Bioethical Prescriptions
TO CREATE, END, CHOOSE, AND IMPROVE LIVES

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Rationing and the Disabled
SEVERAL PROPOSALS

In this chapter I will first critically examine some recently published views of Peter Singer about rationing scarce health care resources, in particular to the disabled. For purposes of comparison, I will then briefly summarize some alternative proposals about rationing and the disabled which I have made in greater detail in earlier work. This will lead me to also compare my proposals to some of those more recently made by Dan Brock. I hope that distilling the essence of my proposals will make them more accessible, and comparing them with other proposals will show the need for distinctions they draw. Finally, I shall point to some concerns raised by my proposals. Throughout, the discussion focuses on resources that are not under personal control and that it is impermissible to distribute according to purely personal preferences. I shall be particularly concerned with whether favoring the nondisabled over the disabled in distributing scarce resources involves invidious discrimination, mistakenly focuses on maximizing health benefits, or exhibits no moral fault at all.

I. Singer

Singer is concerned with maximizing health benefits per dollar spent using a quality adjusted life year (QALY) measure. For example, he thinks a teenager should be saved rather than an 85-year-old person because we can expect much more future life from the teenager than from the old person. In response, it should be pointed out that this is also true if we compare a teenager with a 50-year-old. If we think the 50-year-old should not be disfavored relative to the teenager, it may be because sometimes persons have a right to certain types of health care independent of whether this maximizes health benefits per dollar.

On the other hand, suppose that the teenager could be saved for fewer good years than the 85-year-old. It might be argued that we should still save the teenager because she would die having had much less life overall than the older person if
she is not helped. Helping the person who if not aided will have had much less life overall so that she improves to some significant degree might also be relevant to how to allocate resources, not just maximizing expected health benefits per dollar. This is related to giving priority to the worst off.

Singer also considers how to compare the health benefit achieved in saving one person's life with the benefit achieved in curing a serious condition in another person that does not threaten that person's life (e.g., quadriplegia). He argues that the way to think about this question is to consider the tradeoff each person would reasonably make in his own life between years lived and quality of life. For example, if every person (already disabled or not) believed that living ten years as a quadriplegic or living five years nondisabled were equally good options, this would indicate that people take living as a quadriplegic to be half as good as living nondisabled. Singer thinks that such data would show that using our resources to cure two quadriplegics is just as good as saving someone else's life, provided the life expectancy of all three people if helped would be the same (for example, ten years). His reasoning (which he does not spell out but which I shall now try to supply) seems to be that if someone would give up five out of ten years of his own life rather than be quadriplegic, that would justify curing one person’s quadriplegia rather than saving someone else’s life for five years. If there are two people whose quadriplegia we can cure, the combined benefit of curing both, he thinks, is equal to saving the life of another person who would live for ten years.

There are several problems with this conclusion and the reasoning that leads to it, I think. First, in the tradeoff between quality and quantity that a person might make in his own life, it is that person who benefits from the tradeoff. When we make tradeoffs between different people, the people who get the improved quality of life are not the same people who suffer the loss of more life years. Rather, we are doing what results in the loss of life for one person who does not benefit for the sake of benefitting others. This raises different moral issues than the tradeoff within one life, I think. Second, the conclusion that curing two quadriplegics who would live for ten years anyway is equal to saving someone else who would otherwise die so that he can live for ten additional years depends on weighing the aggregate (total) benefit to two people against the loss of the benefit to the third person. However, calculating total health benefits produced by aggregating smaller benefits to a greater number of people can be problematic. For example, suppose the tradeoff test within one person's life showed that a small disability (e.g., a damaged ankle) made life only 95 percent as good as a nondisabled life. Then a person would rather have 95 years without the small disability than ten years with it. On Singer's view, this implies both that we should cure one person's small disability rather than save someone who would otherwise die so he can live for an additional half year, and that we should cure small disabilities in twenty-one people rather than save a single person who would otherwise die so that he could then live for ten years. This is the sort of reasoning that led to the discredited rationing plan in Oregon.
many years ago in which resources were to be allocated to cap many people's teeth rather than save a few people's lives. It can lead us to deny significant help to people who will be the worst off (and badly off in absolute terms) because they will die if they are not helped in order to help many who are disabled only in a small way and thus not very badly off.\footnote{8}

To see a third problem, notice that Singer's way of reasoning is independent of the particular values found through intrapersonal tradeoffs of quality and quantity of life. Suppose people who are severely paralyzed would trade off only a few days of life in order to live without their disability. This result in a tradeoff between quality and quantity of life would imply that their disability has only a slightly lower value than nondisability. Taking this data, Singer's method of reasoning implies that we simply need a much larger number of people who could be cured of severe paralysis in order to compensate for not saving the life of someone who would go on to live for ten years. A particular problem to which this case gives rise is that the conclusion to which Singer's method leads may now seem reasonable.

That is, it may be said that curing thousands of severely paralyzed people is indeed to be preferred to saving one person so that he can go on to live for an additional ten years. Aggregating benefits across people seems to give the right answer here. However, if we agree with this conclusion, it is probably because we are assuming that severe paralysis makes for a type of life that is very bad for each person in contrast with nondisability and, hence, that someone would trade much more than a few days of life in order to be unparalyzed. But Singer's reasoning implies that such a low value need not be attached to the paralysis in order for curing the many paralyzed people to outweigh saving the life, and this is why his reasoning is problematic.

Finally, Singer argues that if we accept that disability can make a person's life less good healthwise, other things equal, and we want to maximize the health benefits we get with our resources, we should save the life of a nondisabled person rather than someone whose disability cannot be cured, other things equal. The only alternative to this, he says, is to deny that disability per se makes someone's life not as good healthwise, and to say that would have the unpalatable implication that there is no reason to allocate resources to cure or prevent disabilities.\footnote{7} (Notice, in Singer's defense, that saying that "a life is not as good with a disability" in the sense that the quality of life for the person goes down does not itself imply that the person herself is not as good as or not worth as much as a nondisabled person.)

