

Medicine and Contextual Justice

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Abstract: This article provides a critique of the monolithic accounts that define justice in terms of a single and often inappropriate goal. By providing an array of real examples, I argue that there is no simple definition of justice, because allocations that express justice are governed by a variety of reasons that reasonable people endorse for their saliency. In making difficult choices about ranking priorities, different considerations have different importance in different kinds of situations. In this sense, *justice is a conclusion* about whether an allocation reflects the human interests and priorities that are at stake. The article describes how several principles of justice have a legitimate place in medical allocations. To achieve justice within medical practice, professionals should focus on the human interests and compelling reasons for prioritizing specific principles within their specific medical domain.

Keywords: justice; medical allocations; medical practice; human interests; prioritizing principles

In *The Ethics of Memory*,¹ philosopher Avishai Margalit distinguishes two kinds of philosophers. He explains that “i.e., philosophers” focus on definitions, while “e.g., philosophers” focus on illustrative examples. More than 2000 years earlier, Aristotle made a similar point. Writing in his *Nicomachean Ethics*, he noted that,

Let us not fail to notice, however, that there is a difference between arguments from and those to the first principles. For Plato, too, was right in raising this question and asking, as he used to do, ‘are we on the way from or to the first principles?’ There is a difference, as there is in a race-course between the course from the judges to the turning-point and the way back. For, while we must begin with what is known, things are objects of knowledge in two senses – some to us, some without qualification. Presumably, then, we must begin with things known to us.²

This distinction is especially significant for approaching discussions of justice in medicine. Most approaches in the contemporary bioethics and philosophic literature aim at defining justice. In fact, authors who write broadly about justice treat it as a monolithic ethical concept. Theorists typically put forward their view of a singular principle of justice that they regard as applicable across the board. In their presentations, they argue for acceptance of their principle

The ideas discussed in this article have been developing over the past 15 years. Here, I draw on sections from my previously published articles: “Justice in allocations for terrorism, biological warfare, and public health” (In: Boylan M, ed. *Public Health Policy and Ethics*. Dordrecht: Kluwer Academic Publishers; 2004:73–90); “Justice in medicine and public health” (*Cambridge Quarterly of Healthcare Ethics* 2005;14(1):13–26); “Justice and resource allocation in public health” (In: Quah SR, Cockerham W, eds. *International Encyclopedia of Public Health*, 2nd ed. Oxford: Academic Press, Elsevier, Inc.; 2016;6:320–7 and in the 2nd ed., Oxford, 2016). Portions of this material were also presented at the International Bioethics Retreat, Pavia, Italy, June 2003; at the Association for Politics and the Life Sciences, Philadelphia, September 2003; and at the International Bioethics Retreat, Paris, France, June 2017. I thank audience members at those meetings for their insightful comments, and also thank Joe Fitschen, Mia Smartt, and Caitlyn Tabor for their editing help.

and against the singular concepts proposed by others. And when they employ examples to illustrate their positions, their examples are carefully selected or created from an author's vivid imagination to fit their point of view.

As I see it, these "i.e." approaches that aim at defining the essence of justice or, somewhat more narrowly, justice in medicine, fail to explain the concept or fail to appreciate the complexity of justice and how distinctive the numerous different allocations of medical resources are. In what follows, I will be acting as an "e.g." philosopher and "begin with things known to us." I will use well-known examples of justice and injustice in medicine to argue against the reigning monolithic views and to demonstrate the complexity and contextuality of justice. I will then argue for specific principles that are and should be regarded as salient principles for governing the allocation of resources within different domains of medical practice.

In my discussion, I therefore will not be using the term "principle" in its Platonic sense, the meaning ascribed in many dictionaries. For example, the *English: Oxford Dictionaries* defines "principle" as "A fundamental truth or proposition that serves as the foundation for a system of belief."³ Instead, I will be employing "principle" to mean a reason that is broadly accepted and endorsed as a frequently important and salient consideration for action. As an "e.g., philosopher," I will be trying to demonstrate that some reasons are principles of justice by showing their salience and broad endorsement.

Theories of Justice

Aristotle

With prescient insight, Aristotle acknowledged the complexity and contextuality of justice. In his lengthy discussion of justice in Book 5 of the *Nicomachean Ethics*, Aristotle equates justice to the entirety of interpersonal virtue and defines justice as giving each his due and treating similarly situated individuals similarly.⁴ At the same time, he discerns the difficulty involved in determining which features of a situation should be taken into account in deciding that individuals are similarly situated and which of generally important factors should be given priority in a particular situation. According to Aristotle, justice does require equality in treatment of equals. He also notes many incommensurable factors, such as relationship, history, consequences, and feasibility that may or may not be relevant considerations in justly distributing a limited resource. Justice requires moral discernment to identify which sorts of factors are significant and how they should be compared in order to make a just allocation in a certain type of circumstance or in some particular situation.

Although some contemporary philosophers follow Aristotle's insights and recommend an account of justice that draws on an array of reasons,⁵ most of those who write on issues of justice and healthcare appear to prefer a more Platonic approach. Characteristically, they attempt to articulate a singular essentialist conception as the comprehensive account of justice. To illustrate the prevailing approach, I will briefly sketch views of a few philosophers who write about justice and prominent competing contemporary accounts of justice that enter discussions of medicine and public health. In this brief overview, I will, of necessity, omit many details and lump together approaches that authors may regard as making their views distinctive and better than other similar positions.

Utilitarianism

Utilitarianism has a long history in ethics, tracing back to the writings of Jeremy Bentham⁶ and John Stuart Mill.⁷ Utilitarians regard policies that produce the best outcomes in terms of a single designated measurable outcome to be just. For example, Bentham argued that pleasure is the only thing that all people value, hence justice should aim at maximizing pleasure. Similarly, Mill adopted happiness as his singular value, and argued that justice should aim at maximizing happiness.

Utilitarians thus identify an objective standard for calculating outcomes, and employ that single standard in determining policies and making policy decisions. Utilitarian allocations aim at maximizing their singular outcome over an entire population. A utilitarian conception of justice is committed to treating people as equals and deliberately ignoring their relational and relative differences. Utilitarians compute positive and negative consequences of implementing a proposed policy and select the policy that should be implemented based upon the aggregate of desired results for the entire population governed by that policy. On utilitarian grounds, a policy is just when it is efficacious, that is, when it provides the most likely production of the greatest aggregate amount of the specified desired end.

When addressing medical allocation decisions, utilitarians focus on measurements of health or life span. A cost–benefit analysis in terms of the one chosen factor is employed to determine policy for a population. Nothing else is considered because, for utilitarians, justice is defined only in terms of the end that is to be maximized. Who will benefit and who will not, how they will use the benefit, and what will happen to those who do not benefit, are all irrelevant factors that are deliberately ignored.

