The Principle of Justice: A Bioethical Perspective

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Do newborn infants matter in themselves or –as some philosophers argue– *do they matter only to the extent that they are loved and wanted by their parents? Is age an appropriate criterion for the allocation of health care? Would the currently-proposed revisions to the Declaration of Helsinki be unjust to the poor and disadvantaged?*

Our answers to these questions will be influenced by our sense of justice –our sense of what we owe to others and our sense of who counts as 'another'.

In the present essay, four different approaches to justice will be considered, namely, utilitarian, egalitarian, libertarian and natural law. It is our belief that the natural law approach to justice provides us with the best principled account of our obligations in justice as health-care professionals.

1. Three Questions

The following are three questions –about care of the newlyborn, care of the elderly and treatment of research subjects– that raise difficult issues on justice:

(a) *Is there anything wrong in itself with killing newlyborn children?*

According to some philosophers, there is not. Of course, most parents can be presumed to love and cherish their newlyborn children,

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so the morality of infanticide does not often arise in paediatric care. But it lurks in the background frequently enough to make it worth reconsidering. Parents who do not want their child to start out on life's uncertain voyage with prospects clouded by disability sometimes wish to cut themselves free of the ties that bind them to that infant and make 'a fresh start' with another child having better prospects. Some will not baulk at the taking of 'active means' to bring about the death of a disabled child. Others will, but they may tolerate 'allowing such a child to die'.

(b) *Is it legitimate to withhold health care from the elderly just on account of their age?*

There is plenty of evidence that withholding health care on account of a person's age is already standard practice across medicine.[1] Indeed, since no society can afford to provide all the health-care that its citizens need, let alone want, many people think justice requires we give priority to the health care needs of the young over those of the old. This is explained in various ways. Some say that the elderly benefit less from health care than do the young[2], others that the elderly have already had their fair share of health-care[3], and others that the elderly have already enjoyed a life long enough to make the most of the opportunities that life typically affords to us.[4]

(c) *Is it legitimate to conduct clinical trials which would be considered unethical in affluent countries on population in poor countries?*

Are the responsibilities of researchers to research participants governed by universal ethical standards? Indeed is it sometimes le-

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[1] See for example Boyd, Kenneth (1983). The ethics of resource allocation, *Journal of Medical Ethics*, 9: 25-27.

[2] See, for example, Kluge, Eike-Henner W (1988): 'The calculus of discrimination', in JE Thornton (ed) *Ethics and Aging: The Right to Live and the Right to Die*, Vancouver: British Columbia UP, 1988, pp. 84-97.

[3] Norman Daniels, *Am I My Parents' Keeper*? Oxford University Press, 1988.

[4] Daniel Callahan, *Setting Limits: Medical Goals in an Aging Society*, Simon & Schuster, New York, 1987.

gitimate to conduct clinical trials which would be considered unethical in affluent countries on populations in poor countries? Recently, groups of reputable clinicians have been withholding efficacious drugs from HIV-infected women during perinatal transmission trials in developing countries. Researchers wish to find out whether a shorter, cheaper course of zidovudine is as effective in preventing mother to child transmission of HIV as a longer, more expensive course. To do so, they want to run clinical trials –as in standard double-blind, placebo-controlled trials– in which some women would be given no treatment at all. Now the American Medical Association proposes revisions to the Declaration of Helsinki which would sanction such practices.[5]

Four of those proposed changes are the following:[6]

> 1. The Declaration currently makes a fundamental distinction between 'medical research in which the aim is essentially diagnostic or therapeutic for a patient, and medical research, the essential object of which is purely scientific and without implying direct diagnostic or therapeutic value to the person subjected to the research' (*Para. 6, Introduction*). The proposed revision does away with that distinction on the grounds that randomized clinical trials are 'complex activities that invariably include both therapeutic and non-therapeutic components'.[7] Thus it is proposed to omit the very distinction on which responsible research on human subjects is based, the distinction between testing something on a person because you think it will benefit that person

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[5] In November 1997, at the meeting of the World Medical Association (WMA) in Hamburg, the American Medical Association (AMA) introduced a draft revision of the Declaration. Of course the Declaration of Helsinki has been revised before. Following almost ten years of reflection on the revelations of the grossly evil conduct of Nazi doctors at the Nuremberg Trials, the WMA originally made the Declaration in 1964 and it was subsequently revised in 1975, 1983, 1989 and 1996. However, apart from Tokyo revision in 1975, in which a clear distinction was made between 'research combined with therapeutic care' and 'research for purely scientific purposes', the firm basis of expression and structure it provided for the ethics of research on human subjects, has not been called into question. Now, however, the AMA propose a sweeping revision to the principles, terminology and structure of the Declaration.

