# BIOETHICS OUTLOOK

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# Justice in the allocation of health care resources: the debate about criteria

**Bridget Hogan**

## In this issue

This issue is devoted exclusively to a discussion of some contemporary ideas about the criteria which should be used in decisions about the allocation of scarce medical and nursing resources.

Bridget Hogan, a graduate of the Master of Arts in Applied Ethics at Australian Catholic University, argues that considerations of social worth criteria, considerations relating to a sick person's capacity to pay, and considerations relating to the thought the sick person is somehow 'responsible' for his or her own ill health are all morally-irrelevant criteria.

She explains and defends the idea that distributive criteria should reflect the nature of what is being distributed, and in particular the idea that the distribution of health care should primarily reflect considerations of health care *need*.

*George Burnham and Donald Mattison were patients in adjoining rooms in the rehabilitation division of a state medical centre.*

*George was a thirty-three year-old, severely retarded man who had lived in state institutions since the age of three. His family had had no contact with him for over twenty years. George had been trained to feed himself and to keep himself reasonably clean but, at the age of twenty-five, he had suffered a cardiac arrest that left him with some paralysis. After rehabilitation, he only occasionally lacked bowel control. A second cardiac arrest left him semi-paralysed and totally incontinent. The chances of his regaining even his former level of continence, the staff felt, were hopeless.*

*Donald Mattison, a forty-eight-year old businessman, active in community and church affairs, married, and the father of four, had suffered a minor stroke, which left him slightly paralysed. In his six weeks on the rehabilitation ward, he had regained almost total use of*

*paralysed arm and leg. His prognosis for full recovery seemed excellent.*

*The hospital had at least one cardiac arrest team on duty twenty-four hours a day, and one crash cart in every patient area at all times. The possibility of simultaneous cardiac arrests seemed remote. If it were to happen, there would not be time to transfer an additional crash cart from another patient area, since the rehabilitation ward was served by an extremely slow elevator.*

*But in this case the improbable happened. George had a cardiac arrest at 3:00 one morning. Within four minutes the cardiac team had arrived in his room and was ready to begin work. At that very moment, Donald also had a cardiac arrest. Knowing of the simultaneous cardiac arrests, every team member hesitated. Two also knew both patients' histories; the others, including the team leader, did not. After a moment, the team leader said, "First come, first served. Let's go to work." With no further hesitation, the team began to resuscitate George.*

*Without the emergency aid, Donald died. George was resuscitated but suffered yet another cardiac arrest at 8:20 the next morning. This time another team was unable to revive him and he, too, died.*[1]

This case demonstrates the moral dilemmas often faced by health care professionals in the absence of sufficient means to treat all in need. It also highlights the two competing theories that most often influence decisions about who to treat in situations of scarcity: utilitarianism and egalitarianism.[2] In this case, without any other knowledge but that of the immediate medical need, the medical team leader defaulted to the egalitarian principle of 'first come, first served'.[3] However, clinical experience and research provide evidence that, when there is either *actual* or even *assumed* information about competing patients in situations of scarcity, utilitarian judgements of social worth often influence the allocation of medical resources: in effect, determining some lives to be less worthwhile than others. In arguing against such utilitarian determinations, I shall use Walzer's idea that there are various spheres of life in which different criteria of justice are relevant and that tyranny ensues when the principles of justice appropriate to a distributive sphere are disregarded.[4] I shall argue that it is the criteria of *traditional medical ethics* that rightly belong to the sphere of health care, and that their omission from considerations of rationing do indeed lead to the tyrannies of utility judgments, blame judgments and judgments which invoke the ability to pay. All of these can harbour judgments of social worth that can undermine a patient's human worth. While traditional medical ethics, which was once sufficient for the traditional, largely non-rationing medicine of the one-to-one, physician-patient relationship is not wholly sufficient for modern rationing *population medicine*, nonetheless if we are to protect against the tyranny of social worth criteria, the criteria of traditional medical ethics still need to take priority in considerations of medical resource allocations.