Today, utilitarianism appears to be the dominant approach to justice in medical and public health policy. It is popular because utilitarian calculus is simple and focused on things that people do value. It provides a metric that allows for numerical calculations and, therein, offers a method for evaluating all decisions in the same way. For example, some utilitarian policies employ a metric of quality adjusted life years (QALYs), others employ disability adjusted life years (DALYs), and others employ disability adjusted life expectations (DALEs). These approaches are all utilitarian, and they produce allocations that at least seem fair in that they evaluate every allocation decision according to the same singular standard.

John Rawls

Since 1971, many of the positions on justice espoused by philosopher John Rawls, first in *A Theory of Justice*⁸ and later in *Political Liberalism*⁹ and other works, have come to play a significant role in philosophical discussion of non-utilitarian criteria for just allocations of social resources. Rawls famously advances two principles of justice. According to Rawls's first principle, justice requires a liberal democratic political regime to meet its citizens' basic needs for primary goods and assure that citizens have the means to make effective use of their liberties and opportunities. Rawls's second principle regulates the basic institutions of a just state so as to assure citizens fair equality of opportunity. The first principle has priority over the second in that it requires political institutions to provide for citizens whatever

they must have in order to understand and exercise their rights and liberties. According to Rawls, his two principles taken together assure basic political rights and liberties such as: liberty of conscience, freedom of association, freedom of speech, voting, running for office, freedom of movement, and free choice of occupation. They also guarantee the political value of fair equality of opportunity in the face of inevitable social and economic inequalities.¹⁰ Both principles, therefore, express a commitment to the equality of political liberties and opportunities.

These two principles of justice express Rawls's view of the basic commitments that a liberal political society should endorse. Rawls's principles are intended as "guidelines for how basic [political] institutions are to realize the values of liberty and equality" and assure all citizens "adequate all-purpose means to make effective use of their liberties and opportunities."¹¹ Together, these principles specify certain basic rights, liberties, and opportunities, and assign them priority against claims of those who advocate for the general good or promotion of perfectionism (i.e., the best possible society).

In Rawls's account, the difference principle is the second condition of the second principle of justice. Recognizing that economic and social inequalities are an unavoidable feature of any ongoing social arrangement, Rawls established his second principle to express the limits on unequal distributions. He holds that equal access to opportunities is a necessary feature of a just society, and to compensate for disparities and maintain equality of opportunity, he calls for corrective distribution measures. According to Rawls, his difference principle requires that, "[s]ocial and economic inequalities ... are to be to the greatest benefit of the least advantaged members of society."¹² In other words, governmental policies that distribute goods among citizens must be designed to rectify inequality by first advancing interests of those who are otherwise less well off than their fellow citizens.

Rawls himself does not explain how to extend his principles of justice to policies involving health and medical care. He specifically maintains that "variations in physical capacities and skills, including the effects of illness and accident on natural abilities" are not unfair, and they do not give rise to injustice so long as the principles of justice are satisfied.

Several prominent authors who write about justice and medicine have extended Rawls's principles to the allocation of healthcare. One Rawlsian concept that has received especially broad endorsement in the bioethics literature is his commitment to "fair equality of opportunity." Another widely supported concept is the "difference principle," and those who have embraced the principle now refer to such views as "prioritarian" or "egalitarian."

Norman Daniels and Fair Equality of Opportunity

Norman Daniels has used the Rawlsian concept of fair equality of opportunity to argue that healthcare should be treated as a basic need.¹³ He maintains that "[h]ealth care is of special moral importance because it helps to preserve our status as fully functioning citizens."¹⁴ Daniels wants us to count at least some medical services as "primary goods" so that they are "treated as claims to special needs."¹⁵ From Daniels's point of view, therefore, allocation of healthcare resources should be aimed at equalizing social opportunity.

Daniels concludes that a just society should provide its members with universal healthcare, including public health and preventive measures. Recognizing that societies must limit the amount of healthcare provided, Daniels proposes “normal functioning”¹⁶ as the benchmark for deciding which care to deliver. For him, healthcare that restores or maintains normal function should be provided. Nothing has to be provided, however, for those who are already within the normal range of functioning. Furthermore, in his recent writing Daniels points to many social determinants of health inequalities. He maintains that a society should address socially determined health disparities by attending to needs of those who fall below normal levels of human function, in order to allow those disadvantaged individuals to have equal access to social opportunities. In other words, Daniels’s standard for the design of healthcare systems is providing fair equality of opportunity. Neither total number of life-years produced, nor feasibility, nor any other factor is a relevant consideration.

Prioritarianism

Prioritarian views build on Rawls’s difference principle rather than his principle of fair equal opportunity and oppose utilitarian approaches to distribution of scarce resources. Whereas utilitarian allocations aim at maximizing an outcome over a population while deliberately ignoring relational and relative differences among individuals, prioritarian allocations aim at identifying unwanted inequalities and distributing resources so as to compensate for or correct them. Prioritarian allocations reflect a concern for how individuals fare in relation to each other and attempt to advantage those whose position is worse than others’, in a sense, to make people roughly equal. For that reason, the position is also called “egalitarianism.”

Numerous articles in the bioethics literature address the conflict between prioritarian concerns and utilitarian aggregation in healthcare resource allocations. For example, Dan Brock,¹⁷ Frances Kamm,¹⁸ and David Wasserman¹⁹ argue the merits of these approaches in a variety of vexing cases. They reflect on differences between policies that will save the lives of a few people or save an arm for several other people. They are concerned with whether public policies should provide a greater advantage to some who are already well off (e.g., save the lives of the able-bodied), or provide a smaller advantage to some who are worse off (e.g., save the use of an arm for those with some other preexisting disability). These discussions of “tragic choices” aim at discovering a principled basis for determining who is worse off, and for making these tradeoff decisions. Sometimes they focus on identifiable individuals, but sometimes not. They sometimes address tradeoffs of future significant harms against present small harms or more certain imminent harms against more hypothetical distant harms. Typically, these discussions favor policies that will allocate resources to immediate needs over future needs and benefits to identifiable individuals over benefits to those who cannot be currently identified.

Regardless of these differences, prioritarian views maintain a singular focus on the idea that justice requires advantaging those who are worse off than others. As with Daniels, neither the total number of life years produced, nor feasibility, nor any other reason is considered relevant.

Challenging the One Size Fits All Conceptions of Justice

In opposition to these reigning views of justice, examining things that we know shows that we actually employ different principles of justice for allocations in different sorts of life activities. For instance, every lottery ticket purchased has an equal chance of winning the big prize, and the winner takes all. When it comes to allocating tickets for a blockbuster movie, we rely on the first-come/first-served principle of distribution. Honors are distributed according to past achievements. Respect is often accorded to the aged and protection to the young. Places on the Olympic Team as well as research grants are awarded to those who promise the greatest future contribution. Invitations to our holiday dinners go to family members and close friends, while family vacation plans may be determined by considering which venue is likely to produce the overall greatest amount of happiness for all involved. Although these different allocation principles may each be just in particular contexts, we need to notice two things. First, allocations involve different principles. Second, acting in accordance with some principles may be consistent with justice in some circumstances, but unjust in others.