[6] These can be found in recent issues of the *Bulletin of Medical Ethics*, in particular in No. 150, August, 1999.

[7] '[This] distinction is no longer used in this Declaration' (*Introduction*, paragraph 7).

and testing something on a person because you wish to add to your medical knowledge.

2. The Declaration currently states that 'every patient – including those of a control group, if any – should be assured of the best proven diagnostic and therapeutic method' (*Art.* 2.3). Article 18 proposes merely that a research subject 'not be denied access to the best proven diagnostic, prophylactic or therapeutic method that would otherwise be available to him or her'. Thus it is proposed to dilute our traditional understanding of equivalence from existing best medical practice to whatever is local medical practice.

3. The Declaration currently states that a physician 'should ... obtain the subjects' freely-given, informed consent, preferably in writing' (*Art.* 1.9). The proposed revision would waive such requirement if an ethics committee determined that the risks posed by the research are slight or if the procedures to be used in the research are customarily used in medical practice without informed consent (*Art.* 24). In addition, the current Declaration states that consent must be obtained by a physician who has no conflict of interest (*Art.* 1.10), but the proposed revision states that this is merely desirable (*Art.* 23). Thus it is proposed to dilute that cornerstone of ethics of research on human subjects, the requirement that research subjects be genuine volunteers.

4. The Declaration currently prohibits publication of research not in accord with its principles (Article 8). The proposed revision would allow editors to consider the justifications that investigators offer and make their own decisions about the publication of unethical research (*Art.* 34). Thus it is proposed to dilute that last chance the community has to ensure that unethical researchers do not profit by their unethical activities.

Three sets of questions – about care of the newborn, care of the elderly and treatment of research subjects raise difficult issues of justice. What we think about each of these questions will depend on our understanding of the principle of justice. However, we are often attracted, at least initially, to inadequate or partial accounts which contain only some part of what genuine justice entails.

2. Paradigms of Justice

What is justice? Though the writer of the Hippocratic Oath insists that it is part of a doctor's duty to keep his patients free from

injustices they can do to themselves, justice is generally thought to be giving others their due.[8] This idea can be understood in different ways: most narrowly, as fulfilling responsibilities defined by prior undertakings, more widely, as being fair to others, quite generally, as acting uprightly in any actions bearing on others. Scripture uses justice in the widest sense, to mean goodness and holiness in general. However, philosophers mostly use it in a more specific sense to refer to rightness in people's interactions and interrelationships.

Let us take this idea, rightness in people's interactions and interrelationships, as a general account of the principle of justice. Justice consists in the giving to others what is owed to them. Certain objective situations, certain morally good acts, the character of certain persons and certain societies and social structures may all be called just.

Three questions arise: What do we owe to others in general? What do we owe to others in the particular field of health-care? Who are these others to whom we owe what is their due?

Justice as whatever brings about the greatest good of the greatest number[9]

For the utilitarian, justice is not an independent moral principle. Rather it is a principle dependent on, governed by, that sole principle of morality, the principle of utility. It names that most paramount and stringent form of obligation created by the principle of utility. The principle of utility says: Work out all the predictable benefits and all the predictable losses of some proposed change or state of affairs, calculate the net sum (or utility) of these proposed changes and then choose that

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[8] Paragraph 3 of the *Hippocratic Oath*: 'I will apply dietetic measures for the benefit of the sick according to my ability and judgment; I will keep them from harm and injustice.' See Leon Kass' 'Is there a Medical Ethic? The Hippocratic Oath and the Sources of Ethical Medicine' for an examination of this idea. Leon Kass, *Towards a More Natural Science*, The Free Press, New York, 1985.

[9] The greatest debt I owe in the writing of this essay is to the doctoral thesis of my colleague Anthony Fisher O.P. entitled: *The Principles of Distributive Justice considered with reference to the Allocation of Resources*. In my judgment it contains not only the best analysis of the elements and implications of contemporary moral philosophy on this subject but also the most sound and coherent account of what justice actually does require of us with respect to health care.

states of affairs which will bring about the greatest good for the greatest number, that is, will maximise utility. Justice consists in the distributed result of that calculation. A state of affairs is just if it represents the greatest good for the greatest number and unjust to the extent that it does not effect that result.