## Clinical experiences of social worth

Research and clinical experience demonstrate that the allocation of scarce medical resources is often influenced by social worth criteria. The report of the Australasian Conference on Hepatitis C found that the disease is stigmatised because it is associated with injecting drug users. The report also found clinical evidence of its being treated as a 'second class disease' by health care professionals who exhibited 'attitudes of blame'.[5] It reports patients receiving substandard treatment or being refused treatments and having their serostatus reported to non-appropriate health care workers without their permission. The report also revealed that the perceived discrimination of health care workers and society at large resulted in people with hepatitis C failing to present for testing, treatment and support.

McConnell observes that the majority of health care professionals are decent people who often expose themselves to risks in order to provide proper care for their patients. But he claims that *being decent* is too vague; that

health care professionals lack specific guidelines as to *how* a decent person ought to act in day-to-day health care. So, in situations of resource scarcity, discriminatory attitudes of physicians and nurses can come to affect decisions.[7] The American Nurses Association (ANA) supported McConnell's claim when it expressed its concern over the evidence of discrimination by its nurses, 90% of whom are white females, toward patients of non-white races and lower socio-economic classes.[8] The ANA said that even when black, lower socio-economic people have equal access and can pay, they are less likely than are whites to receive surgical or other therapies and that these disparities derive from *personal characteristics* and *race*. The ANA notes similar disparities in treatment in regard to the aged and disabled. It calls for health care workers to examine their own attitudes and practices so that biases may be eliminated from decision making by medical and nursing professionals.

McConnell and Campbell point out that rationing often involves moral dilemmas and that it involves moral as well as medical considerations.[11] They suggest that it is this recognition of the moral element involved in decisions about rationing that explains why so many hospitals have formed ethics committees, which include lay people who are to represent the moral norms of society. But many critics from across the philosophical and medical spectrum argue that ethics committees cannot help but enjoin criteria of social worth.[13]

Critics often cite the Swedish Hospital Committee in Seattle as a point in case. The Swedish Hospital Committee was formed in 1962 to help decide which victims of kidney failure should have access to the hospital's dialysis machine. The Committee was so composed as to represent the different elements of the society: it was made up of two physicians, a banker, a lawyer, a home-maker, a labour leader and a member of the clergy. Such a composition was supposed to prevent prejudicial judgements; however, it did not. The Committee adopted a two-stage process: the first stage engaged only medical criteria; but the second stage allocated scarce resources on the basis of the utility and social worth of the candidates.[14] The Committee considered the candidate's age, gender, marital status, number of dependents, income, emotional stability, occupation, education background, past performances and future potential. It is claimed the committee looked favourably on those who played an active role in a church, as this was thought to be an indicator of moral strength. Measured by such criteria, George, from our opening case, would have been deemed socially worthless, while Duncan would have made the ideal candidate.

Six studies by Furnham *et al*, from 1993 to 2002, strongly suggest that the inclusion of lay people on ethics committees making rationing decisions, even if they are drawn from all strata of society, can invite the use of criteria of social worth.[16] These studies found that, while the gender of a patient needing kidney dialysis or a heart transplant had little influence on lay decisions, other variables did. Furnham *et al* found that participants favoured patients who were younger over those who were older, married over unmarried, natives over foreigners, non-smokers over smokers, patients with children over patients without children, non-drinkers over drinkers; Christians over atheists and, finally, those patients with "low" responsibility for their illness over those with "high" responsibility. As Childress and Chadban observe, some of the afore-mentioned criteria favoured by the Seattle Hospital Committee and the Furnham studies, may be medically justified: the outcome of a particular scarce medical treatment might be considerably worse for a non-compliant smoker or drinker, or for the elderly or someone without necessary and substantial family support.[18] The studies of Furnham *et al* recognise that smokers and drinkers could have been rejected due to medical considerations; however, these particular factors aside, the studies showed that participants consistently opted for the *conventionally good* patients who demonstrated socially desirable behaviours.[19] Furnham *et al* suggest that people are likely to default to utilitarian, social worth models of decision-making in situations of rationing

