibid.
- ^{xiii} See, for example, <http://www.sciencedaily.com/releases/2008/02/080206131643.htm> and <http://news.bbc.co.uk/2/hi/africa/7058701.stm>.
- ^{xiv} Sisko, et. al.
- ^{xv} Office for National Statistics 2008.
- ^{xvi} Baker 1992.
- ^{xvii} Jagsi, et al. 2004, pp. 2246-2250.
- ^{xviii} Rescher 1966, pp. 81-82.
- ^{xix} Peterson and Jensen.
- ^{xx} Ibid.
- ^{xxi} Barry 1965, p. 97.
- ^{xxii} Carr 2000, p. 47.
- ^{xxiii} Rawls 1958.
- ^{xxiv} Barry, op cit., p. 103.
- ^{xxv} Ibid., p.97.
- ^{xxvi} Carr, op cit., p. 2.
- ^{xxvii} Peterson and Jensen, op.cit.
- ^{xxviii} Goodwin 1992, p. 101.
- ^{xxix} Ibid., pp. 78-83.
- ^{xxx} Sher 1980, p. 213.
- ^{xxxi} Ibid., pp. 203-216.
- ^{xxxii} Goodwin, op cit., p. 78.
- ^{xxxiii} Ibid., p. 85.
- ^{xxxiv} Rawls 1999.
- ^{xxxv} Ibid., p. 266.
- ^{xxxvi} Ibid.
- ^{xxxvii} Okin 1989.
- ^{xxxviii} Daniels 2001, p. 3.
- ^{xxxix} Ibid., pp. 9-10. See also Daniels 2008, especially Ch. 4
- ^{xl} Ibid., p. 10.
- ^{xli} Ibid., p. 9.
- ^{xlii} Ibid., p. 9.
- ^{xliiii} Ibid., p. 9.
- ^{xliv} Parfit 1997, p. 213.
- ^{xliv} Ibid., p. 213.
- ^{xlvi} Ibid., p. 214.
- ^{xlvi} Rescher, op cit. See Ch. 4.
- ^{xlvi} Ibid., p. 82.
- ^{xlix} Ibid., p. 82.
- ^l Rescher, op cit., p. 83.
- ^{li} Broome 1990-1991, p. 95.

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- lii *Ibid.*, p. 95.
liiii *Ibid.*, p. 91.
liv *Ibid.*, p. 92.
lv *Ibid.*, p. 91.
lvi *Ibid.*, pp. 93-94.
lvii *Ibid.*, p. 96.
lviii *Ibid.*, p. 90.
lix *Ibid.*, p. 96.
lx *Ibid.*, p. 93.
lxi Jagsi, et al., op cit.
lxii Kilner 1990.
lxiii See Kilner, op cit., p. 116; Norris 1999, pp. 2-3; and Winslow, op cit., pp. 92-95 for examples of this confusion.
lxiv Wiggins 1998, pp. 7-10.
lxv Thomson 1987, pp. 3-4.
lxvi *Ibid.*, p. 3.
lxvii *Ibid.*, pp. 6-7.
lxviii Frankfurt 1981, p 1.
lxix Doyle 1998, pp. 170.
lxx *Ibid.*, pp. 162-163.
lxxi *Ibid.*, p. 158.
lxxii Wiggins, op. cit., pp. 9-11, 14-16.
lxxiii Thomson, op. cit., p. 8.
lxxiv Wiggins, op. cit., p. 14. All punctuation and italics are Wiggins'.
lxxv *Ibid.*, p. 15. Italics are Wiggins'.
lxxvi Feinberg 1984, p. 33.
lxxvii *Ibid.*, p. 139.
lxxviii Bentham, esp. ch. 4.
lxxix Gems 2003, p.35.
lxxx Homeric Hymn to Aphrodite.
lxxxi Schermer 2003, p. 38.
lxxxii Nussbaum 1999, p. 41.
lxxxiii Blagg 2004.
lxxxiv Dirckx 2001.
lxxxv United Network for Organ Sharing 2009.
lxxxvi Saab et al. 2003.
lxxxvii Northup and Berg 2004.
lxxxviii Kilner, op cit. p. 77.
lxxxix *Ibid.*, p. 78.
xc *Ibid.*, p. 81.
xci Kilner, op cit., p. 80.; Daniels 1988; Cupit 1998; McKerlie 2002; among others.
xcii Cupit, op cit., pp. 703-704.
xciii *Ibid.*, p. 704.
xciv Schoen C, et al. 2005.
xcv Kilner, op cit., pp. 177-78.
xcvi Committee on the Consequences of Uninsurance, 2002.
xcvii Nozick 1974.
xcviii This is actually a point made by Jared Diamond in a different context. See Diamond 1997.
xcix Cohen 2008.
c Winslow op cit., p. 78.
ci Kilner, op cit., p. 67.
cii Feinberg 1970, p. 56.
ciii *Ibid.* p. 61. See also Olsaretti 2003, p. 4.
civ See Feinberg 1970, op. cit. pp. 58-59 and Olsaretti, op. cit., p. 4.
cv See Olsaretti, op. cit., p. 4 and Sher 1987.