In health-care, contemporary utilitarians use two principal criteria for working out utility: quality of life measures and social contribution measures. Though different utilitarians advocate different health-care policies, in general they tend to favour the following broad principles: (a) prevention is to be preferred to cure, and cheaper therapies are to be preferred to more expensive ones; (b) expensive or scarce therapies are only to be available to the young and those who are likely to lead long productive lives; (c) preference should be given to those likely to receive the greatest benefit in terms of improved length and quality of life and to those likely to make the greatest future social contribution; (d) short-term services are to be preferred to longer-term care, and institutional care eliminated as far as possible; (e) healthcare for the terminally ill, dying, elderly, chronically sick or incapacitated, severely handicapped and permanently unconscious, is to be given the lowest priority.[10]

Who counts as 'the other'? Utilitarianism has no one theoretical answer to this question, except to insist on impartiality in the calculation of benefits and burdens.'[11] In practice, however, the most influential utilitarians in the field of bioethics tend to combine their utilitarianism with a view which excludes certain categories of human beings from counting as persons and thus as our others to whom we have obligations in justice. The Australian utilitarian philosopher, Peter Singer, combines his utilitarianism with John Locke's view about who counts as 'the other' only persons are our 'others'. John Locke defined a person as a 'thinking intelligent being that has reason and reflection

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[10] Anthony Fisher, O.P., *op. cit.*, identifies these four broad principles.

[11] ' ... in making ethical judgments we go beyond our own likes and dislikes. From an ethical point of view the fact that it is I who benefit from, say, a more equal distribution of income and you, say, who lose by it, is irrelevant. Ethics requires us to go beyond 'I' and 'you' to the universal law, the universalizable judgment, the standpoint of the impartial spectator or ideal observer.' Peter Singer, ***Practical Ethics***, Cambridge University Press, 1979, p. 11.

and can consider itself as itself, the same thinking being, in different times and places'. Singer argues that (a) certain categories of human beings –newlyborn infants, the permanently comatose, the demented– are not persons; and (b) certain groups of non-humans –gorillas, chimpanzees, the higher apes– might turn out to be persons.[12] The American utilitarian philosopher, Michael Tooley, has a similar view. According to Tooley, the morality of infanticide rests on one question. Is the newborn infant a person? For only if it is a person has it a serious right to life.[13] This view has clear implications in utilitarian thinking for the ethics of prenatal diagnosis, selective abortion, infanticide, care of the disabled newborn, cloning, the use of anencephalic infants as sources of organs for transplantation and about the health care for the old, the demented, the permanently comatose, etc.

Strengths and weaknesses:

Peter Singer has used utilitarianism to remind us, more effectively than any other philosopher, of our undeniable obligations to the poor, particularly to the poor who live in far away places. He has also used it to reveal what is wrong with cultural relativism in ethics (which is relevant to thinking about our obligations to research subjects) and to remind us about the importance of efficiency and effectiveness in health-care. However, utilitarianism is deeply flawed. It captures only a part of what is true in morality: consequences matter, but they are not all that matter. It pays little attention to individual rights and duties and thus to the moral significance of particular relationships. In its insistence that we must always maximize the good, it asks too much of us. And it invites us to consider doing evil for the sake of some greater good. When it is combined with a Lockean account of personhood, utilitarianism threatens to undermine the authentic goal of health care.

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[12] Peter Singer, *Rethinking Life and Death*, Text Publishing Company, Melbourne, 1994.

[13] 'An organism possesses a serious right to life only if it possesses the concept of a self as a continuing subject of experiences and other mental states, and believes that it is itself such a continuing entity' Michael Tooley, 'Abortion and Infanticide' in Marshall Cohen, Thomas Nagel and Thomas Scanlon (eds): *The Rights and Wrongs of Abortion*, Princeton University Press, 1974, p. 59.

Justice as the equal distribution of [at least some] good and services

Taking their lead from the idea of impartiality, egalitarians argue that justice is essentially equality or, following the most influential of contemporary egalitarians, fairness. Unlike utilitarians, egalitarians treat justice as an independent moral principle, one among a plurality of moral principles of which (say) *benevolence* is another.

According to John Rawls' theory of qualified egalitarianism, principles of justice can be derived from what people would choose if they were forced to be impartial, if they had to choose principles on which to base a social structure which will satisfy them wherever they turn out to be located in it. He thinks people would choose two principles: first, each person should have the most extensive system of basic liberties compatible with similar liberties for all; second, social and economic inequalities should be arranged so that they are to the greatest benefit of the least advantaged and are open to all under conditions of fair equality of opportunity. In brief, justice consists in *fair equality of opportunities*.

Rawls himself has never applied his theory to the distribution of health care. Though its application to health-care is a matter of some debate, Rawls-inspired approaches to health-care distribution, such as that of Norman Daniels, insist that each person, irrespective of wealth or position, should be provided with equal access to an adequate –though not maximal– level of health care (contingent on social resources), enough to ensure 'equality of opportunities'. Distribution should be on the basis of need (which is understood as what is necessary for equality of opportunity).