life-saving resources. The researchers themselves acknowledge that the fact that the study required participants to prioritise patients would itself elicit such a model of decision-making. But, the very real possibility of discrimination sounds in the words of one of the Seattle Hospital Committee members who claimed, *"The choices were hard...I remember voting against a young woman who was a known prostitute. I found I couldn't vote for her, rather than another candidate, a young wife and mother. I also voted against a young man who, until he learned he had renal failure, had been a ne'er do-well, a real playboy. He promised he would reform his character...But I felt I'd lived long enough to know that a person like that won't really do what he was promising at the time".*[21] Again, as Annas points out, while there may be justified medical grounds for rejecting the prostitute and the playboy, given that their lifestyles may suggest a poor prognosis for each, one cannot help but *hear* that the committee member was making decisions based on criteria of social worth and stereotyped assumptions rather than on purely medical criteria.

## The utility of social worth criteria

The utilitarian thesis promotes the use of social worth criteria as it seeks to maximise the overall good for society by maximizing benefits and minimizing harms for the greatest number of people. Utilitarianism sees a just allocation of scarce medical resources as an investment that seeks returns for the good of the most.[23] Utilitarian distributive justice requires that Donald be chosen over George for, unlike George, Donald has contributed much to society and has yet more to contribute. Selecting Donald also maximises pleasure and minimizes harm, as Donald has a wife and children who would suffer emotionally and financially at his loss; whereas there is no one harmed by George's loss, except perhaps George himself. Indeed, a utilitarian might challenge us by proposing that, on coming to the end of the George and Donald scenario, part of our ordinary intuitions would lead us to think that Donald suffered the greater loss, all things considered. As Rescher observes, generations brought up on maxims such as "Judge not" and "Live and let live" find it too difficult to decide between George and Donald at the clinical coal-face and so hide behind the maxim of "First come, first served". This merely avoids addressing the very real dilemmas of health care rationing and often causes greater harm than good.[24]

## Utility: at what cost?

As Annas points out, in the utilitarian thesis it is an individual's *interests* and not the *individual* that has value: anyone can become expendable in society at some time.[25] Utilitarianism seeks to maximise pleasure and minimise pain by satisfying human *interests* and *desires;* the one/s who is able to enjoy a greater satisfaction of human interests or desires is favoured over the other/s.[26] Donald ought therefore to be favoured over George, as Donald has a greater capacity for satisfying a greater range of interests and desires than George. But choosing to let George die on such grounds is to disregard his interests; small though they may be, they may have been of great worth to him: perhaps he had interests in the companionship of the rehabilitation division's cat or the care of a favourite therapist. Meanwhile, what about the emotional interests of the therapist who cares for George? And interests are not stable: Donald may be selected for treatment and recover but then lose his job and family and think life not worth living. Then George's interests might rate relatively higher and Donald would become expendable; so too, at some time, may any of us become expendable in utilitarian calculations.

The utilitarian aggregation of benefits also allows for consequences that our ordinary moral intuitions tell us are morally wrong: as measured on the utilitarian scale of social worth, three children can be readily sacrificed to save a hundred others; and in its Singer-esque form, utilitarianism would allow a healthy dog with loving owners to be selected for a scarce medical treatment over a permanently brain-damaged human.[27]

Utility must surely undermine society's view of the preciousness of human life.

## Libertarian exclusion: systematic application of indirect social worth criteria

While utilitarianism aggregates the good for the greatest number, libertarianism aims to provide market opportunities for individuals to aggregate their own greatest good, if they can pay. In the libertarian thesis, a just distribution of goods is not determined by the outcome pattern, such as maximum value or equality, but by how the distribution came about.[28] Health care is left to the unfettered operation of fair market procedures and an individual's access to health care is largely decided by their ability to pay, directly or indirectly through insurance.[29] In the libertarian society, health care is not a right; rather society protects rights of property and liberty, to allow people to improve their circumstances and protect their health on their own initiative. The ideal health care system is privatised.[30] The government is considered to act coercively in taxing the better advantaged to pay for the medical welfare of those who have not made the most of market opportunities.[31]