I have argued that there is another alternative that does not deny that disability makes life significantly worse for a person, other things equal, and yet does not lead to Singer's conclusions about allocation: We should recognize that a consideration can give us a reason to do something in one context but not another. For example, having a paralyzed finger can make life not as good in a small way, holding other factors constant. This can give us some reason to try to cure this condition while also recognizing that, when it comes to deciding whose life to save, it is an irrelevant consideration that one person has a paralyzed finger and
another person does not. The additional admitted good of a nonparalyzed finger in the life of one person is what I called an "irrelevant good" when deciding whose life to save, and so equal chances should be given to each. It is not necessarily irrelevant when deciding whether to spend dollars on a curative treatment for finger paralysis.  

This explanation suggests that it is not the judgment that disability can make an outcome worse that has to go; it is the judgment that we should always maximize health outcomes with our resources that has to go.

It may be clear that small differences in victims, like a paralyzed finger, should not affect who is chosen for a lifesaving resource. But what is the explanation of this irrelevance? Here is a possible explanation: In this two-person contest for a scarce lifesaving resource, either person would get the greater part of the best possible outcome that can be gotten by someone (i.e., a worthwhile life whether with or without a paralyzed finger). It is also the case that the alternative for each to being saved would be very bad (death), and each wants to be the one to survive. It is crucial to this explanation that we are dealing with separate persons and that we think that from a moral point of view their different perspectives on an outcome (viz. each cares who survives) should influence what we should do. Otherwise, it would be clear that we should maximize QALYs. This is what we would do if we had a choice with respect to one person of merely saving his life or saving his life and also unparalyzing his finger, holding costs constant.

But what of larger disabilities that bring down quality of life as far as 0.5 or somewhat below, so that it is not true that either person would get the greater part of the best possible outcome that can be gotten by someone? I have suggested at least two grounds for why we should still give equal chances for a lifesaving procedure to the disabled and nondisabled. Importantly, neither ground depends on the view that a disabled life is as good for someone as a nondisabled one, other things equal. First, each person can get what it is most important that people have, namely a worthwhile life, and each wants to be the one to survive. (Call this the Moral Importance Ground.) Second, when one's only option is to have a life at 0.5, it may be reasonable to care about it as much as it would be reasonable to care about keeping a life rated at 1. (Call this the Only Option Ground.) Note that this is consistent with its being reasonable to care to have the life rated at 1 rather than 0.5 and even its being reasonable to risk death to get it, were this possible. This implies that it could be reasonable to risk death to get a life at 1 about which it will not be reasonable to care more, once one has it, than one should care about the life one has now (at 0.5) were it one's only option. All this may seem puzzling, yet I think it is true. Neither of these grounds applies when quality of life rating falls very low (e.g., coma) and I will not consider such cases here.

But now imagine two nondisabled patients. One could live for twenty years if he had a scarce lifesaving surgery and the other could live for five years. The Moral Importance and Only Option Grounds also seem to imply that it would be wrong to favor the person who would live much longer. If we disagree, we will need an
argument that allows significant differences in length of life, but not significant differences in quality of life, to count in rationing decisions. One suggestion I have made is that we distinguish between the "type" of person someone is, constituted by the qualitative features of his life, and how long any type of life goes on. Respect for persons might often require ignoring types when rationing but not big differences in how long any given type will persist.  

Call this the Respect Ground.)

In sum, using quality-of-life considerations and comparing and aggregating benefits across different people, at least in the manner Singer recommends, to determine how good a health outcome is often seems to be the wrong way to ration scarce resources. It is important to realize that we might be able to think seriously about how to allocate scarce resources among different people—and even be willing to endorse rationing sometimes—without necessarily reaching all of Singer's conclusions.

It is also worth pointing out that, in cases not involving life-and-death decisions (such as treating gastritis with a scarce resource), it need not matter whether we treat the disabled or nondisabled even if we, like Singer, were only concerned with how much good health there will be in an outcome overall. This is because if a scarce treatment for gastritis is equally effective in a disabled or a non-disabled person, both people will continue to exist and the same improvement in the gastritis will occur whomever we treat. Using abbreviation makes this clear; where C is "cure gastritis," P is "paralyzed person," and U is "unparalyzed person." If we treat P so that we have P(C), U is still alive (unlike in a case in which we do not treat his life-threatening illness in order to save P), albeit with gastritis, and prima facie P(C) + U(-C) contains as much good as P(-C) + U(C), only distributed differently. It is true that there is no "perfect specimen" in the outcome if the nondisabled person is not treated—no U(C)—but medicine is not concerned with producing perfect specimens. (Of course, it might be reasonable to give the cure for gastritis to someone who will already have the problem of paralysis to deal with, rather than treat someone who has no such additional problem. This concern for the person who would be worse off is, arguably, independent of concern for the amount of good in the outcome overall, unless we think there is diminishing marginal utility of a gastritis cure to the nondisabled, which seems unlikely. It may simply be that there is greater moral value in giving the same amount of physical good to someone who otherwise would have less physical good.)

II. Proposals for Counting Disability

Although I have provided some possible reasons for ignoring many quality-of-life differences in rationing, in earlier work I have also suggested additional reasons why taking account of such differences sometimes does not involve the particular problem of invidious discrimination. This is so even if taking account of the differences raises the different problem of giving too much weight to what should be
irrelevant goods, and even if favoring the nondisabled over the disabled for scarce lifesaving resources sometimes does involve invidious discrimination. Consider some of the arguments for the view that there need not be invidious discrimination when deciding whether to treat someone just recently seriously paralyzed or, instead, some unparalyzed person. One argument focuses on cases where there are multiple causes of a condition such as paralysis. This condition gives us a reason to treat a specific illness with a scarce resource. For example, suppose we are equally able to treat two patients for a specific illness that causes both paralysis and pain, but we are most concerned with the illness because it causes paralysis. However, there is another cause of paralysis in one of the patients that we cannot treat. We can refer to such cases as “condition similarity cases.” I argued that there would be good reason not to treat the patient who will still be paralyzed due to the other cause even though our treatment against the specific illness is equally effective in both patients. It seems that it is better to get rid of both pain and paralysis than to just get rid of the lesser problem of pain. Hence, it may be permissible to leave the unavoidably paralyzed person with pain and treat pain and paralysis in the other person.