Each theoretical conception of justice discussed above reflects a consideration that is important for guiding some allocations. The problem with each of these theories is that their claims are too sweeping. Because these ideas about justice are typically discussed singly, in artificially isolated contexts, it is hard to notice when and how the concepts clash with reality. As philosopher Ronald Green has noted in his criticism of Daniels, the “mistake...is trying to decide such matters by reference to a single consideration—and not necessarily the most important one.”²⁰ No single conception of justice provides guidance that is reasonable in every circumstance.

I will offer several examples to challenge the assumption that there is a single principle of justice. Some relatively recent events that required allocations of medical and public health resources occurred within a short span of time: the attack on the World Trade Center in New York City in September 2001, the anthrax attacks in October 2001, the flu vaccine shortage in the fall of 2004, and Hurricane Katrina in September 2005. I will consider those catastrophes and what unfolded in their wake as providing a starting point for understanding justice in medicine and public health.

Although there has been some debate about strategy (e.g., responding to an actual terrorist smallpox disease attack with universal vaccination versus ring vaccination), and about resource allocation (e.g., which victims to benefit and how much, whether to allocate resources for planning and which plan, whether to allocate resources for research and what to study), the principles that underlie the decisions made during these crises have been assumed with relatively little contention. Implicit in this silent agreement are the presumptions that (1) everyone knows *the* guiding principle of justice and (2) *the* principle has the solid endorsement of a broad majority.

In what follows, I will question both presumptions. Investigating these examples will shed some light on justice in allocations of a society’s limited medical and public health resources.

Consider two illuminating examples of public health policies that were implemented in the fall of 2001 immediately after the attack on the World Trade Center.

September 11, 2001

Triage is the broadly endorsed approach for responding to medical emergencies. It is the approach that had previously been accepted for disaster responses in New York City and rehearsed for implementation at medical facilities throughout New York State. Triage was instantly adopted by healthcare workers on September 11, 2001 for dealing with the medical needs that were expected once the Twin Towers of the World Trade Center were attacked, and its suitability has not been challenged in the literature that I have encountered since then. Allocation by triage acknowledges the seriousness of widespread medical needs and the immediate scarcity of human and material resources for fully responding to all medical needs. Triage requires medical professionals to make judgments about the likely survival of patients who need medical treatment. Recognizing that some people have urgent needs (i.e., they will die or suffer significant harm if not treated very soon) and that the resources available are inadequate relative to the needs (e.g., supplies, facilities, trained personnel), patients are sorted into three groups and are either treated immediately or asked to wait according to their group classification. In the most extreme circumstances, those who are not likely to survive are deprived of treatment so that the available resources can be used to save the lives of those who are more likely to live. Those who are likely to die without treatment but who are likely to live if treated promptly are treated first. Those who are in need of treatment but can wait longer without dying are treated after those who are urgently ill.

On the morning of September 11, 2001, the disaster plan that had been previously developed and practiced was implemented at hospitals in the New York City vicinity. Many beds in intensive care units (ICUs) were emptied, elective surgeries were canceled, and patients who could have been sent home were discharged. Collection activities in blood banks went into high gear, but they were only accepting donors with O- blood type.

It is important to notice the principles of justice that are and are not reflected in these allocations. In medical emergencies, healthcare professionals deliberately disregard the concepts of giving everyone a fair and equal opportunity to receive medical treatment, and they pointedly ignore relative differences in economic and social standing. Instead, they focus exclusively on the medical factors of urgency of need and likelihood of survival. No one presumes to measure whether or not each patient has previously received a fair or equal share of available resources, and no one stops to assess who has been more or less advantaged. No one sorts out the small differences among individuals that would provide somewhat greater utility in one allocation rather than another, and no one criticizes medicine for not attending to those differences.

The long tradition of medical ethics, dating back at least to the Hippocratic tradition, requires physicians to provide treatment based on need. Hence, medical ethics appears to require physicians to commit themselves to unequal treatment (because need is unequal), and also to nonjudgmental regard of each patient's worthiness. These long-standing expectations have not changed over the centuries since Hippocrates or in the years following the tragedies of September 11. These commitments remain intact irrespective of recent writing on the just allocation of medical resources, and they have been neither eroded nor transformed by reflection on our responses to the events of the autumn of 2001.

Emergency triage provides neither equal shares of care nor equal opportunity for future social participation. On the contrary, triage distributions aim at avoiding the most deaths. Triage gives everyone a better chance for survival than could be had by an equal distribution of resources.

Consequentialist considerations of efficacy and equality support well-accepted views on emergency triage. When the time constraints of an emergency and the need for medical resources significantly outstrip available resources, responses should be based on efficacy and treating everyone with similar medical needs similarly. It is important to notice, however, that the sweeping exclusions of triage do not mesh with the utilitarian aim of maximizing outcomes, particularly when utility might require fine-grained sorting and ranking to distinguish those with the very best chance of survival from those with a good but less optimal chance, or those who are likely to live the longest from those with a somewhat shorter life expectancy. Triage, or avoiding the worst outcome, is, therefore, not entirely compatible with utilitarianism.

Triage is also neither consistent with fair equality of opportunity nor prioritarianism, which take factors into account that are deliberately ignored in medical triage. Clearly, if these different principles of justice (i.e., triage, maximize utility, fair equality of opportunity, and prioritarianism) were applied to the same issues, they would point to very different decisions. Intuitions that support prioritizing the disadvantaged in order to equalize social opportunities are undermined by the strong sense that nonmedical relative differences should not come into play in decisions about emergency responses. Triage allocates resources by taking everyone's prognosis and expected outcome into account. When the triage principle is applied, individuals certainly get unequal lots and no priority is allowed to those who are worse off. So, questioning the commitment to fair equality of opportunity in medical triage also invites questions about what the appropriate framework for medical allocations should be.

The Aftermath of September 11 and the Anthrax Attacks

Biomedical research and public health policies typically focus on populations. Biomedical research attempts to disconfirm hypotheses about predicted outcomes, and thereby develop facts about the response of organisms with certain common characteristics. With respect to human subject research, groups of people are selected for study because of some relevant biological or environmental similarities. Any knowledge gained from the process is useful to the extent that it is applicable to all of those who share that condition.

Public health policies are also designed to have an impact either on everyone or on only those individuals who are similarly impacted by a particular disease or a health-related condition. The goals of biomedical research and public health are pointedly directed at everyone in the group who might benefit from them. In deliberately focusing on affected groups, biomedical research and public health policies typically provide benefits only to those target groups. By looking back at outcomes, researchers attempt to develop knowledge about biological or psychological reactions. By looking toward the future, public health officials attempt to develop a generalizable approach to the prevention, reduction, or treatment of biological or psychological problems. And, as with medical triage, biomedical research and public health have not been criticized for holding to these agendas.