However, as Rawlsian egalitarianism asserts, this thesis assumes too much. It assumes that market procedures will be fair; that fair procedures are sufficient to secure equal opportunities for each individual to improve their circumstances, so that they can afford to pay for their health care; and that not being able to access health care means that an individual has not made good use of the opportunities the market provides.[32] The health care situation in America, which is largely shaped by the market thesis, puts the lie to these libertarian assumptions. Studies by the Physicians for a National Health Program (PNNP) lobby group in the US show that many Americans cannot afford private health insurance and, so, many are un-insured or under-insured and unable to access necessary non-luxury treatments; rather, their names are added to a lengthy waiting list in the public Medicaid system.[33] There they are required to wait for painful months and years for hip and joint surgeries, dental work and other non-life saving treatments because, even after living hard-working responsible lives, they cannot afford them.[34] As Goodin argues, for every market success there are thousands of blameless failures.[35]

Gutmann points out that, even if the long-term health of poor blacks in ghettos may not be affected by longer waiting times for health care treatments, the discrimination in waiting times for an essential health good does damage to the self-respect of those who are systematically allocated to the end of the queue.[36] The social markers for equal respect are *universal suffrage* and, more recently, equal access to the goods of *health, education* and *police protection*. As such, many blameless under-insured and un-insured people feel as though they are being treated as second-class citizens as the market excludes them from an equality of access on a par with those who are better able to pay.[37]

## Liberalism: individual worth not social worth

Liberalism's egalitarian thesis rejects libertarianism's uncompromising hard commitment to the pure procedural "justice" and of the marketplace that bars and neglects those who, due to arbitrary circumstances beyond their control, are unable to trade and buy on equal terms and to gain an equal opportunity of access to health care.[38] Liberal egalitarianism asserts that health care is a right, and that the social institutions affecting health care distribution should be arranged to allow each person a fair share of the normal range of health care opportunities present in society.[39] In Rawls's concept of *justice as fairness*, the principles of justice are decided on in what he calls the *original position*, a hypothetical place "removed from and not distorted by the particular features and circumstances of the all-encompassing background framework, from which a fair agreement between persons regarded as free and equal can be reached".[40] These free and

equal persons are to make judgements from behind a 'veil of ignorance', that is, they are to be free of any particular knowledge of their position within the community and of any particular desires and interests; so that their judgements, in a general way, "try to protect their liberties, widen their opportunities and enlarge their means for promoting their aims, whatever they may be".[41] Rawls argues that, within the original position, people would agree to two principles of justice: i) each person is to have an equal right to the most extensive basic liberties compatible with a similar system of liberty for all; ii) any social and economic inequalities are to benefit the least advantaged[42]. Liberalism recognizes a positive societal obligation to eliminate or reduce morally arbitrary obstacles to fair and equal opportunity, and asserts the need for programs to correct or compensate for the various disadvantages that anyone may be born with or may meet throughout his or her life.[43] The liberal thesis attempts to address the wrongful assumptions of libertarianism that allow for discrimination and for people to be treated like second-class citizens.

Within the liberal egalitarian thesis, George would receive the health care goods that are required to allow him to fulfil those life plans he could reasonably hope to pursue, given his disabilities. Indeed, George may receive more health goods than Donald over the course of his life, for George's needs require an unequal allocation of health care to bring him as close to being on a par with Donald as is possible. And, according to Rawls, each fair-minded person in society would not object, for each may have been born a George. And, despite the discrepancy in the life plans each could hope to pursue, neither George's nor Donald's life is to be regarded as of greater or lesser value than the other. Each life has a right to an equal amount of respect and cannot be sacrificed to assessments of interests or social worth, which arbitrarily change over time. Yet, as Dietrich claims, a *strong* egalitarian concept that never allows any life to be chosen before another, even on medical grounds, avoids addressing the very real dilemmas of modern health care rationing and can often cause greater harm than good.[44]