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- cvi Sher, op. cit., p. 15.
cvii Rawls, op cit.
cviii Feinberg 1970, op. cit., p. 62.
cix Ibid., p. 63-65.
cx Ibid., p. 74.
cxii Sher 1987, op. cit. pg. 199. See also Feinberg 1970, op. cit. pg. 61.
cxiii Sher, op. cit. pp. 44-45.
cxiiii Ibid., pp. 141-145.
cxv Ibid. pg. 45.
cxvi Ibid., p. 40.
cxvii Ibid., p. 45-46.
cxviii Ibid., p. 204.
cxviiii Ibid., p. 204.
cxix Winslow op cit., p. 73.
cxx Foot 2002, p. 24.
cxxi Winslow, op.cit. p. 73.
cxxii Taurek 1977. See also Russell 2002.
cxxiii Taurek, op cit., p. 307.
cxxiv Winslow, op cit. p. 74.
cxxv Ubel et al. 1993, p. 2471.
cxxvi Ibid.
cxxvii Ibid.
cxxviii Veatch 2000, pp. 331-332.
cxxix Ibid., p. 331.
cxxx Ibid., p. 330.
cxxxi Winslow, op cit., p. 100.
cxxxii Larson 1987, p. 895.
cxxxiii Ibid., p. 896.
cxxxiv Winslow, op cit., pp. 98-101.
cxxxv Brady 2002, p. 163.
cxxxvi Childress 1970.
cxxxvii Ibid., pp. 348-349.
cxxxviii Ibid., pp. 347, 352.
cxxxix Committee on the Consequences of Uninsurance, op cit., pp. 11-12.
cxli Ibid., pp. 5-6.
cxlii Ibid., p. 6.
cxliii Ibid.
cxliiii Fried C in Winslow, op cit., pp. 99-100.
cxliiii Winslow op cit., p. 3.
cxliiii Childress, op cit.
cxliiii Veatch, op cit. p. 301.
cxliiii TX HSC 166.009.
cxliiii Bjorkman and Hansson 2006.
cxlix Locke www.constitution.org/jl/2ndtr05.htm.
cli CBO Report, op cit.
cli CBO Report, op cit.
clii Ortega, et al. 2007.
cliii Goldberg, et al. 2007.
cliv CBO Report, op cit.
clv Ibid.
clvi Ibid.
clvii Davis 1992, p. 337.
clviii Goldberg, et al., op cit.
clix Davis, op cit.
clix Goldberg, et al. op cit.

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- clxi Opinion JC-0394
clxii Opinion GA-0219
clxiii Dancy 2009. See also Dancy 2004, p. 18-19.
clxiv Dancy 2009, op cit.
clxv Ibid.
clxvi Ibid.
clxvii Ibid.
clxviii Ibid.
clxix Ibid.
clxx See also Hempel 1942; Danto 1965; and Kuhn 1996.
clxxi Ibid.
clxxii Ibid.
clxxiii Ibid.
clxxiv Ross 1930. See especially pp. 19-20.
clxxv Dancy 2004, op cit. p. 19.
clxxvi Broome op cit., p. 97.
clxxvii Cookson and Dolan 2000. Although they do not exclusively use a hierarchy system, see Jagsi et al.,
op cit.
clxxviii For a sample of the debate, see the "Debate" section of the *Journal of Medical Ethics* 28: 2002; pp.
192-204.
clxxix Jonsen 2007.