Public health research sometimes has no impact on social participation, health, or longevity of the entire population. If it turns out that we never have another disaster similar to what occurred on September 11, 2001, or if we never again experience a catastrophe that creates enormous amounts of pulverized concrete and incinerated computers and office furniture, research on their effects may never promote anyone's social participation or health. In addition, if the burdens of studied interventions turn out to be prohibitively costly (e.g., give up skyscrapers and computers), they will not be adopted and no one's fair equality of opportunity will be advanced. Public health research involves a quest for information that may or may not be useful. It also sometimes directs resources to the needs of only a few affected individuals. Although the principles of promoting fair equality of opportunity or maximizing health may sometimes be important, they may also sometimes be incompatible with the requirements of justice. In some circumstances, other appropriations of resources could be more likely to promote fair equality of opportunity, yet, the consensus in favor of research on those thousands of individuals who lived or worked or participated in rescue, recovery, and clean-up operations at the World Trade Center site and surrounding areas was broadly endorsed. Because research was conducted, it produced evidence that justified government-supported treatment and compensation for people who sustained injuries and developed exposure-related medical conditions.

The broad endorsement for undertaking those studies reveals additional reasons, that is, more principles of justice, that are relevant to the allocation of medical resources. Whereas public health policies sometimes meet the standard of promoting utility, fair equality of opportunity, or priority for the worse off, sometimes they do not. In some cases (e.g., anthrax, smallpox), interventions are adopted because they are likely to save more lives than alternative plans would. Although the tremendous number of resources devoted to decontamination of post offices and office buildings after the mail-disseminated anthrax attacks were widely accepted, cleanup policy had only a hypothetical and distant possible benefit.

The Flu Vaccine Shortage and Hurricane Katrina

Recall the flu vaccine shortage in the fall of 2004 and Hurricane Katrina in the autumn of 2005, and consider the actions that were taken in response. In 2004, when it became clear that there would not be enough flu vaccine to meet the expected demand, people recognized that it was important to find a better way to allocate the limited supply of flu vaccine than to allow it to go to the aggressive, lucky, rich, or those with good connections. Communities around the country, and then, finally, the United States Centers for Disease Control and Prevention (CDC), promulgated distribution policies that allotted vaccine to those who were likely to die or suffer serious harm if they contracted flu and implemented schemes to restrict distribution accordingly. The vaccine supply was, therefore, directed to the immunocompromised, the very young, pregnant women, the elderly, medical care providers who would be called upon to treat affected individuals, and first responders.

These policies were broadly endorsed and supported with excellent compliance. The almost total absence of debate over their implementation was evidence of the extent of consensus on how allocations should be handled. Aside from the

advocates for children and the elderly, who each argued that their constituent group should have even more priority over others in the vaccine target group, the United States population accepted the plans that were implemented.

The principle supporting flu vaccine allocation was not utilitarian, because utility alone would have disqualified those with only a short remaining life span: Vaccination for elderly and immunocompromised people could be expected to provide few life-years. Also, the distribution did not take previous injustices or disadvantages into consideration, and it did not give priority to the least well off or try to equalize opportunities. The principle inherent in vaccine distribution policy was “avoid the worst outcome” which, in that context, was taken to mean avoid the most serious illnesses and deaths. The consensus of support and lack of opposition speak to the salience of one particular principle of justice and how its importance in a particular context can be obvious to experts and the public.

Reaction to what happened before, during, and after Hurricane Katrina illustrates a broad consensus on injustice. In the aftermath, there was general agreement that the United States government had failed to adequately prepare for the disaster, failed to warn and protect Gulf Coast residents, failed in its attempts at rescue and meeting the tremendous needs of affected communities, and failed in providing honest and timely communication about the formaldehyde risk in the trailers that were provided to shelter some of those who had been left homeless. These realizations point us to further broad agreement on social justice requiring investment in disaster preparedness, meeting urgent needs of all citizens, making leadership appointments based on qualifications rather than cronyism and politics, and timely and honest communication.

Again, this consensus on requirements of justice is not a matter of chance or coincidence. Rather, it reflects the central importance of initiating measures to protect the public, focusing on promoting the importance of critical human concerns, and taking the lead in planning and acting to justly steward and allocate medical resources. As philosopher John Gray has noted, “humans have a stock of needs that does not change much and which constrains the forms of life in which they can thrive.”²¹

The variety of concerns that these examples highlight reveals that no single conception of justice explains the array of broadly endorsed principles that support distributions of medical resources. This plurality of concerns suggests that there is no single and authoritative conception of justice. No simple formula can tell us what justice requires in all circumstances. Rather, justice requires investigation and examination of the situation, reflection on the problems involved and consequences of choosing one path or another. Such engaged moral thinking will lead to a conclusion as to what justice requires in the specific context or type of context that is being considered.

The Complexity of Justice

The incongruity between the situational consensus that I have noted, on the one hand, and lauded principles of justice, on the other hand, suggests that those who search for *the* ruling single, essential principle of justice are on a wild goose chase. It also suggests an alternative view of justice. When we stop to examine our own thinking about these issues, we notice that we actually invoke different reasons and different rankings of considerations in different contexts.

With sensitivity to the complexity of human values and to the different contexts of medical needs, we can appreciate that a variety of reasons justify different medical resource allocations.²² In the final section of their discussion of justice in the sixth edition of *Principles of Biomedical Ethics*, Tom Beauchamp and James Childress seem to make a similar point. They note that “public policies will sometimes emphasize elements of one theory and at other times elements of another theory.”²³ Nevertheless, they appear to hold out hope for identifying a singular comprehensive principle of justice.

Instead, I am urging that the quest for a singular principle be abandoned in favor of a contextual approach to determining the just distribution of resources.²⁴ In some sorts of circumstances one or a few principles should guide distribution decisions and other principles should be employed in other kinds of situations. Good allocation decisions will express widely shared views about the primacy of some considerations over others and reflect reasons for adopting one or more governing principles that no one can reasonably reject for decisions in such circumstances. In this sense, a contextual view of justice is not random and not idiosyncratically subjective. Rather, it expresses deep similarities in human concerns and shared priorities that relate to our human mortality and vulnerability.