## Causal responsibility criterion

Dietrich thinks that the *satisfaction of needs* in health care can no longer be the guiding principle. Rationing is becoming more urgent as medicine progresses and more people are being kept alive longer and require greater medical resources over time. Choices about who should receive scarce medical resources must be made. Dietrich suggests that *causal responsibility* is a more suitable criterion in rationing than the current arbitrary "First come, first served" or social worth criteria such as *age*. Dietrich takes up Dworkin's distinction between *brute luck*, experienced by someone who is not responsible for his/her predicament, and *option luck*, experienced by those who weighed up the risks, took them anyway and who are now suffering the consequences and should be financially liable for those consequences.[46] Dietrich suggests that, in situations of medical scarcity, those patients who are ill due to option luck should have a lower priority than those who are victims of brute luck. Dietrich focuses on the fact that fifty percent of those in need of liver transplants are alcoholics and argues that it would be unjust to choose any of them over a patient who was not responsible for his or her liver failure. While critics counter that such prioritising reeks of social worth judgements as it seeks to punish unwanted behaviour, Dietrich points out that the causal responsibility criterion does not imply that an alcoholic's life is of lesser value, just that he/she *caused* his or her illness. Even an alcoholic of great value to society would be given a lower priority. But Gutmann questions our ability to determine the relative causal role of voluntary versus non-voluntary factors. It is often difficult to determine whether an incident of lung cancer was due to smoking or living in a heavily polluted environment. Dietrich argues that, in the case of alcoholism and other drug abuse, it is fairly easy to ascertain causal responsibility.[49] But Gutmann counters that it is often difficult to determine whether a person had a greater genetic disposition to drug addiction.[50] Also, one does not have a choice as to which socio-economic group one is born into, and being born into poverty exposes a person to stresses and peer-pressures that can often make one

more vulnerable to addictions than are those who are better advantaged.[51]

Gutmann also takes issue with Dworkin's idea that patients are financially liable for those health needs arising out of voluntary health risks. Gutmann questions what is to be considered a voluntary health risk; rock climbing, skydiving, cycling, football and a myriad of other common pastimes carry health risks, as do many occupations, such as law enforcement, bushfire control, military service and high-rise construction work.[52] As Gutmann points out, the concept of being liable for health needs arising out of voluntary health risks holds the potential for the poor being further marginalised as they are inequitably barred from many of life's arenas and experiences.

## The criteria of traditional medical ethics

In the light of these powerful practical and philosophical problems with distributive criteria based on ideas of utility, social worth, etc, I propose to use Walzer's idea about the relativity of criteria of justice to their sphere of application to put forward and defend a different, and better, solution to the problems of scarce medical resources.

Walzer claims that, in the various spheres of life, different criteria of justice are relevant, and that tyranny ensues when the principles of justice appropriate to a particular distributive sphere are disregarded.[54] Over several millennia, certain principles of justice have evolved and guided medicine from within, and it is these principles and their associated criteria that rightly belong to the sphere of health care. Their omission in considerations about rationing of scarce medical resources can lead to the tyranny of utility, social worth judgements and blame, each of which can undermine the conviction in a patient's worth.

The fundamental principle of traditional medical ethics requires the physician to act "...in the best interests of the patient".[55] Until the relatively recent emergence of *population medicine*, much of medicine was conducted in the setting of the largely non-rationing, one-to-one physician-patient relationship. The patient usually saw the same doctor, and the doctor - not having to meet patient quotas - had more time to spend with the patient. A relationship could develop in which the patient could trust that intimate confidences would be limited to his/her physician, and the physician was provided with greater insights into the larger story behind the patient's illness.[56] Within this relationship, the physician was able to be dedicated to the patient's best interests and, importantly, the patient could trust that this was the case. And, in deciding what was in the patient's best interest, the physician considered such criteria as the patient's medical need, prognosis, patient dignity and quality of life wishes. Traditional medical ethics would not have entertained the considerations of social worth, causal responsibility or ability to pay that are in play in modern population medicine.