Bibliography

American College of Physicians. Achieving a high-performance health care system with universal access: What the United States can learn from other countries. *Annals of Internal Medicine*. 148(1): 2008; 55-75.

Anderek W. From patient to consumer in the medical marketplace. *Cambridge Quarterly of Healthcare Ethics*. 16: 2007; 109-113.

Anscombe G. Who was wronged? *Oxford Review*. V: 1967; 16-17.

Armstrong CR and Whitlock R. The cost of care: Two troublesome cases in health care ethics. *Physician Executive*. 24(6): 1998; 32-35.

Baily M. The democracy problem. *The Hastings Center Report*. 24(4): 1994; 39-42.

Baker R. The inevitability of healthcare rationing: A case study of rationing in the British National Health Service. In Strosberg M, Wiener J, Baker R and Fein A. Rationing America's medical care: The Oregon Plan and beyond. The Brookings Institution Press: 1992.

Barry B. Political argument. The Humanities Press: 1965.

Bayer R, Caplan A and Daniels N. In Search of Equity. Plenum Press: 1983.

Beauchamp T and Childress J. Principles of biomedical ethics: 5th edition. Oxford University Press: 2001.

Bentham J. An introduction to the principles of morals and legislation. <http://www.utilitarianism.com/jeremy-bentham/index.html#four>. Chapter 4.

Bergthold L. Medical necessity: Do we need it? *Health Affairs*. 14(4): 1995; 180-190.

Berenson A. Pinning down the money value of a person's life. *New York Times*. June 11, 2007.

Bjorkman B and Hansson SO. Bodily rights and property rights. *Journal of Medical Ethics*. 32: 2006; 209-214.

Blagg C. Triage: Napoleon to the present day. *Journal of Nephrology*. 17(4): 2004; 629-632.

Broome J. Fairness. *Proceedings of the Aristotelian Society* 91: 1990; 87-101.

Brady F. Lining up for Star Wars tickets: Some ruminations on ethics and economics based on an internet study of behavior in queues. *Journal of Business Ethics*. 38: 2002; 157-165.

Brock G. Morally important needs. *Philosophia- Philosophical Quarterly of Israel*. 26(1-2): 1998; 165-181.

-----, Ed. Necessary goods. Rowman and Littlefield Publishers, Inc.: 1998.

Brock G and Reader S. Needs-Centered Ethical Theory. *Journal of Value Inquiry*. 36(4): 2002; 425-434.

Brody B. Life and death decision making. Oxford Press: 1988.

Callahan D. Medical futility, medical necessity. *The Hastings Center Report*. 21(4): 1991; 30-35.

Carr C. On Fairness. Ashgate Publishing Ltd.: 2000.

Cassell E. The principles of the Belmont Report revisited. *The Hastings Center Report*. 30(4): 2000; 12-21.

Childress J. Who shall live when not all can live? *Soundings*. 53(4): 1970; 339-362.

Chapman G and Elstein A. Valuing the future. *Medical Decision Making*. 15(4): 1995; 373-386.

Clarke C. Rationing scarce life-sustaining resources on the basis of age. *Philosophical and Ethical Issues*. 35(5): 2001; 799-804.

Cookson R and Dolan P. Principles of justice in health care rationing. *Journal of Medical Ethics*. 26(5): 2000; 323-329.

Coleman M and Kellermann A, Chairs, Committee on the Consequences of Uninsurance, Board on Health Care Services, Institute of Medicine. Care without coverage: Too little, too late. National Academy of Science Press: 2002.

Cohen J, Neumann P and Weinstein M. Does preventive care save money? Health economics and the presidential candidates. *NEJM*. 358(7): 2008; 661-663.

Cupit G. Justice, Age and Veneration. *Ethics*. 108: 1998; 702-718.