Better services, such as luxury hospital rooms and expensive but optional dental work, should be available for purchase at personal expense by those who are able to and wish to do so. But everyone's basic health needs should be met at an adequate level. On this approach, there is a right to a decent minimum of health-care, enough to ensure equality of opportunities, and an obligation for society to provide that to all its citizens.

Rawls argues that the state must be neutral about what constitutes a good life for an individual. It must allow maximum scope for self-determination in keeping with people's personal values and life-plans. His 'thin theory of the good' recognises only those 'primary goods'

which people need to pursue their particular plans and projects and a few principles of justice-as-fairness. On this account, health-care need ought to be understood as care which provides or restores opportunities in life to those whose opportunities are limited by illness. Our health-care needs are whatever is necessary to achieve, restore and maintain equality of opportunities at specific levels of functioning.

Who counts as 'the other' in Rawls' theory? Rawls' theory assume that individuals are to be understood in a Kantian sense as conscious and free moral agents who devise, revise and seek to achieve their own conceptions of the good. This has implications for those human beings who are not at a particular time, or may never be, competent moral agents. Anthony Fisher is right to claim that Rawls' theory at least invites the introduction of a 'consciousness criterion' in the allocation of health care. Rawls' view of the person has been used in support of the idea that health care should be distributed with a preference for those who are or will be capable of exercising moral agency.[14] This clearly has implications for the provision of health care for newborn infants and the elderly.

Strengths and weaknesses:

To my mind, Rawls' theory marks an advance on utilitarianism in that it recognises the plurality of moral values, and the independent value of justice. His theory tries to provide an approach to justice which respects individuals and the diversity of conditions in which they flourish whilst at the same time providing a reasoned basis for a harmonious life between them. Its claim that 'need' is the criterion for the proper distribution of health-care rings true, as does its steadfast insistence on what we owe the poor and disadvantaged. However, by insisting on a 'thin theory of the good', that is to say, by recognizing only those goods which people need to pursue their own life-plans (whatever they are) and insisting on neutrality about what constitutes a good life for a human being, it seems to be internally incoherent.[15] It seems both to *preclude* state involvement in the provision of health-care, since individual people differ significantly about what health care they want, and at the same time to *require* it –since good health is clearly a pre-

[14] Anthony Fisher, OP, *op. cit.*

[15] Ibid.

condition and determinant of the freedom and independence in the pursuit of one's life plans that Rawls' theory is intended to secure.

Justice as the lack of restraints on individual liberty

Contemporary libertarians often use Rawls' view of justice as the backdrop against which to present their own theory. They believe that it is not the role of the state to impose any pattern of distribution of benefits and burdens on its members, since that will violate the rights of individuals. Robert Nozick's claim that 'individuals have rights, and there are things no person or group may do to them without violating their rights' is the most famous modern expression of a libertarian approach to justice.[16] Persons have a range of rights –to life, liberty, property– which they are entitled to enjoy and exercise free from external interference as long as they do not thereby interfere with the similar rights of others. The sole function of the State is to protect citizens against unjust interference, e.g. by violence, theft, fraud or the non-fulfilment of contracts: it is not the business of the state to distribute benefits and burdens such as health-care since that will violate the rights of individuals.

According to libertarianism, the only just system of allocation of health care is the operation of the free market. It is up to people individually to choose what healthcover or services, from whom, and for whom they wish to spend their own resources. It is up to health professionals to decide how, when, for whom, with whom and for how much they wish to work. Libertarians thus treat autonomy, both of the patient and of the professional, the central ethical notion in health-care. Individuals must be encouraged to take responsibility for their own health.[17] They should not look to others to bail them out, nor should others be ready to do this.[18] It is simply unfortunate, not unfair, if someone cannot afford to pay for health care or health care insurance. And the doctor-patient relationship should be understood as a rela-

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[16] *Anarchy, State and Utopia*, Blackwell, Oxford, 1968, p. ix.

[17] See, for example, Ronald Dworkin, 'What is equality?' *Philosophy and Public Affairs*, Vol. 10, 1981.

[18] Well meaning charity may simply discourage people from taking responsibility for themselves.

tionship between two autonomous contracting individuals. Health-care workers are obliged to provide care only that health care in keeping with their own prior undertakings or present choices. And they may legitimately decide for themselves what distribution standards to apply to their own practices: profit maximization through an 'ability to pay' criterion, personal satisfaction through a 'preferred group criterion' ('I don't treat people who cannot pay!') or some more altruistic criterion. Any attempt to distribute health-care in any other way constitutes an infringement of the rights of individual health care workers.