Overview

To the extent that we can identify appropriate reasons for determining the allocation of medical resources within a specific kind of medical context, we can say that justice in that domain is determined by those principles. To the extent that we can rule out reasons that are inappropriate, or those that should have low priority in a medical context, we can say that acting for those reasons would be unjust. A variety of appropriate and compelling reasons will be relevant or irrelevant in different kinds of medical contexts. Decisions that reflect those reasons that can be broadly endorsed as fitting considerations will be just. The just allocation of medical resources is and should be governed by a variety of reasons that reasonable people endorse for their saliency. In this sense, *justice is a conclusion* about whether an allocation decision reflects the human interests and priorities that are at stake in a certain kind of situation.²⁵

Several principles of justice have a legitimate place in medical allocations.²⁶ To achieve justice in resolving the practical problems of resource allocation that arise within medical practice, medical professionals' decisions should focus on mutually supported and compelling reasons. These broadly endorsed overarching reasons are the principles of medical justice. They include: *the anti-free-rider principle, avoid undue burdens, triage, the difference principle, efficacy, equality, maximin, provide public goods, and attend to the vital and constant importance of well-being.*²⁷ To the extent that resource scarcity makes it impossible to fulfill all legitimate claims, some principle(s) will have to be sacrificed and some medical interventions that are supported by compelling reasons will have to be scaled down from an ideal level, delayed, or abandoned. When these hard choices have to be made, medical professionals are trusted to make decisions for reasons that reasonable people would support.²⁸

In making difficult choices about ranking priorities, different considerations will have different importance in different kinds of situations. There is no obvious reason to presume that one priority will always trump others. When the priority

of a principle reflects the endorsement of a broad consensus of medical professionals²⁹ and can muster society's endorsement, the principle's priority is just.³⁰ When large groups of informed reasonable people³¹ rank competing considerations differently, a significant consensus on the principles that are irrelevant may emerge, and that consensus can serve as the basis for regarding some consideration as irrelevant and rejecting them as considerations for making decisions within that particular context. To the extent that flexibility can be supported by available resources, policies should show tolerance for different priorities. But when extreme scarcity and urgency limit options, the need for finding agreement on the most salient considerations can be an urgent matter.

Thus far, I have offered criticisms of various monolithic views of justice, and tried to justify the relevance of several principles of medical justice. I will now turn to explaining what justice requires within the practice of medicine. Without claiming to offer a complete account that covers every sort of medical activity, I will sketch what justice requires in three of the most notable medical domains: (1) non-acute care, (2) acute care, and (3) critical scarce resources.³² These domains are primarily distinguished more by the principles of justice that are relevant than by location, and it is important to attend to how different principles of justice function in each domain. By addressing allocation issues that arise in these different medical domains, I will try to avoid the pitfall of cherry picking examples to exemplify my view. As you should expect at this point, I will be arguing for the salience of several different principles of justice in each domain.

Justice in Non-acute Care

Non-acute care includes several different patient care venues and circumstances. These groupings are not mutually exclusive. Some patients actually receive care in several venues, some all at once, and some at different times over the course of an illness or over their lives.

Chronic Care

Many people live with illness. Most of the time, they do not require acute care and they manage their condition(s) largely on their own with periodic oversight from medical professionals. The range of chronic conditions includes, for example, asthma, diabetes, kidney failure, high blood pressure, colitis, HIV, lupus, and cancer. The medical needs of people with chronic illness may be serious or mild, but all of these patients should receive whatever medical care they require. Allocation of medical resources is supported by the principle that requires clinicians to *attend to the vital and constant importance to well-being*. Patients should receive what they require to maintain or restore their well-being. As in every treatment decision, the choice of specific treatment for individual patients should involve considerations of maximizing the desired result while minimizing burdensome side effects. That is, they should be governed by the *maximin* principle. The more serious the anticipated consequences of foregoing treatment, the greater the tolerance for treatment-related side effects: The less serious the consequences of foregoing treatment, the lower the tolerance for burdensome side-effects. In other words, selecting the treatment plan that is right for a patient will always involve a comparison of risks and benefits.

To the extent that well-being is important to everyone, people with similar medical needs should receive comparable treatment in accordance with the principle of *equality*. And to the extent that available resources are limited, *efficacy* should guide the use of interventions. When a costly intervention early on, such as consultation with a disease expert, is likely to effectively alter the course of disease progression, it should be provided. When an inexpensive option seems appropriate, it should be tried first, and when expensive interventions are likely to provide little benefit, it is legitimate for them to be withheld.

The *difference principle* should also play a significant role in the just provision of chronic medical care. The *difference principle* reflects a broadly shared commitment to the idea that some people need more help than others, and because of that need, they should receive more help than others do. People who are poor, work several jobs, and have a hard time making ends meet, people who care for several children with little social support, people who live in environments that present special health challenges (e.g., pollution, violence, contamination),^{33,34} people with mental or physical disabilities,^{35,36} people who are old and frail,³⁷ people who are distrustful of medical professionals,³⁸ and people with limited medical literacy are likely to need more resources than others with similar medical conditions who are more able to manage on their own.

The Black Report on the health outcomes of people in Britain who have access to the very same National Health System demonstrates that merely providing equal medical care still leaves the less well-off with significant health disparities in comparison with those who are better off.³⁹ This evidence suggests that to compensate for social disadvantages, justice requires greater investment of medical resources to help people who are worse off in some respect(s) to achieve health outcomes that are comparable to others'. Different sorts of interventions will be required depending on individuals' needs and what is likely to be useful. Strategies can include more frequent checkups, accessible clinic locations, extension of clinic hours, educational interventions, home visits, and even incentives for accepting healthcare.⁴⁰

Well Patient Care

Many people who are well still want and need medical care. These patients include people who have no illness as well as people who seek medical attention for issues that are not *per se* disease related. This fact is frequently overlooked, but today's medicine includes services across the spectrum from well baby care, to pregnancy management, to aid-in-dying.

In this light, it is important to recognize that the medical profession is a social artifact created by giving control over a set of knowledge, skills, powers, and privileges exclusively to a select few who are entrusted to provide their services in response to the community's needs and use their distinctive tools for the good of patients and society.⁴¹ Medicine is very much like other fields in this respect. Consider that firefighters are called to rescue cats and children from tall trees, and we rely upon police to return lost children and call upon them to subdue an escaped tiger even when no fire or law enforcement issues are involved. Firefighters and police have the wherewithal, so they get the job. Similarly, the special knowledge, powers, and privileges of medicine explain why the role of medical professionals extends beyond the boundaries of health and disease.

In the bioethics literature, numerous authors make a project of defining *the* goal of healthcare or *the* scope of medicine. They typically define them in biological terms. They either employ the concepts of health and/or disease,^{42,43,44} or rely upon the concept of normal function.⁴⁵ These approaches are appealing because they facilitate drawing neat lines with seemingly objective standards between services that should be covered by health programs and services that should not. Such approaches typically exclude services such as plastic surgery and assisted reproduction. Unfortunately, distinguishing legitimate claims for medical services from those that are not is not that simple, and employing these biological definitions creates problems of injustice.