I also argued that we should distinguish treating a person differently on the basis of (a) disability as a component of someone’s life, making him a certain type of person, versus (b) disability as a cause of other bad effects in the person’s life. So when the presence of a disability has the causal effect of interfering with treatment of another condition (e.g., we cannot perform heart surgery as well because of paralysis), there might be no objectionable discrimination in providing treatment to a nondisabled person instead. (This is consistent with there possibly being objectionable failure to prioritize the worse off.) Also, counting differences in life expectancy caused by the disability in deciding whom to help need not involve invidious discrimination if it is permissible to count an otherwise-caused difference in life expectancy. Similarly, it can be permissible and nondiscriminatory to take into account obstacles to treatment that arise from not having a disability (e.g., we cannot perform heart surgery as well because someone has two legs rather than one). Or if nondisability reduced life expectancy, this may be taken into account consistent with nondiscrimination. Hence, someone’s undeserved disability can sometimes determine that he suffers a further loss (his life), without this involving objectionable discrimination. This is what I called “linkage.”

I further distinguished between (1) producing a better outcome in one patient than in another by (what I call) “piggybacking” on the good property a patient already has or will have but that we do not, per se, produce, and (2) producing a better outcome in one patient than in another by causally producing the additional good property. For example, I discussed what I called Switch Cases. (See figure 22.1, where $\Rightarrow$ signifies causing paralysis or nonparalysis and $\Rightarrow$ signifies absence of such a causal role, all in cases in which we would cause the saving of the life of any person we treat.) In all three cases, two people compete for a scarce lifesaving treatment. The difference is only in the impact on paraplegia.
In Case 1, two paraplegic people are up for a scarce lifesaving treatment but in the first person the treatment, as a side effect, will undo the paralysis (i.e., \( P \Rightarrow U \)). In Case 2, two paralyzed people are up for a scarce lifesaving treatment but in the first person the treatment, as a side effect, will cause paraplegia (i.e., \( U \Rightarrow P \)). (Case 3 will be discussed later.) In Case 1, if we choose to save the paralyzed person whom we cause to become unparalyzed, we do not merely get a better outcome by saving an already unparalyzed person or one who will become unparalyzed independently of our treatment that cures paralysis. Rather, we get a better outcome by saving a person and unparalyzing him. I argued that this different causal route to the same better outcome might make a moral difference to whether it is permissible to decide not to save a person who will remain paralyzed. That is, it might be permissible not to give a person who will remain paralyzed an equal chance to be saved relative to another person whom we can save and unparalyze. This is so even if it is impermissible not to give a person who will remain paralyzed an equal chance relative to another person whom we can save but whose being unparalyzed, per se, is not due to our efforts. This moral difference is not taken into account by those who, like Singer, claim that all that matters is how good the outcome is (i.e., that the person we save be unparalyzed). Nor is it taken into account by those who claim that deciding whom to save on the basis of whether they will be disabled always involves objectionable discrimination. (This is so even if we assume, for the sake of argument, that favoring \( U \Rightarrow U \) over \( P \Rightarrow P \) involves invidious discrimination and not just giving too much importance to maximizing QALYs.)

To capture these results, I described the following principle:

The Causative Principle: It may be morally permissible to take account of large differences in QALYs if and only if we cause them.\(^7\)

But how can we justify there being a difference between a better outcome achieved by piggybacking and one achieved by causing? Perhaps we have greater entitlement to decide on the grounds that a better outcome will come about (i.e., there will be a nonparalyzed person in existence rather than a different paralyzed person) if we cause the nonparalysis rather than piggyback on this property by saving a person already unparalyzed. This entitlement could weigh against other factors pulling in another direction. (Similarly, we might be entitled to avoid causing something bad like paralysis in \( U \Rightarrow P \) rather than piggybacking on it as in \( P \Rightarrow P \); in Case 2.)

I argued that the Causative Principle could not simply be subsumed under what I called the Treatment Aim Principle.\(^8\) The latter is the view that if our treatment
for a particular problem would be equally effective in a narrow sense (e.g., cure heart failure) in either a disabled or nondisabled patient, each should have an equal chance for the treatment. This is a common justification for giving equal chances for a scarce lifesaving drug to a disabled and nondisabled person. However, the Treatment Aim Principle also implies that if the treatment outcome in a narrow sense would be different, we might permissibly decide to treat the patient who will get the better outcome. One reason I gave for not subsuming the Causative Principle under the Treatment Aim Principle is that if a treatment aimed at curing heart failure unexpectedly cures or causes paralysis, as in the Switch Cases, this would ordinarily be considered a side effect of treatment, not part of the narrow sense of effectiveness of the heart treatment. By contrast, the Switch Cases and the Causative Principle are intended to suggest that the good or bad side effect we cause might also be relevant to deciding how to allocate the scarce lifesaving resource. I did note that we might modify the Treatment Aim Principle so that it would take account of side effects in determining the effectiveness of treatments.29 (However, this would be a wide rather than a narrow sense of equally effective treatment.) I also noted that if a drug’s good side effect were consistently present in many patients, one might come to consider the drug as a treatment for two different problems, either together or alone (even though it was not developed with this in mind). If the drug were considered a treatment for two problems at once, its effectiveness might be judged, even in a narrow sense, by whether it cured both problems rather than just one.

The important point, I argued, is that sometimes having a causal role in making someone disabled or nondisabled might be a ground for deciding whether to treat someone with a scarce resource for a completely different problem, such as heart disease, without this involving objectionable discrimination. This could be true regardless of whether having this causal role means that our treatment is more effective for the different problem per se.