Applying Nozick's libertarianism to health-care, Engelhardt argued that 'a basic human right to the delivery of health-care, even to the delivery of a decent minimum of health care, does not exist'.[19] Nor does anyone have a responsibility to provide it for others. Social intervention to secure health-care for all perverts justice by placing unwarranted constraints on individual liberty. Organs, babies, even the use of women's wombs, may be transferred for money by individuals in a free market. A libertarian is not opposed to any mode of health care distribution which has been freely chosen by a group. However, in a complex modern state in which agreement amongst individuals is virtually impossible, a libertarian will generally prefer a system in which health care insurance is privately and voluntarily purchased by individual initiative.

To whom do libertarians think the obligations of justice are owed? Once again, there is no one answer. However, Engelhardt combines his version of Libertarianism with a commitment not only to a Lockean notion of personhood but also to the idea that it is only 'persons' who really matter: 'Persons, not humans, are special..., obligations of respect or beneficence vary according to the moral status of the entities involved.'[20] And generally, the centrality of autonomy in Nozick's theory would seem to support a 'consciousness criterion' in the allocation of health-care resources. Those who can exercise moral agency ought to

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[19] H. Tristam Engelhardt, *The Foundations of Bioethics*, Oxford University Press, 1986, p. 336. Anthony Fisher OP, (*op. cit.*) queries whether this actually follows from the details of Nozick's theory.

[20] H. Tristam Engelhardt, *op. cit.*, p. 104-5.

be preferred to those who cannot. And in addition those who bring their ill health on themselves do not deserve to be rescued by the State.

Strengths and weaknesses:

Libertarians are right to insist that health care is not (or is not entirely) a common resource –like land, air, rivers, the sea– which may be distributed according to some patterned formula. Those who work in health care are not merely 'resources' to be distributed according to someone else's interests or grand plan –though they employ a great deal of what is 'common stock'. And there is something right in libertarianism's emphasis on the entitlement of the individual to look after his or her own life and health: certainly, one of the starting points of the Catholic (natural law) tradition of health-care ethics is the recognition that each individual person has the primary responsibility to preserve and maintain his or her own health –and that of any dependents. But libertarianism takes both of these ideas too far. Health-care workers do not 'own' their labours. Their knowledge, skill and judgment are not purely of their own creation, however crucial free will and personal motivation are in their cultivation. Health-care workers are educated largely at the public expense, usually in public institutions, and the knowledge they receive is a social product not of their own making. In addition, without a high level of collaboration, there would be no sophisticated hospitals, medical schools, etc. As for the responsibility of each individual to preserve and maintain his or her own health; many things which influence health lie beyond the scope of individual responsibility: poverty, social class, ignorance, genetic predisposition, to name a few.

Justice as doing unto others what one would have them do to oneself

Aristotle's remark that when men are friends they have no need of justice, and indeed that the truest form of justice is a friendly quality, sets the tone of what I shall call a 'natural law' approach to justice.[21] On this account, justice consists in favouring and fostering the common good of one's communities.[22] The common good is the good of

[21] *Nicomachean Ethics*, 1155a25.

[22] Buckle's 'natural law' ethics shows how disparate are many of its elements. See his 'Natural Law' in *A Companion to Ethics*. Peter Singer (ed), Blackwell, 1991.

individuals, an aspect of whose good is friendship, understood as a readiness to promote the well being of other members of one's community. 'Few will flourish and no one will flourish securely unless there is effective collaboration between members of a community and co-ordination of their resources and enterprises.'[23] These common enterprises are not ends in themselves but rather means of assistance to individuals. So, one part of justice requires distributing things which are essentially common but which must be appropriated to individuals if they are to serve the common good: resources, opportunities, profits and advantages, roles and offices, responsibilities, taxes and burdens.

Given that the objective of justice is the common good and, consequently, the flourishing of all members of the community, a distribution is *just* if it is a reasonable [re]solution to the problem of allocating the things that are essentially common but that need –for the sake of the common good– to be appropriated to individuals. Proportionality rather than equality is a key to recognizing the demands of distributive justice. Inequalities of wealth are not unjust *per se*. What is *unjust* is the failure of the rich to redistribute that portion of their wealth which could be better used by others for the procurement of basic goods in their lives.

Anthony Fisher has worked out the details of a natural law approach to the distribution of health-care. Starting from the idea that health-care truly is –at least in some regards– a distributable resource,[24] he argues that it ought to be distributed according to what he calls the 'Golden Rule of health care', as revealed by the application of the following two-part test. This Golden Rule is: *'Would I think that a healthcare budget and principles of allocation were fair if I [or someone I loved] were in healthcare need, especially if I were one of those excluded from provision or were among the weakest in the community, i.e. sick with a chronic, disabling and expensive ailment, poor, illiterate,*

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[23] John Finnis, *Natural Law and Natural Rights*, Clarendon Press, Oxford, 1980, part viii.