## Modern population medicine v traditional medical ethics

Scientific and technical advances have produced life-saving and life-supporting treatments that have resulted in a population with a larger percentage of aged, disabled and chronically ill, who place an unparalleled demand on health care resources. It is a demand greater than health care practitioners and agencies have been able to meet.[58] Modern population medicine has developed in response to this situation. After an initial visit to a local general practitioner, a patient is now *referred on* to any number of *teams* of health care professionals who are trained in the specialised services/treatments; or, rather, the patient is referred on if the medical resource required is sufficiently available. If there is a scarcity, the patient may not be referred on if he or she does not meet certain rationing criteria such as age, immediate risk of death or ability to pay for exorbitantly expensive treatments.[59] Modern population medicine is not primarily about the best interests of the individual patient *at*

*all costs* but about treating the individual's interests relative to the interests of other stakeholders in society. Other stakeholders include other patients competing for the same resource, hospitals with limited budgets and beds, and commercial health care organisations.

Pellegrino and Cottingham, proponents of traditional medicine, claim that the mechanisms and ethic of modern population medicine are 'of economics' and 'of the market', and that they are liable to subjugate the physician, the practice of medicine and the best interests of the patient to the abuses of economics and libertarian market practices.[60] Whether population medicine is government funded or provided by commercial health care organisations or by a combination of both, medicine is being carried out with an eye to budgets and/or profits, which compromises the physician's professional ethics and practice.[61] Reports from physicians in the US and Australia indicate that the financial drivers of their employers, especially in the flourishing for-profit sector, pressure them into failing the fundamental tenet of acting "in the best interests of the patient".[62] Costa and other physicians find themselves not referring some patients to necessary but expensive services, spending less time with each patient so as to see more patients and meet patient/cost quotas, spending more time on the vast administrative work their large patient lists produce, recommending early discharges even though the elderly may have no one waiting at home, and performing minor surgeries they feel are beyond their scope.[63] Physicians report that they are constantly feeling that they are failing the "moral test" of their traditional professional tenet while fearing their next performance review.[64]

Pellegrino and other traditionalists claim that modern population medicine is undermining the physician-patient relationship.[65] Costa thinks that the trust of the traditional physician-patient relationship has been undermined in the US and has begun to be undermined in Australia.[66] The traditionalists claim that patients feel they are being short-shrifted, and that they feel as though they are on a conveyer belt as they are rushed through their visits with a doctor or, more commonly, multiple doctors.[67] They feel devalued and believe the physician to be more concerned with economics than with their best interests.[68]

## Traditional medical ethics: appropriate but not wholly sufficient

Defenders of modern medical practices observe that the ethic of traditional medicine lacks the philosophical and practical wherewithal to address the necessity of rationing.[69] While longing for the purer tenets of traditional health care that protect human value, Cohen concedes that the traditional health care principle of always acting in the patient's best interest is unrealistic in the face of contemporary medical resource scarcity. He observes that to try to provide maximal health care for all patients at all costs would lead to the very distributive injustices and devaluing of patients that traditional practice accuses modern population medicine of perpetrating.[70] Beauchamp and Childress think that caring at all costs could result in expensive trial treatments being prescribed for a terminally ill eighty-four year old when there are two teenage brothers who may be denied life-saving treatments due financial stresses in health care.[71] Caring at all costs requires that the "first come" be "first served", an approach which arguably avoids addressing the very real dilemmas of health care rationing and, incidentally, allows Donald no quarter, even if the medical team leader in the opening case knew all the medical facts and had had time to reflect on whether George or Donald had the greater medical need.[72] Defenders of modern population medicine question the justice and human valuing of such *caring at all costs* allocations.[73]

## Letting the consequentialist genie out of the bottle

Traditionalist-at-heart Cohen thinks that scarcity requires traditional medical ethic to compromise with the ethic of the market

place.[74] Deville and Buchanan advocate a new 'organisational ethic' in which the rationing mechanisms of modern population medicine are informed by the authority of the physician and traditional medical ethics[75]. While traditionalists like Pellegrino concede that rationing can be moral and respectful of the human value of each patient (if it is determined by traditional medical ethics and medical criteria rather than utilitarian economic concerns), they believe that compromises like that described by Deville and Buchanan are too idealistic.[76] They argue that the physician's authority cannot long resist the economic pressures of modern population medicine, especially that delivered by for-profit organisations. Pellegrino and Cottingham claim that the physician's authority succumbs to budgets and financial incentives and disincentives and, rather than shaping an ethic to guide modern population medicine, physicians are being socialised and professionalised by its utilitarian ideology and processes.[77]