-----, Fairness. *Mind*. 113(450): 2004; 387-390.

Daniels N. Just health: Meeting health needs fairly. Cambridge University Press: 1985.

-
- . Am I My Parents' Keeper? Oxford University Press: 1988.
- Four unsolved problems: A challenge. *The Hastings Center Report*. 24(4): 1994; 27-30.
- Justice, health and healthcare. *The American Journal of Bioethics*. 1(2): 2001; 2-16.
- Just health. Cambridge University Press: 2008.
- Dancy J. Ethics Without Principles. Clarendon Press: 2004.
- Moral Particularism. Stanford Encyclopedia of Philosophy Online <http://plto.stanford.edu/entries/moral-particularism/> Accessed Jan 14, 2009
- Danto A. Analytical philosophy of history. Cambridge University Press: 1965.
- Davis D. Organ transplants, foreign nationals and the free rider problem. *Theoretical Medicine*. 13: 1992; 337-347.
- De Meester J, Persjin G, Claas H and Frei U. In the queue for a cadaver donor kidney transplant: New rules and concepts in the Eurotransplant International Foundation. *Nephrology Dialysis Transplant*. 15: 2000; 333-338.
- Diamond J. Guns, Germs and Steel. W.W. Norton and Co.: 1997.
- Dirckx JH, ed. Stedman's concise medical dictionary for the health professions: Illustrated 4th edition. Lippincott, Williams and Wilkins: 2001.
- Donaldson C. Valuing the benefits of publicly provided health care: Does 'ability to pay' preclude the use of 'willingness to pay'? *Social Science and Medicine*. 49: 1999; 551-563.
- Doyal L. The moral foundation of the clinical duties of care: Needs, duties and human rights. *Bioethics*. 15(5/6): 2001; 520-535.
- Doyle L. A theory of human need. In Brock G. Necessary Goods. Rowman and Littlefield Publishers, Inc.: 1998.
- Ells C. Good policy, good process. *The American Journal of Bioethics*. 1(2): 2001; 34-35.
- Elster J. Local justice. Russell Sage Foundation: 1992.

Engelhardt H T, Rie M. Intensive care units, scarce resources and conflicting principles of justice. *JAMA*. 255(9): 1986; 1159-1164.

Engelhardt HT Jr., and Iltis AS. Allocation of medical resources. *A Companion to Applied Ethics*. 2003: 396-409.

Feinberg J. Doing and deserving. Princeton University Press: 1970.

----- Harm to others. Oxford University Press: 1984.

Fleck L. Healthcare justice and rational democratic deliberation. *The American Journal of Bioethics*. 1(2): 2001; 20-21.

Fleischaker S. A short history of distributive justice. Harvard Press: 2004.

Foot P. Virtues and Vices. Oxford University Press: 2002.

Friedman A and Friedman E. Illegal aliens are not entitled to federally funded organ transplants. *Transplantation*. 83(1): 2007; 21-23.

Frankfurt H. Necessity and desire. *Philosophy and Phenomenological Research*. 45(1): 1984; 1-13.

----- Comments on Gillian Brock's essay "Morally Important Needs"
Philosophia- Philosophical Quarterly of Israel. 26(1-2): 1998; 179-180.

Gems D. Is more life always better? The new biology of aging and the meaning of life. *Hastings Center Report*. 33(4): 2003; 31-39.

Goldberg A, Simmerling M, Frader J. Why nondocumented residents should have access to kidney transplants. *Transplantation*. 83: 2007; 17-20.

Goodin R. The priority of needs. *Philosophy and Phenomenological Research*. 45(4): 1985; 615-625.

Goodwin B. Justice by lottery. Harvester/Wheatsheaf Press: 1992.

Gorovitz S. Justice in healthcare and dimpled chads. *The American Journal of Bioethics*. 1(2): 2001; 29-30.

Green R. Access to healthcare: Going beyond fair equality of opportunity. *The American Journal of Bioethics*. 1(2): 2001; 22-23.

Hackler C. Justice and human nature. *The American Journal of Bioethics*. 1(2): 2001; 38-39.