In sum, I argued that even those who disagree with Singer and think that picking U→U instead of P→P is objectionably discriminatory could agree with the following: There is no objectionable discrimination in taking disability into account when (1) our treatment causes or cures it, (2) the disability affects treatment, (3) the disability causes further bad effects such as reduced life span, or (4) the disability is similar to the effects of an illness we are specifically trying to treat.

However, even if these four reasons for distinguishing people do not involve objectionable discrimination, attending to them may involve giving too much weight from a moral point of view to differences in outcome. That is, some differences in outcome may still be “morally irrelevant goods” in certain contexts. For example, given that life itself is at stake for both candidates for the scarce resource and each wants to be the one to live, the fact that taking account of a minor difference in outcome that we cause did not involve objectionable discrimination per se need not show that taking account of it is morally permissible. Hence, I suggested, objections to not treating the disabled in many contexts may have to rest on violation of a Principle of Irrelevant Goods rather than a claim of improper discrimination.20
III. Brock on Equally Effective Treatment

The distinctions I drew between the Causative Principle and the Treatment Aim Principle are relevant to evaluating some views of Dan Brock's on rationing and the disabled. By contrast to Singer, Brock suggests that we accept a narrow notion of equally effective treatment. This is a "treatment specific" understanding of effectiveness (p. 41). He considers the case of heart surgery. Brock says that surgery that fixes heart valves can be equally successful in each of two people even though we can predict that one person will live for ten years and another will live for one year because the second will be executed within the year (p. 41). The measure of the surgery's success on this account is how well the valves are fixed, independent of how long the person goes on to live. Similarly, he says, "specific medical treatments are developed for specific medical conditions and their effectiveness is determined by how well they correct that condition" (p. 41). This implies that if a treatment designed to remove an impairment does so entirely in one person (even for a limited time, e.g., before she is executed), but only partially in someone else, the treatment is more effective in the first person.

Given this narrow notion of treatment effectiveness, it is theoretically possible for a paralyzed person to have just as successful a heart surgery as a nonparalyzed person. Hence, contrary to what Singer suggests, Brock thinks that if surgery must be rationed, there is no reason to favor the nondisabled person. Indeed, it could be objectionably discriminatory not to give equal chances for surgery to each.

My concern is whether Brock's narrow notion of treatment effectiveness is consistent with some other claims that he goes on to make. This is where the discussion of my earlier work is relevant. First, in discussing a case of hip replacement, he says:

... a pre-existing disability in effect often acts as a comorbidity that makes treatment less effective in improving a patient's health-related quality of life. Patients with COPD [chronic obstructive pulmonary disease], for example, have substantial limitations in mobility and ability to carry out a variety of activities requiring physical exertion; this would reduce the benefit they would otherwise receive from an intervention like a hip replacement, which is also intended to restore mobility and ability to carry out physical activities. (p. 30)

If we were to decide not to treat the COPD patient for these reasons, Brock says it would be a "form of discrimination [that] seems less morally problematic because it is based on an arguably relevant and defensible difference in treatment effectiveness, although that difference in effectiveness is caused by a pre-existing disability" (pp. 41-42).

What Brock means here is not that the hip cannot be replaced as successfully because the COPD makes surgery more difficult. Rather, Brock is here considering that the disabled person will get less out of what the new hip is meant to help provide.
(e.g., mobility). But this does not seem to involve use of a narrow notion of treatment effectiveness because it considers what further benefits someone gets from a treatment in judging how effective the treatment is. This is a wider notion of treatment effectiveness. If we used this wider notion, then if one person got more out of heart valve surgery because he got more of what it is was supposed to provide than someone else (e.g., longer life), then the first person’s heart treatment would be judged more effective. This seems contrary to what Brock originally claimed to be the correct understanding of surgery that would fix each person’s heart to the same degree. (Brock’s case is also like the Condition Similarity Case that I discussed earlier: We can treat one cause of absence of mobility equally well but only get mobility in one patient due to another cause of immobility in the other patient.)

Second, Brock considers a hypothetical case considered by a government agency using the Americans with Disabilities Act (ADA). In that case, two people are imagined to have sustained life-threatening injuries in a car accident that also left them unable to walk (p. 29). We can save each person’s life but a cure for the disability only works in one of the people. The agency argued that automatically saving the person who could also be made nondisabled would be objectionable discrimination according to the ADA. One reason given for this conclusion was that judging an unparalyzed life to be better than a paralyzed life, other things equal, was itself discriminatory. This reason seems wrong for, as Singer noted, it is because we think an unparalyzed life is better for someone than a paralyzed life, other things equal, that we try to cure and prevent paralysis in cases where there is no conflict for a scarce resource. Doing so is not thought to involve an objectionable discriminatory judgment. The agency also suggested that choosing to save the unparalyzed life implies that one thought the life of a paralyzed person was not worth as much. Brock thinks this complaint fails to distinguish between the equal worth of a person and the unequal worth of the contents of that person’s life. Apparently, he thinks the latter can be relevant to allocation decisions consistent with respect for the equal worth of persons.

Brock’s positive view about the hypothetical case considered by the government agency is that our treatment will be more effective if it both saves a life and cures a disability incurred in the accident. Therefore, it is not objectionable discrimination to save the person who will not be disabled. Notice that we are probably considering this to be a case in which we are aiming to reverse all the damage—life threatening as well as disability causing—that has occurred in the accident. Hence, we are probably not conceiving of this as a case in which a treatment that is aimed only at saving someone’s life also has a unforeseen but unusual side effect of curing his disability, as in my Switch Cases. Indeed, in the government’s case there may be two treatments: one is life saving and will work on each person equally well in the narrow sense; another is a disability-curing treatment that will work on only one person. Suppose we are concerned not with whom we can treat most effectively (as Brock puts it), but with in whom a treatment will be most effective. Then the question becomes whether we should choose one of the patients
to get a lifesaving treatment that works equally well in either patient simply because another treatment we have is effective at curing disability only in him. But loss of life is the most pressing concern (and length of the expected survival is not said to be different). So it seems that the narrow standard of treatment effectiveness implies, as it would imply if my Switch Cases, that we should ignore whether we can cure a disability in deciding whom to save.