Schrader points out that, unlike Americans brought up within a health care system based on the libertarian market *ability to pay* principle, Australians have enjoyed a health care system that has been driven by the traditional egalitarian-cum-*according to need* philosophy.[78] Campbell claims that the Australian health care system is more compatible with the values and sense of justice of a 'caring society' and has 'softened' the market values that come with population medicine.[79] But much to the concern of Schrader, Costa and many of their Australian co-physicians, a two-tier system of public and private health care has evolved in Australia, within which a more libertarian, 'profit and process' private sector is increasing, undermining the traditional "in the patient's best interests"/according to need ethic. They claim that successive Australian governments have fostered the expansion of the private sector into basic health care delivery, so as to reduce the burden on government of increased health care costs.[80] Schrader and Costa warn that we are already seeing the effects of this encroachment: in undertreatment, overtreatment, under-coverage, rushed medical checks, waiting lists and some doctor's compromising their ethical beliefs and their patient's care.[81] And Cottingham warns, "Once the consequentialist genie is let out of the bottle, it is hard to get it back in".[82]

## Countering the consequentialist genie

In the face of such developments, the Australian Medical Association (AMA) reminds physicians that it is their duty to do all they can for their patients in situations of scarcity, and that the only "ethically appropriate" criteria for the allocation of scarce medical resources is that of traditional medicine: medical need/prognosis/the patient's best interests.[83] Any non-medical criteria are not to be considered. The AMA also stresses the need for the professional expertise of the physician to inform rationing decisions at all levels of society, to ensure the valuing of all patients. The AMA advises physicians to allocate scarce medical resources via two steps: first, appealing to medical criteria; second and finally, appealing to the "first come, first served" approach or some other equal opportunity mechanism.[85] This two-step method is recommended as a means of facing the reality of rationing while resisting the encroaching practices of utility and social worth judgements.[86]

The AMA recommendations suggest that the valuing of patients can be preserved if the medical criteria of patient interest, need and prognosis guide allocation decisions in instances of scarcity. As a result of medical advancements, western populations are aging, and aging placing increasing pressure on medical resources. Callahan observes that we are increasingly trying to avoid old age and mortality rather than recognising and facing the fact that we have a *natural* life span.[88] Callahan argues that given scarcity and the fact that life is finite, population medicine should prioritise improving the quality of life of the very elderly over prolonging their lives.[89] Callahan's thesis suggests that age allocation need not be about social worth judgements but about coming to

terms with our finite nature. As such, expensive life-prolonging treatment could be withheld from the terminally ill eighty-four year old, of Beauchamp and Childress's earlier example, without her life being devalued.[91]

Medical criteria, rather than utilitarian calculus, need to inform rationing guidelines. And, if physicians become socialised into the utilitarian processes of modern population medicine, then the line between medical and utilitarian criteria may be blurred and physicians may not be aware that their decisions are utility - driven rather than medically- driven. As recommended by the American Nursing Association, guidelines and programs need to be provided that reinforce and ingrain the ethic and criteria of traditional medicine, to counter those practises and processes of modern medicine that may be necessary to provide for a large population but which undermine patient care and worth.[95]

## Conclusion

As Walzer claims, different criteria of justice are relevant to different spheres of life. Tyranny ensues when the principles of justice appropriate to a distributive sphere are disregarded. It is the criteria of traditional medical ethics, which are primarily concerned with medical need, prognosis and the best interests of the patient, which are the criteria relevant to the sphere of health care. Their omission in considerations of rationing of scarce medical resources can lead to the tyranny of utility, social worth judgements and blame, each of which tends to undermine our sense of the patient's worth. Though traditional medical ethics, which was once sufficient for the traditional, largely non-rationing medicine of the one-to-one, physician-patient relationship, is not wholly sufficient for modern, rationing population medicine, Nonetheless, the criteria of traditional medical ethics must still to take priority in considerations of medical resource allocations.

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**A full list of the original references is available on request to the Plunkett Centre.**

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## Footnotes

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