[24] Though health care professionals should not be treated as though they were hospital beds or doses of drugs which can be moved about, reorganized, allocated, etc., health care itself is a largely social creation (an accumulated body of knowledge and skill which is passed on in public universities and exercised in public hospitals) which must be appropriated to particular individuals if it is to occur at all.

etc.? Would I think them fair were I [or someone I loved] a healthworker, healthplanner, taxpayer and / or insurer?'[25] Applying this two part test, –he argues–, we can conclude that the primary basis for healthcare distribution is simply healthcare need, where satisfaction of that need is compatible with the fulfilment of similar and more important needs of other members of that community.

The concept of need as found in Fisher's work is not 'capacity to benefit', nor 'what is required for self-determination', but more generally, along with food, water, clothing, shelter, exercise, freedom, safety, rest, family, what is required for participation in the goods of human life and health. There is a certain necessary indeterminacy in the concept of health care need. Customs, expectations, standards of living, current technology – all influence people's perceptions of their needs. However interventions which are not instrumental to participation in human life and health but which serve some other goal are not genuine health care needs: cosmetic surgery, breast enlargement, sex selection of children, euthanasia. The specific goal of health care is 'the benefit of the sick'.

Who counts as 'the other' in a natural law approach to justice? As in the case of the other three approaches, there is no answer to this question. Certainly Aristotle was at least tempted to think that what is owed in justice is owed only to male members of one's political community. However, today the most vibrant expression of a natural law ethics is found in Catholic Christianity's concept of the sacredness of human life itself. Every human being then is to be treated as one's neighbour; and there is also a special requirement of solidarity with the poor and the vulnerable. The very young, the very old, the disabled, the sick, the frail, the demented, the permanently unconscious, those who may be thought to have contributed to their own illness... all these deserve our preferential care. The natural law tradition which is embodied in Catholic moral theology, thus rejects –as unjust– the idea that only those who possess 'personhood' are the proper recipients of health care.[26] Nor is the provision of health-care to the poor only an

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[25] Anthony Fisher, OP, *op. cit.*, p. 135.

[26] As Bernard Williams has pointed out, almost all the characteristics associated by philosophers with 'personhood' – such as the capacities for responsible action, for

expression of justice; it also expresses compassion and fellow-feeling for those who suffer, encouragement and support for those who are disabled, gratitude to those who have benefited one, solidarity with those who approach death, love and friendship for those who are one's dependents, etc.

Strengths and weaknesses:

Many health care administrators are very impatient of a natural law approach to justice in the allocation of health-care resources because absolutely-general rules of resources allocation cannot be derived from it. More challenging is the criticism that, at least in the sophisticated version advanced by Germain Grisez and John Finnis, natural law theory does not make sense outside a Catholic context for morality, that their version of natural law theory does not and cannot provide a rational basis for moral action for any human community. According to Jean Porter, Grisez and Finnis have articulated a version of natural law theory which defends Catholic moral teaching –particularly about the beginnings and end of life– at the cost of being rationally necessary.[27] This is a serious objection to that version of natural law theory, one which I have not seen convincingly refuted. To my mind, the natural law approach is the most coherent of the four approaches to justice that I have sketched. Like utilitarianism, it insists on the equality of all persons and on impartiality among persons. Like egalitarianism, it insists on what is owed –as a matter of fairness– by the rest of us to the poorest and most vulnerable members of our communities. Like libertarianism, it recognizes the centrality of individual autonomy. But, unlike all of them, it treats solidarity with every other human being –in particular with the poor and disadvantaged– the sick, the disabled,

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relations with others, for first-personal reflection, and so on – come in degrees. Indeed, they come in different degrees, and are not simply correlated with each other, nor with different ages, states of mental health or other such attributes. Bernard Williams: 'Which slopes are slippery?' in *Moral Dilemmas in Medicine*, edited by Michael Lockwood, Oxford University Press, 1985.

[27] John Finnis: *Natural Law and Natural Rights,* op. cit. Germain Grisez: *The Way of the Lord Jesus*, Vols. 1-3, Franciscan Press, Vol. 1:1983, Vol. 2: 1993, Vol. 3:1997. Jean Porter elaborated this criticism in a talk entitled 'is there a distinctively Christian morality?' at the Catholic Institute of Sydney in 1998. See her *Moral Action and Christian Ethics*, Cambridge University Press, 1995.

the vulnerable, not only as elements of communal life but as irreducible aspects of the flourishing of affluent, healthy, articulate, powerful people. What the rich owe to the poor, the healthy to the sick, the independent to the dependent, is not merely a matter of fairness to them but, more deeply, of solidarity with them.