Third, Brock says that if a treatment for an unrelated condition (such as heart disease) causes a disability (such as paralysis) in one person but not in another, as it did in my Switch Case 2, the treatment is less effective in the first person, other things equal.24 However, the idea of unequal effectiveness that Brock employs here seems inconsistent with his original, narrower notion of treatment effectiveness: If the fact that it caused disability counted against a treatment's narrow effectiveness, so should the fact that it caused a reduced life span in one patient but not another. This limits the scope of Brock's view that we should not consider how long a patient survives after a lifesaving treatment in deciding on treatment effectiveness (p. 41).

Further, if a drug for heart disease caused paralysis, on the narrow view of treatment effectiveness, we would presumably consider it a bad side effect of the drug, just as if it caused dandruff; causing a bad side effect is not an indication of a less effective treatment for heart disease. We might seek another drug that treated the heart disease as effectively but without the bad side effect, but we would not describe this as seeking a more effective treatment, in a narrow sense, for heart disease.

It is only if we adopt a wide notion of treatment effectiveness that good or bad side effects will speak against treatment being equally effective in different people. Hence, it does not seem that the narrow standard implies that we should prefer to save the person in whom the treatment does not produce or does cure a disability. (This issue arises, in part, because Brock introduces the narrow notion of treatment effectiveness in conjunction with the idea that "specific medical treatments are developed for specific medical conditions." So it seems that it is only the condition for which the treatment is developed that matters in deciding whether effective treatment is present. Focusing on development for specific medical conditions, if this means specific illnesses, will also raise problems if we consider cases in which "condition similarity" due to different illnesses (as described earlier) exists, or in which a patient will be treated successfully for heart disease but soon die of liver failure anyway.

Brock himself specifically qualifies his conclusions based on the narrow notion of treatment effectiveness, saying that they hold "unless attending to treatment effectiveness is ruled out on other moral grounds" (p. 42). Still, I think that Brock does not correctly draw out the implications of the narrow conception of treatment effectiveness that he favors. Furthermore, the correct implications of the conception are often inconsistent with what seem to be the correct views about possible nondiscriminatory handling of cases. Hence, we have reason not to always rely on such a narrow notion in deciding whether allocating scarce resources is or is not invidiously discriminatory.
IV. Problems with the Causative Principle and Ideas of Discrimination

Having distinguished the Causative Principle from a narrow treatment effectiveness view, I want to discuss some problems I have elsewhere raised for the Causative Principle. The problems show that the principle fails, despite avoiding some of the problems raised by the narrow treatment-effectiveness view. Moreover, some of its failings involve (other) forms of invidious discrimination.

1.

Recall that the Causative Principle states that it is morally permissible to take account of large differences in QALYs if and only if we cause them (rather than piggyback on them). Consider a case in which we must choose whether to give a lifesaving scarce drug to an unparalyzed person who will remain unparalyzed because we do not affect this property of his in any way (U→U) or, instead, to a recently paralyzed person in whom the lifesaving drug has the side effect of unparalyzing him (P→U), where ⇒ indicates our causal role in treating paralysis. (This case involves the second person in Case 2 and the first person in Case 1, figure 22.1 earlier.) In this case, our causal role is greater in the originally paralyzed person than in the originally unparalyzed person. Yet, I believe, it would be morally wrong and even invidiously discriminatory to make this factor relevant in deciding whom to help. This is because both people will be unparalyzed in the outcome and there is no difference in their past lives that would imply that one person will have lived a much worse life overall if he is not helped to live on. That is, suppose we endorse some morally acceptable role for the Causative Principle (on the basis of cases where the choice is between giving a scarce lifesaving drug to P who will remain P and P whom our treatment can make U, as in Case 1). Then we may make the wrong decision and, it seems, even an invidiously discriminating one, in some cases. This is so if we choose to aid the person on whom we have a much greater positive causal effect, in cases where the candidates' outcomes are the same. (Brock does not consider such cases and the problems they raise in his discussion of our greater impact on one patient than another. I shall comment on this further below.)

In response to such same-outcome cases, I suggested that a mark of invidious discrimination may be that we hold it for or against someone in a contest for a scarce resource that he is disabled or nondisabled when we did not cause those states in him. In cases in which the outcomes for both patients would be U, if we count it in favor of one person that we would cause his being U, we will really be holding it against the other person that he would be U rather than P independently of anything we do. This is because it is his being and remaining U that makes it true that we cannot have a causative role in producing U in him. Hence, sometimes if we want not to be engaged in invidious discrimination against either the disabled or the nondisabled, we should not attend to the causative role of our treatment.
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(The same may hold when we must decide between saving U→P and P→P. The fact that our causative effect is negative in one person but not the other can be irrelevant if the outcome is the same. This is so even though we would be harming one of the people, especially since depriving him of a chance for the procedure that paralyzes him would result in a worse effect for him, namely death.) This is why I suggested that we should move beyond the simple Causative Principle (and also beyond seeing where our treatment narrowly construed is most causally effective). Hence, in deciding how to allocate a scarce resource, insofar as we are concerned with quality in outcome and assume that invidious discrimination can occur when we piggyback, we should focus on whether we would cause a significantly better or worse outcome in one patient than in another.27

This solution to the problem raised by the simple Causative Principle for same-outcome cases helps refine the idea of invidious discrimination.28 As suggested by what I have said above, I do not think that judging paralysis to be worse than nonparalysis, other things equal, is itself an instance of an invidiously discriminatory value judgment. Now suppose it is sometimes not invidiously discriminatory to differentiate candidates for a scarce resource on the basis of the expected presence or absence of disabilities when our treatment for some other condition would cause or cure the disabilities. Then we also cannot conceive of invidious discrimination as taking account of someone's disability when this will lead to a worse outcome for him (e.g., he loses his chance for a scarce resource for another medical problem). But one sense of invidious discrimination seems to involve doing what holds someone's disabled or nondisabled state against or in favor of him just because our treatment does not cause the state when outcomes are the same. Finally, we have been supposing that someone believes that invidious discrimination occurs in attending to differences in outcome when they come about through piggybacking, yet he also thinks this is not true when the same difference is caused by us (as in the Switch Cases). Putting all this together, we get a conception of discrimination that seems to involve holding someone's nondisabled or disabled state against or in favor of him in a contest for a lifesaving resource when our treatment does not cause the difference (i.e., whether outcomes are different or the same). (One exception is when the disabled state is similar to the condition that gives us reason to try to treat an illness with our scarce resource.)