Hemple C. The function of general laws in history. *Journal of Philosophy*. 39(2): 1942; 35-48.

Henderson M, Meyers F, Ibrahim T and Tierney L. Confronting the brutal facts in health care. *American Journal of Medicine*. 118(10): 2005; 1061-1063.

Hume D. An enquiry concerning the principles of morals. In Selby-Bigge LA. *Enquiries*. Clarendon Press: 1902.

Jagsi R, DeLaney T, Donelan K and Tarbell N. Real-time rationing of scarce resources: The Northeast Proton Therapy Center experience. *Journal of Clinical Oncology*. 22(11): 2004; 2246-2250.

John B. Fairness versus doing the most good. *The Hastings Center Report*. 24(4): 1994; 36-40.

Jonsen A. The God squad and the origins of transplantation ethics and policy. *The Journal of Law, Medicine and Ethics*. 35(2): 2007; 238-240.

Kamm F. *Morality, Mortality*. Oxford University Press: 1993.

----- To Whom? *The Hastings Center Report*. 24(4): 1994; 29-32.

----- Health and Equality of Opportunity. *The American Journal of Bioethics*. 1(2): 2001; 17-19.

Kilner J. *Who lives? Who dies?* Yale University Press: 1990.

Koch T. *Scarce goods*. Praeger Press: 2002.

Kraut R. Desire and the human good. *Proceedings and Addresses of the American Philosophical Association*. 68(2): 1994; 39-54.

Krohmal B and Emanuel E. Access and Ability to Pay: The Ethics of a Tiered Health Care System. *Archives of Internal Medicine*. 167: 2007; 433-437.

Kronick R. Valuing charity. *Journal of Health Politics, Policy and Law*. 26(5): 2001; 993-1001.

Kuczewski M. The illegal alien who needs surgery. *Cambridge Quarterly of Healthcare Ethics*. 9: 2000; 129-135.

-
- Kullgren J. Restrictions on undocumented immigrants' access to health services: The public health implications of welfare reform. *American Journal of Public Health*. 93(10): 2003; 1630-1633.
- Kuhn T. The structure of scientific revolutions: 3rd edition. University of Chicago Press: 1996.
- Kumar R. Rationing problems and the aims of ethical theory. *The American Journal of Bioethics*. 1(2): 2001; 30-31.
- Langtry B. Young on decisions concerning medical aid. *Theory and Decision* 8: 1977; 377-379.
- LaPuma J and Lawlor E. Quality adjusted life-years: Ethical implications for physicians and policy makers. *JAMA*. 263(21): 1990; 2917-2921.
- Larson R. Perspective on queues: Social justice and psychology of queueing. *Operations Research*. 35(6): 1987; 895-905.
- Liu L, Rettenmaier A and Saving T. Longevity bias in cost-effectiveness analysis. *Health Economics*. 17: 2008; 523-534.
- Loewy E. The social nexus of healthcare. *The American Journal of Bioethics*. 1(2): 2001; 37.
- Mahowald M. Why Retreat to Procedural Justice? *The American Journal of Bioethics*. 1(2): 2001; 25-26.
- Maus A. Debate. *Journal of Medical Ethics*. 28: 2002; 192-204.
- McKerlie D. Equality between age groups. *Philosophy and Public Affairs*. 21(3): 1992; 275-295.
- Justice between the young and the old. *Philosophy and Public Affairs* 30(2): 2002; 153-175.
- Menzel P, Gold M, Nord E, Pinto-Prades J, Richardson J and Ubel P. Toward a broader view of values in cost effectiveness analysis of health. *The Hastings Center Report* 29(3): 1999; 7-15.
- Mooney G, Jan S and Wiseman V. Staking a claim for claims: A case study of resource allocation in Australian Aboriginal health care. *Social Science and Medicine*. 54: 2002; 1657-1667.