3. Justice in our care of the newborn, of the elderly and of the poor

What do these four traditions have to say about our original three scenarios?

Care of newlyborns

The critical question about care of the newlyborns is: *Are they the kind of beings to whom we have obligations of justice?* I have argued that utilitarianism, egalitarianism and libertarianism, at least as they are represented by the thinking of the philosophers I have mentioned, would all agree that newborn infants are not the kind of beings to whom justice is owed. In the light of this point of agreement, all other points of disagreement between them fade into insignificance. For what this implies is that newborn infants do not matter in themselves, that they matter only in so far as they matter to their parents, and that therefore the kind of health-care they should be offered should depend primarily on the wishes of their parents.[28] In short, although we should not cause a newborn child unnecessary pain, a newborn child is not entitled to the kind of protection owed to a person. Having made this move in common, utilitarianism, egalitarianism and libertarianism then offer their own distinctive approaches to how parents should go about making up their minds.

The natural law tradition starts from the very different idea that justice is owed to every human being and that therefore, no matter how much parents may wish for a perfectly healthy child, they have at least the obligations of justice to their newborn children that they have to all other human beings. (Of course, they have some other substantial obligations to their own children). Consequently, it is contrary to justice deliberately to bring about the death of a newborn child, whether by deliberately killing it or by deliberately letting the child die. Of

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[28] Singer, *Rethinking Life and Death*, op. cit., p. 212.

course, difficult decisions have to be often made about the care and treatment of severely deformed or disabled newborn children, but such decisions need to be made in the light of a variety of factors, such as the goals of health-care itself (the restoration and maintenance of health), the responsibility of parents for the health and well-being of all their children, the legitimacy of refusing futile or overly-burdensome treatment, etc.

Care of the elderly

The same question (*Are they the kind of beings to whom we have obligations of justice?)* is also central to our thinking about justice to the elderly. The 'consciousness criterion' for the allocation of resources endorsed by those in favor of the first three approaches to justice, encourages us to think that we are not obliged to provide health-care for all categories of the elderly, in particular the permanently comatose and the demented, for the simple reason that they are not persons. In this respect all three traditions stand in stark contrast to the natural law tradition. Even when we set aside what we owe the elderly as a matter of gratitude and piety, the natural law tradition reminds us that justice requires us to devote health care resources to the elderly as a matter of priority: for as a group they are often amongst the most powerless and the most socially vulnerable in our communities.

What about the legitimacy of an age criterion in the allocation of health care resources? Certainly, utilitarianism, in its emphasis on the maximisation of returns on health care investments, is not opposed to the use of such a criterion. Since we should give preference in our allocations to those most likely to receive the greatest benefit in terms of improved length and quality of life, and since the elderly cannot benefit 'as much' from health-care as can the young, utilitarianism will tell us that we should devote scarce resources in favor of the elderly.

Egalitarianism will be ambivalent on the matter. It ought to oppose the use of an age criterion on the grounds that this would be unfair to the elderly. However Norman Daniels has argued that most people would prefer to use their health care entitlements when they are young, when they can get the most benefit from them, and that the health care system should reflect this fact. (This is a factual claim, the truth of which I doubt.) And egalitarianism itself might positively support the use of an age criterion on the grounds that it spreads opportu-

nities more widely. After all, the elderly have already had their fair share of health care resources. It would not be unfair to limit the elderly's access to health care resources since, generally, everybody will be subject to ageing and thus will be entitled to the same range of health care over a life time.

The libertarian tradition, on its part, has little to say about the withholding of health care resources for the elderly since libertarians do not believe it is the role of the state to impose any pattern of health care resource distribution on the society. But, by claiming that the only duties we have are those deriving from contracts we have voluntarily entered into, libertarianism does encourage us to ignore the debt of gratitude we owe the elderly and the duties of care which follow from our particular relationships with them. However, the current debates about libertarian-inspired managed care arrangements in the United States have barely engaged with ethical issues associated with care of the elderly.

Contemporary natural law sends a very different message. It is critically sensitive to prejudice against the elderly. The way we look after our elderly reveals what kind of people, as individuals and as community, that we really are. It is true that health care does not aim at the extension of life but at the maintenance and restoration of health. But this does not justify the abandonment of the elderly, even those who may have lived a reasonable length of life. Certain kinds of hi-tech medical intervention maybe recognized as inappropriate for the elderly and even, in circumstances of substantial scarcity, may have to be routinely withheld from the elderly. But even if such hard choices have to be made, the elderly are still entitled to a broad range of community-provided care, such as good pain relief, home and institutional nursing care, hospices for the dying, etc.