Daniels, for example, employs normal function as his standard for determining which patients should be allocated medical treatment and which should not. His paradigm case involves providing growth hormone for children who will have short stature. Daniels is willing to support treatment for those children who are growth hormone deficient, but not for children who would benefit equally but whose short stature is related to having short parents and not abnormal levels of growth hormone.

Daniels's use of the normal function criterion occurs within the context of his broader view of justice in healthcare, and introducing the biological standard of normal function within his theory actually creates an internal conflict. The problem begins with his framing the issue in terms of the biologically based concept of "health care" rather than the profession-based concept of "medical care." Then Daniels argues for the importance of providing health care as a basic human need and frames his argument in terms of Rawlsian principles of justice. He seems to overlook the fact that the ability to enjoy fair equality of opportunity and participate in the social and political sphere without unfair disadvantage is a social standard for achieving justice, not a biological one. Daniels's acceptance of Rawls's social standard implies that factors that amount to social barriers to fair competition should be taken into account in the just allocation of medical resources, even when those factors do not involve deviations from normal function. Thus, all children with expected short stature should equally have access to growth hormone therapy, because short stature is a detriment in our social world, and it is likely to limit their future opportunities.

Furthermore, access to primary goods, which is required by Rawls's first principle of justice, is not circumscribed by biology. Primary goods certainly include food and healthcare, as Daniels would acknowledge, but they also include social elements. Numerous factors that might interfere with being treated with respect within the social domain, and factors that may frustrate an individual's ability to participate in the social life that members of our society aspire to share, could merit medical resources based on Rawlsian principles.

Another factor supporting well patient care is that some of it, such as periodic monitoring of low-risk pregnancies, well baby visits, and annual checkups that may have a preventive justification, are primarily provided to assure the comfort and support of knowing that everything is going well and to establish and maintain an ongoing physician-patient relationship. Other well patient care is actually focused on helping patients achieve social goals. Healthy male and female patients may want medical assistance for purposes of birth control because, at various stages in their lives, procreation is not consistent with their other social goals. A female patient who is over the age of 35 and has normal low fertility may want

medical intervention for assisted reproduction. For her, the desire to be a mother, raise a biologically related child, and share parenting experiences with her peers may be a significant element in achieving happiness and well-being. A 70-year-old male patient with normal virility may want medical assistance for sexual activity to enhance his well-being through physical intimacy. And a patient with a large hemangioma on her face that does not impede any biological function may want treatment to shrink it away so that her appearance will no longer impede her social interactions.

In the twenty-first century, we have come to regard homosexuality as a normal condition and we are beginning to accept gender dysphoria as a medical condition that merits hormonal therapy, surgery, and other supportive interventions. When a mature transgender patient experiences social difficulty because the patient's facial features do not match the chosen gender and prevent social acceptance as a person of that gender, facial reconstructive surgery may be important for improving the patient's well-being.

At a certain point, some patients are left with diseases that have no cure. There is nothing that medicine can do to improve their health or extend their lives. They may even be dying. They may be experiencing pain that is normally associated with their condition. Pain management that does nothing to address the underlying cause of the pain or prolong life may nevertheless be an important benefit that medicine can provide.

And then there is aid-in dying, physician-assisted suicide, and euthanasia. When life is burdensome, as every life sometimes is, it can be important to be able to share one's thoughts about ending it all with one's doctor. It may also be important, especially for people who value their independence and control over their lives, to feel as if they have the power to end their lives. Doctors have unique roles to play in these decisions. Because of their experience, they can appreciate when an elderly patient with no underlying illness has irremediably lost the will to eat and live and can help support that patient's choice of hospice care. They can also appreciate the burdens of disease-related deterioration and provide desired assistance in bringing the suffering to an end. They can also assess when the wish to die is the effect of a treatable depression and provide interventions to help the patient heal.

Because only medicine has the wherewithal to address these needs, these are all legitimate uses of medical resources. Patients should be entitled to these needed interventions and physicians should be paid for their time and effort. Allocation of medical resources to meet patients' social goals should be supported because of the services' *importance to well-being*. Every patient with similar needs should be treated similarly in accordance with the principle of *equality*.

Preventive Medicine

Although we often think of medicine as curing disease or ameliorating its effects, many medical measures aim at protecting, promoting, and maintaining health and preventing disease, disability, and death. Some of these efforts involve offering education, others involve advocating for community-wide interventions to prevent disease (e.g., fluoridating drinking water, controlling mosquito populations), and some involve individual interventions (e.g., vaccination). Such efforts are justified by several principles. *Provide public goods* is relevant because the

benefit will accrue to everyone. The *anti-free rider* principle is relevant because, to the extent that disease is communicable, everyone should do a fair share in preventing transmission. For example, everyone should cover their mouth and nose when coughing or sneezing, to help stop the spread of germs. *Avoid undue burdens* is important because some preventive measures that are minimally burdensome to most people may involve serious risks and harms for others. When that is the case, generally required preventive measures may impose an unfair burden on a specific group. When the goal of a preventive measure can be achieved without everyone's compliance, it may therefore be just to exempt a few, such as pregnant women or people who are immune-compromised from vaccination. *Equality* is an important factor because we are all vulnerable to disease and because everyone prefers to avoid it. Preventive measures are also justified by the *efficacy* and *maximin* principles, because preventing disease is often far more clinically effective and cost effective and less burdensome for patients than treating disease once it develops. Screening and testing individual patients for disease (e.g., annual physicals and tests, newborn screening, mammography, Pap smears, reproductive genetic screening and testing) are also justified by the *efficacy* and *maximin* principles. These measures frequently maximize benefit because early detection and treatment for early stage disease is often more effective and less radical than treatment for disease detected at a later stage. Preventive measures also typically involve far fewer resources than would be required for disease treatment. Furthermore, some types of screening provide individuals with the opportunity for taking measures that could avert serious conditions or impede future life choices (e.g., testing for ovarian reserve).

The difference principle will also have a role in the just allocation of preventive medicine benefits. Beliefs, fears, culture, inertia, and the demands of life can all amount to barriers that preventive medicine initiatives have to overcome. Some individuals and groups may have particularly difficult hurdles to surmount in order to receive medical care. In some cases, incentives for accepting testing might be in order. In other cases, extra time and effort to garner trust may be what is needed.

For example, African Americans often harbor residual feelings of distrust toward medicine, derived from a long history of abuse. People from that community, which also has a high incidence of sickle-cell disease, may regard screening for the sickle-cell trait to be a genocidal plot. Helping African-American patients to make informed decisions about screening may, therefore, require extra time, education, and conversation.⁴⁶ *The difference principle* would support such efforts as a matter of justice.

Domiciliary Care

A good portion of home healthcare, nursing home care, and hospice care is merely housing and or the provision of support in activities of daily living. Nevertheless, in the United States the cost of this care is typically included in healthcare budgets because it does involve some medical oversight and services provided by medical professionals. Often, patients who receive domiciliary care are not expected to be cured of their disease, and their residential facilities are frequently expected to be the patients' domicile until death.