2.

Another problem with emphasizing whether our treatment causes or cures disability is the threat of intransitivities:29 Suppose we may sometimes take account of how we causally affect disabilities when deciding how to allocate scarce resources. Then it may be morally permissible to treat P→U and U→U differently when they are each in contests for resources with someone who is P→P. That is, P→U may be preferred to P→P without invidious discrimination, but if we assume the view that taking account of piggybacked disability is wrongly discriminatory,
U\rightarrow U may not be preferred to P\rightarrow P. Yet, it was argued earlier that P\rightarrow U and U\rightarrow U should be treated as equals in a contest between them alone for a scarce resource. So individuals who are equals in a pairwise comparison fare differently when they are compared pairwise with a third party (P\rightarrow P). This gives rise to the (apparent) threat of intransitivity and the problem of whom we should select when all three of these individuals are present at once. (It also implies that it is being held against someone that he was U without our assistance, since he fares worse relative to P than someone who began as P and whom we would make U. To avoid this problem, we could simply settle for avoiding invidious discrimination, as I described it above, in pairwise comparisons only.)

More specifically, the problem of (apparent) intransitivity can be put as follows, where > is "preferred without invidious discrimination": (1) P\rightarrow U > P\rightarrow P; (2) P\rightarrow P = U\rightarrow U; and yet (3) -(P\rightarrow U > U\rightarrow U). Brock does not speak to this issue because, as I noted earlier, he does not deal with cases in which our causative role in helping (or harming) one person would lead to the same outcome for both patients. That is, Brock's discussion considers the comparisons in (1) and (2), but not the comparison involved in (3). This may be why he does not notice that (1) and (2) imply what seems to be untrue, namely that P\rightarrow U > U\rightarrow U.节

What should we do when all three individuals (i.e., P\rightarrow P, U\rightarrow U, and P\rightarrow U) are in competition for the same scarce lifesaving resource? When all three are present, I suggested that it would not involve invidious discrimination to select one of the people who would have the best outcome. We could reason in the following way: P\rightarrow P could be eliminated from the contest by P\rightarrow U, and so not have to be directly compared with U\rightarrow U. Then we can give equal chances to P\rightarrow U and U\rightarrow U. (There will be no cycling.) The underlying view is that we are morally permitted to seek a significantly better outcome, and to follow a path in decision-making that leads us there, so long as our path to this end is not invidiously discriminatory and no other relevant moral principle is violated.

3.

Let me present a third problem I have discussed. I think it is a problem for those opposed to taking account of disability and nondisability in allocating lifesaving scarce resources when P\rightarrow P and U\rightarrow U, but who nevertheless think that significant differences in life expectancy—whether they come about through our causation or piggybacking—should sometimes matter in allocation decisions. Suppose candidate A for a lifesaving treatment will live for one year and candidate B for six years, and this is a reason to select B. Suppose A is nondisabled and B was recently severely paralyzed. Other things equal, if we do not give the treatment to B, we would be holding his disability against him. Suppose B receives the treatment and subsequently wishes to take advantage of a new surgery that will unparalyze him, though it reduces his life expectancy to slightly over one year. (I called this a Switch-and-Reduce Case.) He wants to do this because, let us suppose, it is a reasonable
intrapersonal tradeoff to exchange six years of severely paralyzed life for slightly more than one year of nondisabled life. In fact, it makes him better off. With the Switch-and-Reduce surgery, B would be almost identical to the way A was; the difference in length of life expected (one month) would presumably be morally irrelevant in an interpersonal choice of whose life to save. Had B’s prospects earlier been nearly identical to A’s, the objection we raised to the simple Causative Principle implies that we should have given them equal chances for the lifesaving resource. Even if at the time of allocating the scarce treatment we only knew that B would have the Switch-and-Reduce surgery were his life to be saved, it seems we should have given A and B equal chances.

Might it be that if we select B over A because he will live for six years, we should elicit a promise that he will not have the later surgery so that the five additional years of life that gave us a reason to deprive A of his chance will come about? Limiting B’s options subsequent to his selection would imply that there are moral reasons for his having to make decisions only about his own life from the same perspective that led to him rather than someone else being alive. (This would be even clearer if A would have been preferred over B, with a life expectancy of slightly over one year, because A had a significantly longer life expectancy than one year—e.g., three years.)

Further, suppose that at the time of the choice with A we could have saved B in two different ways: (i) so that he will live for six years paralyzed or (ii) so that we switch him to being unparalyzed with a life span of slightly more than one year. Then if B chose the Switch-and-Reduce option (ii), it seems that equal chances should have been given to A and B. Hence, if at the time of selecting a candidate, B chose the lifesaving procedure (ii) that was better for him intrapersonally, he would eliminate the superior chances to live relative to A that he would have had if he chose to be P for six years.34