In addition, the natural law tradition reminds us that we need to approach the challenges of providing health care to the elderly with a certain kind of character, one marked by the virtues of compassion, moderation, courage, and prudence. To take just one example: Medical moderation involves a willingness to stop treating, and to stop asking for treatments, in the face of the limits of medical endeavour. Life-sustaining treatments which are reasonably judged to be futile or overly-burdensome ought to be forgone. However, we have no right to leap (as some commentators seem to do) from considerations which might mo-

tivate some elderly people to volunteer to decline some health care to the conclusion that society or health-care workers might decide this for all elderly people.[29]

Responsibilities to the subjects of research in poor countries

In spite of the commitment of some individual utilitarians to the relief of poverty and suffering amongst the poor, utilitarianism *itself* seems to require the very kind of revision currently proposed to the Declaration of Helsinki. In spite of its insistence on impartiality in the calculation of benefits and burdens, utilitarianism will endorse the entirely predicable shift of much of the research by for-profit organisations to Third World countries which would most certainly follow the adoption of the proposed revision to the Declaration. Utilitarianism requires the bringing about of the greatest good for the greatest number. If diluting the standard of equivalency from 'best current practice' to 'local practice' and diluting the requirements of informed consent are likely to bring that about, then those changes ought to be made. The generally low standard of health-care in developing countries will give researchers the opportunity to undertake more efficient trials there than in developed countries, and these differences in the availability of treatment between developed and developing countries should be exploited by Western researchers to reduce the costs of clinical trials. For example, a placebo-controlled trial of zidovudine to halt perinatal transmission of HIV infection in a poor country in which the local standard of care is 'no treatment' will deny nothing to the subject in the control arm and the knowledge gained will be useful to others in various countries.

Egalitarian theories of justice, in particular a Rawlsian theory which emphasises our obligations to the poor and disadvantaged, would resist the proposed changes.

Libertarianism would be ambivalent on the matter. On the one hand, a libertarian approach would insist on genuine respect for the rights and liberties of potential research participants and would re-

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[29] Boyle, JM: 'Should age make a difference in health care entitlements?' in Luke Gormally (ed) *The Dependent Elderly: Autonomy, Justice and Quality of Care*, Cambridge University Press, 1992, pp. 147-157.

mind us to be particularly attentive to their capacity to give genuinely free and informed consent. That capacity may be so compromised, by social and political circumstances and by extreme poverty, that research should not be conducted at all. On the other hand, a libertarian approach informs much of the recent growth in research conducted by for-profit organizations and the concomitant emphasis on market principles. Pharmaceutical companies face very high costs in developing new products. Libertarianism would support their right to apply their own standards to their own research projects.[30]

A natural law approach is likely to be consistently opposed to the proposed changes. There are cultural and national differences in the availability of health care resources, and we should not insist on the achievement of impossible goals in the provision of health care in developing countries. However, any utilitarian attempt to justify the exploitation of the poor by the rich for the sake of maximising utility is unjust. Recruiting subjects to a clinical trial, and giving some of them a placebo when a known cure for their condition is available, is a form of exploitation, whether it maximises utility or not: a mere reflection on the fact that conducting such a trial in most developed countries would be prohibited reveals that. It is not enough to argue that the research population will not be harmed because the local standard of care is 'no treatment'. Nor is it enough that successful results bring overall benefit to human health. Clinical trials are just only if there is a reasonable likelihood that the population in which they are carried out itself stands to benefit from successful results.[31] In addition, though a natural law approach does not make a god out of the principle of informed consent, it would nonetheless resist any relaxation of that principle. The common good requires the active participation of individuals in decisions which affect their own lives. Researchers should treat potential research subjects as partners in a project they under-

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[30] Increasingly, as ethics committees of for-profit organizations become as prominent as university-sponsored research ethics committees, and the global economy seeks out the cheapest way of testing new products, market place principles will undermine the Declaration of Helsinki's commitment to the protection of each individual research subject.

[31] Perinatal HIV Intervention Research in Developing Countries Workshop Participants, *Lancet*, 1999, 353; 832-5.

stand and volunteer to parti-cipate in. The local community should be involved in the working out of its own priorities in health-care.[32]

Conclusion

Although justice is only one among the virtues, however, it is the cardinal virtue of social institutions. Henceforth, if an institution is not *just* then it does not matter what other virtues it has: it ought to be changed or vanished. ❑

[32] Researchers should determine actual rather than supposed local attitudes and not treat the approval of a government or national ethics committee as a substitute for community consultation.