Justice requires medicine to provide care that will keep these patient clean, safe, fed, hydrated, and free of pain, because as members of our society we have a duty to *attend to the vital and constant importance to their well-being*. No reasonable person would be willing to forgo these benefits for themselves or their loved ones.

Justice in Acute Care

Consider the emergency room and allocation of hospital beds. There, in apportioning limited medical resources, need matters and urgency matters because they play an important role in *avoiding the worst outcome*. Patients with significant medical needs can only receive the care that they require in an acute care facility: The technology and expertise are available nowhere else. Also, those with urgent needs, that is, those who will die soon or imminently suffer serious harm from delays in treatment, should be treated first, before others who may have arrived earlier but who could wait for treatment without serious untoward consequences. Beyond that, for those who are similarly situated with respect to need and urgency, patients should be treated similarly, that is, the principle of *equality* should govern medical allocations.

Although distributing the same size slice to everyone who pays for a slice of pizza would be just, giving the exact same medical treatment to each patient is obviously not the rule in medicine because patients' bodies and medical needs are different from one another in numerous ways. *Equality* in this sense requires giving similar treatment to patients with similar needs. Patients who are having a stroke or a myocardial infarction should be provided with similar interventions. Differences in their treatment should be justified by physical differences that call for different clinical responses, such as adjusting drug dosage to patient weight or guiding treatment selection by the time of symptom onset.

In allocations of acute medical care, other considerations such as age, past contribution to society, promise of future contribution, or personal attachment, which may be appropriate for the distribution of honors, opportunities, and love, should play no part. Hence, allocations in the emergency room and the rest of the hospital should be governed by a narrow set of considerations (i.e., urgency, need). It may sometimes be politically difficult to ask a colleague, celebrity, or relative of an important donor who is in need of care for a sprained ankle to wait for treatment, but justice requires that urgent needs be attended first in the acute care setting.

Justice in the Allocation of Critically Scarce Resources

Although all medical resources are limited, some resources are critically scarce. Some, such as beds in an ICU, are scarce by design, because states limit the number of ICU beds that each institution may have as a cost-containment measure. Other resources, such as transplant organs, are limited because of individual reluctance to donate the organs of a deceased relative, because of natural scarcity, and because of legal structures (i.e., society's endorsement of required request rather than presumed consent to govern organ procurement). And other critically scarce resources are limited by the rarity of ingredients, manufacturing difficulty, or the tremendous cost of production of, for example, an extremely rare and expensive clotting factor or cancer drug, or a robotic suit that is worn as an exoskeleton to help a disabled person walk.

Triage should be the guiding principle in the allocation of many of these critically scarce resources. When there is not enough for everyone with similar medical needs to receive the benefit, the scarce supply should be withheld from those who are most likely to die soon regardless of treatment, so that treatment can instead be allotted to those who can be expected to receive a significantly greater benefit from the resources. In such circumstances, *triage* often means avoiding the most avoidable deaths or other catastrophic outcomes.

Sometimes the patient with the greatest or most urgent medical need should be passed over so that a patient with lesser need or urgency may receive the resource. In this way, the worst outcome is averted. As illustration, imagine an organ failure patient with metastatic cancer and a life expectancy of less than 6 months. That patient should not be listed for a transplant organ. The organ that would have been allocated to that patient based on need and urgency should instead be allocated to another patient on the transplant list with an excellent chance of surviving for at least 5 years with a transplant. Allocating a transplant organ to a patient who can reap a significant benefit from the gift of life is a better result than having the one with a short life expectancy receive the organ and die soon while someone else who could have been expected to live far longer would also die. Two deaths within a few months is worse than one death and one long life. This is not to say that one life is worth more than another; rather it is a remark about justice. It is just to take the likelihood of significant differences in the extent and duration of medical benefits into account in the assignment of scarce transplant organs. This justification can be explained, and it receives broad public endorsement.

Similarly, it is just to remove a critically ill patient who is unresponsive to treatment from the ICU so that some other patient with an acute medical need for ICU care and a good likelihood of return to normal function will survive. Again, two deaths in a short time span is a worse outcome than one death and one long-term survival, and most people can appreciate and value that difference.

The allotment of scarce drugs should be treated similarly. Some drugs are used for several different purposes. When the limited supply of a drug is inadequate, *triage* should govern the distribution. As a general rule, when some patients need a drug as an urgent lifesaving therapy, they should get preference over those who need it to address some less urgent or less serious need. When some patients need a drug to address a medical problem that has no alternative treatment, their need should be prioritized over needs that can be addressed with a different intervention. And when a shortage affects patients with a similar condition, to the extent that physicians are able to distinguish those who are likely to reap a significant benefit from those who are not, treatment should be provided to those who will benefit on the basis of *triage*.

Whereas decisions concerning expensive treatments should be governed by the same consideration, the issues that they raise may seem different. Some medical treatments are relatively inexpensive, and others are resource intensive and costly. When does a treatment cost too much? This is a question that can only be answered within the context of the wherewithal of a particular society. The answer turns on the needs of people within the society, the wealth of the society, and how much of its wealth the society is willing to allocate to medical care. Some societies decide that they can afford to pay for kidney dialysis treatment and organ transplantation. Others cannot or do not.

Equality requires that the payout threshold within a society should be the same across the board. This means that the same limit to maximum expenditure is applied to an expensive cancer drug, and organ transplantation, ICU care, exoskeletons, and so on. *Efficacy* requires that the payout be tied to outcomes. In some healthcare systems, such as the British National Health Service, QALY calibration is used to assess efficacy, and as a means for assuring that different medical needs are treated similarly and avoiding biases against diseases (e.g., HIV) or patient groups (e.g., alcoholics). This is rationing, and it is just when the standards for disallowing interventions are transparent and based upon limits that are accepted as fair.

Conclusion

In this article, I have put forward a lengthy argument opposing views of justice that strike me as oversimplifying attempts to reduce the unavoidable complexity of justice into a single and often inappropriate principle. In addition to showing that monolithic views of justice are mistaken, I also identified the kinds of reasons that are salient in different arenas of medical practice. By doing so, I have shown that it is a mistake to think of justice as a *monolithic* principle from which decisions about resource allocations can be deduced. Instead, we need to understand that justice is a conclusion from the reasonable consideration of the relevant factors and principles involved in particular kinds of decisions.

Table 1 shows the breadth of medical justice by enumerating the multiple principles that are appropriate to allocating medical resources among those who need them. It also shows the domains in which each principle is a relevant concern and the domains in which some principles should be considered irrelevant. The table makes it vividly clear that some principles are relevant or irrelevant considerations in different medical domains.