The problem in these cases arises because we are refusing to allow the same tradeoff between quality and quantity of life interpersonally that we (are assuming) is reasonable intrapersonally. Such a tradeoff interpersonally (we are assuming) would make six years P in B equal to one year U in A. One ground for not allowing quality/quantity tradeoffs interpersonally was suggested earlier: When all one can have is a life with severe P, it may be reasonable to care about one year with such a life as much as someone else cares about one year with U.35 However, we are also allowing the reasonableness of bringing about the intrapersonal tradeoff between a long life with severe P and a shorter one with U when this can be done. That is, someone who reasonably cares maximally for a year with severe P, when it is all he can have, can consistently care to be U for even much less time when that is an option. As a result of these two moves, B’s P life lasting for six years is judged better interpersonally than A’s U life lasting for one, and yet B’s U life for slightly more than one year, which would intrapersonally be better than the better interpersonally option, is not judged better interpersonally than A’s year.
These cases may remind us of what Thomas Scanlon famously emphasized, that intrapersonal tradeoffs that are adequately reasonable for an individual to make can lack moral relevance from an interpersonal point of view. He described someone (call him Joe) who had a claim on us for food to meet his nutritional needs but for whom it was more important to build a monument to his god than to eat. Scanlon claimed that Joe would have no claim on us to provide him with funds to build the monument instead of spending the same amount for his food. Now suppose that our money is scarce and both Joe and Alice have an equal claim on us for food. The amount we can purchase is the minimum necessary for survival and so there is no point dividing it between them. Then if other things are equal between them, we should give each a maximal equal chance for food. However, if Joe will sell the food we give him to get supplies to build the monument to his god, then, presumably, he should lose his equal chance for the food. His not unreasonable intrapersonal tradeoff would not have a legitimate interpersonal role in his retaining an equal chance with Alice for food. This would be true even if Alice had the same preference ranking as Joe but would not be able to act on it with her food supply.36

Notes

1. My remarks on Singer are in response to his “Why We Must Ration Health Care,” New York Times Magazine, July 19, 2009. All references to Singer are to that article, which he wrote while the Obama health-care proposals were being discussed. A short extract of my discussion of Singer was published as a Letter to the Editor of the New York Times Magazine, August 13, 2009. My remarks on Brock are in response to his “Cost-Effectiveness and Disability Discrimination,” Economics and Philosophy 25 (2009): 27–47. All references to Brock are to this article. I am grateful for comments to audiences at the Conference on Rationing, Erasmus University, Rotterdam, December 2010, at the Bioethics Colloquium, New York University, April 2011, and at the Department of Clinical Bioethics, NIH June 2011. I am grateful for comments to the editors of Rationing Health Care: Hard Choices and Unavoidable Tradeoffs, eds. A den Exter and M. Buijsen (Apeldoorn, Netherlands: Maklu, 2012), in which this chapter also appears, and to the editors of Health Inequality: Ethics, Measurement and Policy, eds. N. Eyal, O. Norheim, S. A. Hurst, and D. Wikler (New York: Oxford University Press, forthcoming), in which this chapter will also appear.

2. The QALY, which multiplies years of life times quality, was invented by Richard Zeckhauser, who also thinks we should allocate health resources to maximize QALYs per dollar. It is not clear why Singer favors maximizing health benefits rather than all benefits. Prima facie, the latter standard could imply that we ought to save rich, beautiful, and productive people over those who lack such traits.

3. He says:

How can we compare saving a person’s life with, say, making it possible for someone who was confined to bed to return to an active life … One common method is to describe medical conditions to people—let’s say being a quadriplegic—and tell them that they can choose between 10 years in that condition or a smaller number of years
without it. ... If most ... have difficulty deciding between 5 years of nondisabled life or 10 years with quadriplegia, then they are, in effect, assessing life with quadriplegia as half as good as nondisabled life. ... (These are hypothetical figures, ...) if that judgment represents a rough average across the population, we might conclude that restoring to nondisabled life two people who would otherwise be quadriplegics is equivalent in value to saving the life of one person, provided the life expectancies of all involved are similar.

4. On why this might be so, see my “Should You Save This Child?” Gibbard on Intuitions, Contractualism, and Strains of Commitment,” a comment on Allan Gibbard’s Tanner Lectures, in Gibbard’s Reconciling Our Aims (New York: Oxford University Press, 2008).

5. Such a rescue is different from deciding when someone is, for example, 20, whether to allocate resources in such a way that he lives to 60.5 rather than to 60. I discuss this distinction briefly in “Aggregation, Allocating Scarce Resources, and the Disabled,” Social Philosophy and Policy 26 (Winter 2009), and in chapter 21 this volume.

6. In general, Singer believes that it could be morally correct to aggregate small benefits to many people, each of whom is not badly off, and produce a large overall benefit, rather than to provide a significant benefit to prevent someone else from being much worse off. So although he is known for his views on the duty to save people from famine, his theoretical position actually implies that it could be morally preferable to save many from headaches rather than save a few from death. For this and other criticisms of Singer’s views, see my “Faminine Ethics,” in Singer and His Critics, ed. D. Jamieson (Oxford: Blackwell, 1999), which somewhat revised is also chapter 13 in my Intricate Ethics (New York: Oxford University Press, 2007).

7. It is sometimes argued that people who are not disabled mistakenly believe that becoming severely disabled is very bad. This is because, it is said, they are poor predictors of how unhappy they would be if they were disabled, as shown by the fact that the disabled are as happy as the nondisabled due to adaptation and various protective psychological mechanisms (even including self-deception). These points are made by Timothy Wilson in his Strangers to Ourselves (Cambridge, MA: Harvard University Press, 2004).

However, there are disturbing implications to basing rationing decisions on these findings, in addition to not allocating funds to cure disabilities. Suppose many people come to an emergency room with severe headaches that will last several hours. At the same time, someone else comes in with a spinal injury that will paralyze his legs if surgery is not done right away. Should we treat all the headaches or do the surgery if we cannot do both? Suppose that we can predict that someone will quickly adapt to paralysis but the people with severe headaches cannot adapt to them now. If experienced well-being were all that mattered, we should cure the headaches. This is the wrong conclusion, I believe. This is an indication that experienced well-being and accurate predictions about it are not all that matters in rationing decisions. The fact that people can adapt to, and deceive themselves about, a bad condition does not mean that we should not prevent the bad condition. (In this connection, it is interesting to note that Daniel Kahneman, who reports that disfigured people’s "daily mood" is the same as nondisfigured people's, also reports that the disfigured people themselves want to have the disfigurement removed (mentioned in his "Evolving Notions of Well-Being," a lecture in the Mind, Brain, and Behavior Distinguished Lecture Series, Harvard University, April 17, 2008).