-
- Mooney G. 'Communitarian claims' as an ethical basis for allocating health care resources. *Social Science and Medicine*. 47(9): 1998; 1171-1180.
- Moriarty J. Against the asymmetry of desert. *Nous*. 37(3): 2003; 518-536.
- Mukherjee J. Basing treatment on rights rather than ability to pay: 3 by 5. *The Lancet*. 363: 2004; 1071-1072.
- Murphy T. The ethics of multiple vital organ transplants. *The Hastings Center Report*. 32(2): 2002; 47-48.
- Nagy G, Tr. Homeric Hymn to Aphrodite.
http://courses.dce.harvard.edu/~clase116/txt_aprodite.html. Accessed March 23, 2009.
- Nickel J. Should undocumented aliens be entitled to healthcare? *The Hastings Center Report*. 16(6): 1986; 19-23.
- Norris P. Medical necessity: A helpful concept? *Health Care Ethics*. 7(3): 1999; 2-3.
- Northup and Berg. Preoperative delta MELD score does not independently predict mortality after liver transplantation. *American Journal of Transplantation*. 4(10): 2004; 1643-1649.
- Nozick R. Anarchy, state and utopia. Basic Books: 1974.
- Nussbaum M. Sex and social justice. Oxford University Press: 1999.
- Office for National Statistics. Expenditure on health care in the UK.
<http://www.statistics.gov.uk/articles/nojournal/ExpenditureonHealth08.pdf>. Accessed April 2008.
- Okin S. Justice, gender and family. Basic Books: 1989.
- Olsaretti S, ed. Desert and social justice. Oxford Press: 2003.
- Olsen J, Richardson J, Dolan P and Menzel P. The moral relevance of personal characteristics in setting health care priorities. *Social Science and Medicine*. 57: 2003; 1163-1172.
- Ortega A, Fang H, Perez VH, Rizzo JA, Carter-Pokras O, Wallace SP and Gelberg L. Health care access, use of services and experiences among undocumented Mexicans and other Latinos. *Archives of Internal Medicine*. 167(21): 2007; 2354-2360.
- Parfit D. Equality and priority. *Ratio*. 10(3): 1997; 202-221.

-
- Peterson M and Jensen KK. The lottery approach to distributive ethics. <http://www.ltu.se/sku/d3811/d141/1.4012>. Accessed February 2009.
- Pojman L and McLeod O, eds. What do we deserve? Oxford University Press: 1999.
- Powers M. Forget about equality. *Kennedy Institute of Ethics Journal*. 6(2): 1996; 129-144.
- Rakowski E. The aggregation problem. *The Hastings Center Report* 24(4): 1994; 33-37.
- Rawls J. Justice as fairness. *Philosophical Review* 67: 1958; 164-194.
- A theory of justice: Revised edition. Harvard University Press: 1971.
- Reader S, ed. The philosophy of need. Cambridge University Press: 2005.
- Rescher N. Distributive justice. Bobbs-Merill Press: 1966.
- The allocation of exotic medical lifesaving therapy. *Ethics*. 79(3): 1969; 173-186.
- Resnik D. The precautionary principle and medical decision making. *Journal of Medicine and Philosophy*. 29(3): 2004; 281-299.
- Rhodes R. Justice, medicine and medical Care. *The American Journal of Bioethics*. 1(2): 2001; 32-33.
- Robberstad B. QALYs vs DALYs vs LYs gained: What are the differences and what difference do they make for health care priority setting. *Norsk Epidemiologi*. 15(2): 2005; 183-191.
- Ross D. The right the good. Stratton-Lake P, ed. Oxford University Press: 1930.
- Rothenberg L. Withholding and withdrawing dialysis from elderly ESRD patients part 2: Ethical and policy issues. *Journal of Geriatric Nephrology and Urology* 3: 1993; 23-41.
- Russell B. Fair distribution and patients who receive more than one organ transplant. *Journal of Clinical Ethics*. 13(1): 2002; 40-48.
- Sassi F. Calculating QALYs, Comparing QALY and DALY calculations. *Health Policy and Planning*. 21(5): 2006; 402.

Saab S, Wang V, Ibrahim AB, Durazo F, Han S, Farmer DG, Yersiz H, Morrissey M, Goldstein LI, Ghobrial RM, Busutil RW. MELD score predicts 1-year patient survival post-orthotopic liver transplantation. *Liver Transplantation*. 9(5): 2003; 473-476.