Although I argued in favor of regarding only a limited set of reasons as relevant in medical justice, the exclusion of other reasons is justified by broadly shared reasonable judgments about what is and should be acceptable within medical practice and what should not be. Unfortunately, there is no simple rule, procedure, or measurement device to rely on in making these distinctions. The only guideposts for long-standing issues are found in the judgments of physicians over centuries that are exemplified in the consensus that we see on what justice requires in different domains of medicine.

Medical professionals who make allocation decisions typically do it thoughtfully and well. This discussion supports the standard decision frameworks in various domains of medical practice as being informed, appropriate, reasonable, and just. It explicates the numerous principles of justice that are employed or eschewed. This analysis is intended both to serve as a critique of other accounts of justice and to provide models for thinking about what justice requires in different domains of medical practice.

Decisions about allocations of medical resources in new and novel situations will have to be developed as the issues emerge. The future is long, new technologies can be expected to create new dilemmas, and novelty is part of life. The models that I have provided are intended to serve as a roadmap for navigating thorny issues that will inevitably demand decisions about what medical justice requires.

Table 1. Justice In Medicine: Principles of Medical Justice

	Anti- free rider	Avoiding undue burdens	Triage	The difference principle	Efficacy	Equality	Maximin	Providing public goods	Promoting well-being
Domains of medicine									
Non-acute care									
Chronic care				√	√	√	√		√
Well-patient care						√			√
Preventive care	√	√		√	√	√	√	√	
Domiciliary care						√			√
Acute care			√		√	√	√		
Critically scarce resources			√		√	√			

Notes

1. Margalit A. *The Ethics of Memory*. Cambridge: Harvard University Press; 2002.
2. Aristotle (trans. Ross WD) *The Nichomachean Ethics of Aristotle*. London: Oxford University Press; 1971, Book 1, chap. 4.
3. *English: Oxford Dictionaries*. Oxford: Oxford University Press, 2017; available at <https://en.oxforddictionaries.com/definition/principle> (last accessed 23 July 2017).
4. Aristotle enumerates three types of justice: distributive, retributive, and equity. The discussion of justice in this section is primarily concerned with distributive justice; that is, how the limited supply of medical resources should be distributed. Retributive justice is principally concerned with punishments, a topic that is beyond the scope of this project. Taking seriously Aristotle's claim that justice is virtue entire (Aristotle: See note 2, original pagination 1130a9), the rest of this article can be seen as a discussion of what equity requires from medical professionals.
5. I count contractarian constructivists, such as Scanlon, in this camp. Scanlon TM, *What We Owe to Each Other*. Cambridge, MA: The Belknap Press of Harvard University Press; 1998.
6. Bentham J (ed. Burns JH, Hart HLA). *An Introduction to the Principles of Morals and Legislation*. London and New York: Methuen; 1982 (originally published 1789).
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8. Rawls J. *A Theory of Justice*. Cambridge, MA: Harvard University Press; 1971.
9. Rawls J. *Political Liberalism*. New York: Columbia University Press; 1993.
10. See note 9, Rawls 1993, at 228–9.
11. See note 9, Rawls 1993, at 326.
12. See note 9, Rawls 1993, at 6.
13. Daniels N. Justice, health, and health care. In: Rhodes R, Battin M, Silvers A, eds. *Medicine and Social Justice: Essays on the Distribution of Health Care*. New York: Oxford University Press; 2012:17–33. Daniels N, Sabin JE. Limits to health care: Fair procedures, democratic deliberation, and the legitimacy problem for insurers. *Philosophy and Public Affairs* 1997;26:303–50.
14. See note 13, Daniels 2012, at 19.
15. See note 13, Daniels 2012, at 20.
16. See note 13, Daniels 2012, at 19.
17. Brock DW. Priority to the worse off in health-care resource prioritization. In: Rhodes R, Battin M, Silvers A, eds. *Medicine and Social Justice: Essays on the Distribution of Health Care*. New York: Oxford University Press; 2002:362–72. Brock DW. Aggregating costs and benefits. *Philosophy and Phenomenological Research* 1998;58:963–8.
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20. Green RM. Access to healthcare: Going beyond fair equality of opportunity. *American Journal of Bioethics* 2001;1(2):22–3.
21. Gray J. *Two Faces of Liberalism*. New York: The New Press; 2000, at 66.
22. I am using the word “context” in its colloquial sense to indicate the multiple kinds of parameters that are likely to be relevant to moral judgements. My use of the term should not be taken to imply any connection to current discussions of “contextualism” in contemporary epistemology and recent related discussions of morality.
23. Beauchamp TL, Childress JF. *Principles of Biomedical Ethics*, 6th ed. New York: Oxford University Press; 2009, at 280.
24. Contextualist approaches to ethics have been discussed by several authors. See, for example, Price AW. *Contextuality in Practical Reason*. New York: Oxford University Press; 2008; Thomas A. *Values and Context: The Nature of Moral and Political Knowledge*. New York: Oxford University Press; 2006; Timmons M. *Morality without Foundations: A Defense of Ethical Contextualism*. New York: Oxford University Press; 1999.
25. In making this claim, I am echoing a point made by John Gray about human rights. Gray writes, “Rights are not theorems that fall out of theories of law or ethics. They are judgements about human interests.” See note 21, Gray 2000, at 113.

26. In this article, I am focusing narrowly on the allocation issues that arise for medical professionals and medical institutions within the practice of medicine. I am pointedly avoiding the allocation issues that arise for health insurance companies and government policies that involve related but different issues.
27. I do not claim that this list is a full elaboration of the relevant considerations for justice in medicine. I am only arguing that the list enumerates principles of justice that should be prioritized within the three domains that I have considered in this article. Here, I have not provided an account of justice in public health and biomedical research, and the relevant factors and priorities in those domains are likely to be significantly different than for the domains that I have discussed. Furthermore, I have not discussed health policy or insurance decisions on the national level. Justice in the context of those decisions is likely to involve additional considerations.
28. See note 13, Daniels 2012, at 26–8. Daniels’s “relevance condition,” which appeals to reasonableness, appears to capture this aspect of policy setting.
29. Here, I have in mind a genuine Rawlsian “overlapping consensus” in contrast to what Rawls would term a “modus vivendi” coincidental agreement. Discussion of this issue is important, but too tangential to address in this article.
30. See note 9, Rawls 1993. In *Political Liberalism*, John Rawls uses the term “overlapping consensus” to describe the agreement of “reasonable and rational” people.
31. Here, I am using the term “reasonable” in the specific Rawlsian sense of reasonableness being bounded by the “burdens of judgment” and constrained by the limits of “what can be reasonably justified to others.” See note 9, Rawls 1993, at 58–66.
32. There are at least two additional domains of medical activity, namely, public health and biomedical research. A great deal can be said about justice in both areas. I am setting those issues aside for another day.
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45. See note 13, Daniels 2012.
46. See note 38, McGary 2012.