9. For more on this issue, see chapter 21 this volume.


11. I deal with the recently paralyzed and to factor out the relevance for rationing decisions the candidate having had a worse life in the past than another candidate. See my Morality, Mortality, Vol. I, for a theory of rationing that takes into account different pasts in candidates for a scarce resource. See also chapters 18 and 20 this volume.

12. See my “Aggregation, Allocating Scarce Resources, and the Disabled,” p. 172. There followed it Treatment Similarity. See also chapter 21 this volume.


14. See my “Deciding Whom to Help, Health-Adjusted Life Years, and Disabilities.”

15. Brock refers to “Kant’s Nonlinkage Principle” (p. 39) to describe the view that age might be morally objectionable in general, but he does not note that I specifically cited this view. See “Deciding Whom to Help, Health-Adjusted Life Years, and Disabilities,” p. 240. I discuss this further in “Aggregation, Allocating Scarce Resources, and the Disabled,” pp. 171–72.


21. It is possible that there is a different reason, in general, for trying to cure and then paralyze, namely a life with the disability is harder even if not less good. It could supererogatory for people to lead the harder life even if it were no less good. But it is not objectionably discriminatory to judge that the paralyzed life is harder. For the supererogation argument, see my “Disability, Discrimination, and Irrelevant Goods” and chapter 21 this volume.

22. He says, “The fifth form of discrimination is where a particular treatment is less effective in some kinds of patients than in another kind, leaving the first kind disabled, but due to any background conditions of pre-existing disability. This case seems simply to difference in treatment effectiveness, with disability entering the picture for some
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patients but not others only as a result of the treatment" (p. 41). This quote probably applies to both cases in which treatment does not cure disability acquired in an accident (as in the text) and where it actually causes a disability (as in my second Switch Case).

23. In my Switch Case that involves life saving and a cure of disability in one patient but not another, the disability was recently acquired in both patients, but independently of the life-threatening illness. When I first wrote about the Switch Case in "Deciding Whom to Help: The Principle of Irrelevant Goods and Health-Adjusted Life Years," I did not know about the hypothetical case considered by the government agency and its analysis of the case. Indeed, Brock informed me of it as a way of criticizing my conclusion that curing disability could matter morally in the Switch Cases. He seems to have changed his position on this.

24. Although Brock cites "Deciding Whom to Help, Health-Adjusted Life Years, and Disabilities" in his article, he does not mention the discussion in that article of the Switch Cases.


26. A full discussion of this point would have to consider as an exception the idea of giving priority to a worse-off paralyzed person because her past and the past of the unparalyzed persons are very different. I owe this point to Carlos Soto.

27. For a more detailed discussion of this, see my "Aggregation, Allocating Scarce Resources, and the Disabled." In moving beyond the simple Causative Principle, I introduced another principle, the Principle of Irrelevant Type Identity. I omit discussion of it here to avoid unnecessarily complicating matters. Elizabeth Pike has suggested that in same outcome cases not involving life and death, we should attend to our causative role. For example, suppose that we could treat either P or U for gastritis. U would remain U if he is treated, but the drug for gastritis would also have the side effect of making P paralyzed. Surely, she says, we should give the drug to P, for then the person who remains U will still be alive and U, albeit with gastritis, and we will both cure gastritis in someone and produce another paralyzed person. I agree that in this case we should give the treatment to P. However, this case shows that it is not enough to focus on just the outcomes for the competitors for a scarce resource in order to know whether we will have produced the same outcome wherever we treat. Because if we treat U instead of P, we will have a world in which there is still a paralyzed person (P), whereas if we treat P we will reduce the number of paralyzed people and cure the same amount of gastritis. Hence our overall outcome will be different depending on whom we treat.


29. This was discussed in "Deciding Whom to Help, Health-Adjusted Life Years, and Disabilities," p. 242, note 13. Further discussion of this is in "Aggregation, Allocating Scarce Resources, and the Disabled."


31. Perhaps there is another reason for his not seeing this problem. It is possible that a treatment that did more for one patient than another should, as in (3), still be considered equally effective in a wide sense in both, and so not grounds for permissibly preferring one patient. This is because the treatment equally deals with all the problems each patient had, even if the nondisabled patient has fewer problems. It would be just as effective in a wide sense although it did not literally affect as much.
32. In "Deciding Whom to Help, Health-Adjusted Life Years, and Disabilities."
33. A round-robin procedure would lead to the same result, according to Peter Graham. 
34. A similar issue arises if B who would be P for six years confronts C who would be P for six years, when only B has the option of another lifesaving treatment that would result in his being U for one and one-eighth years. Suppose the latter is his intrapersonally preferable option. Should B be deprived of his equal chance simply because he selects a better intrapersonal option that we would cause? It at least seems so, because giving him an equal chance with A would involve counting the length of someone’s life differently depending on whether she was U or P. An earlier discussion of this issue is in chapter 21 this volume.
35. I discuss this in "Deciding Whom to Help, Health-Adjusted Life Years, and Disabilities," "Aggregation, Allocating Scarce Resources, and the Disabled," and in chapter 21 this volume.
36. For Scanlon’s case, see his "Preference and Urgency," *Journal of Philosophy* 72(19): 65–69. Thomas Nagel reminded me of the relevance of Scanlon’s case for my discussion of the Switch-and-Reduce Cases. Suppose, however, that Joe used money of his own on monument building when he could have used it for food, and this (foreseeably) left him without money for his food. Would Scanlon think that Joe now had no claim on us to provide him with food? Would he think that Joe had at least a weaker claim on food than someone else whose hunger was not the result of having spent his money on this other project? This case raises many interesting issues about the specificity of the use of our aid (after all, Joe will eat the food we give him) and also about responsibility for one’s condition.