Schaffner K. Biopsychosocial foundations. *The American Journal of Bioethics*. 1(2): 2001; 26-27.

Schermer M. In search of the 'good life' for the demented elderly. *Medicine, Health Care and Philosophy* 6: 2003; 35-44.

Schoen C, Doty M, Collins S and Holmgren A. Insured but not protected: How many adults are underinsured? *Health Affairs Web Exclusive*. June 14, 2005. www.content.healthaffairs.org/cgi/content/full/hlthaff.w5.289/DC1 accessed on October 11, 2007.

Segev R. Well-being and fairness in the distribution of scarce health resources. *Journal of Medicine and Philosophy* 30: 2005; 231-260.

Sen A. Utilitarianism and welfarism. *The Journal of Philosophy*. 76(9): 1979; 463-489.

Shelp E, ed. Justice and health care. D. Reidel Publishing Co.: 1981.

Sher G. What makes a lottery fair? *Nous* 14: 1980; 203-216.

----- Desert. Princeton University Press: 1987.

Silvers A. No basis for justice: Equal opportunity, normal functioning and the distribution of healthcare. *The American Journal of Bioethics* 1(2): 2001; 35-36.

Sisko A, et al. Health spending projections through 2018: Recession effects add uncertainty to the outlook. *Health Affairs-Web Exclusive*. February 24, 2009.

Strauss M, LoGerfo J, Yeltatzie J, Temkin N, Hudson L. Rationing of intensive care unit services: An every day occurrence. *JAMA*. 255(9): 1986; 1143-1146.

Strosberg M, Wiener J, Baker R, Fein A. Rationing America's medical care: The Oregon Plan and beyond. The Brookings Institution Press: 1992.

Tauber A. A philosophical approach to rationing. *MJA* 178: 2003; 454-457.

Taurek J. Should the numbers count? *Philosophy and Public Affairs*. 6(4): 1977; 293-316.

Thompson G. Needs. Routledge and Kegan Paul: 1987.

Truog R, Brock D, Cook D, Danis M, Luce J, Rubenfeld G, and Levy M. Rationing in the intensive care unit. *Critical Care Medicine*. 42(4): 2006; 958-963.

Ubel P, Arnold R, Caplan A. Rationing failure: The ethical lessons of scarce vital organs *JAMA*. 270(20): 1993; 2469-2474.

Veatch R. Egalitarian and maximin theories of justice: Directed donation of organs for transplant. *Journal of Medicine and Philosophy*. 23(3): 1998; 456-476.

----- Transplant ethics. Georgetown University Press: 2000.

Vlastos G. Justice and equality, In Brandt R, ed. *Social Justice*. Prentice-Hall, Inc.: 1962.

Walzer M. *Spheres of justice*. Basic Books: 1983.

Waymack M. Daniels on justice and healthcare: Laudable goals – questionable method. *The American Journal of Bioethics* 1(2): 2001; 28-30.

Weiner S. I can't afford that! Dilemmas in the care of the uninsured and underinsured. *Journal of General Internal Medicine*. 16: 2001; 412-418.

Wennberg J, Fisher E, Goodman D and Skinner J. Tracking the care of patients with severe chronic illness. *Dartmouth Atlas of Health Care*: April 2008.

Weinstein M. Should physicians be gatekeepers of medical resources? *Journal of Medical Ethics*. 27(4): 2001; 268-274.

Westervelt, F. A Reply to Childress: the Selection Process as Viewed from Within. *Soundings*. 53(4) 356-362.

Wiesner R, McDiarmid S, Kamath P, Edwards E, Malinchoc M, Kremers W, Krom R and Kim W. MELD and PELD: Applications of survival models to liver allocation. *Liver Transplantation*. 7(7): 2001; 567-580.

Wiggins D. *Needs, values, truth*: 3rd ed. Clarendon Press: 1998.

Winslow G. *Triage and justice*. University of California Press: 1982.

Young R. Some criteria on decisions concerning medical aid. *Theory and Decision* 6: 1975; 439-455.

Zoloth L. Justice as cardiovascular therapy. *The American Journal of Bioethics* 1(2): 2001; 24-25.