Who Shall Live? Who Shall Die?

Scarcity a Fact of Life

- We don’t want to spend all resources on health
- US already spends higher percentage of its total wealth on medicine than comparable countries yet many uninsured
- News today: more than a million uninsured in Michigan.
- Technological progress means there is more we can do but often at great cost
  - “Three stages of medicine”
    - Early medicine was not effective
    - “Golden Age”—new treatments (e.g., antibiotics) saved many lives at modest cost; no question about advisability of using them
    - Now many procedures available but effectiveness not clear or expense is enormous
  - This may become an even greater issue with genetic therapies.

Macroallocation and Microallocation

- Macro: Distributing resources in society (world) at large
  - Does everyone have a moral right to health care?
  - What level of health care?
  - How much of our nation’s wealth should go to medicine?
- Micro: Distributing resources in particular cases to particular individuals
  - “God committee” or its present day equivalent
  - Eligibility for transplants
  - HMO, Medicare, Medicaid decisions
  - Often the two issues merge, e.g., if certain treatments (e.g., bone marrow transplants) are not made available, no identifiable individuals will receive them.
  - How much should we spend on different diseases (AIDS vs heart disease vs diabetes vs Alzheimer’s)? This will influence microallocation too.
  - Issue goes beyond life-saving (e.g., bypass) but that’s a good first focus: Rescher vs Childress.
Rescher: The Obvious

- Decision is not medical but ethical
- Should be rationally defensible
- [Less obvious perhaps]
  As a matter of policy, simplicity, plausibility, and appearance of fairness also important
- Since not a technical medical question, lay people should be involved in decisions. (Also a question for ethics committees)
- Who has ethical expertise about policies on such things as
  - List of qualifying treatments for Medicaid (e.g., Oregon plan)
  - Hospital ethics committees
  - National guidelines on stem cell research

Rescher’s Criteria: Overview

- Criteria for inclusion (and exclusion)
  - Constituency
  - Progress of science
  - Reasonable prospect of success
- Criteria for comparison (Rescher: medical, family, social)
  - Medical
    - Relative likelihood of success
    - Life expectancy
  - Social
    - Family role
    - Potential future contribution
    - Past service to society (on grounds on equity, not utility; those who have contributed more deserve greater consideration)

One Acceptable System

- Five factors
  - A: Relative likelihood of success
  - B: Life expectancy
  - C: Family role
  - D: Social contributions (future expected)
  - E: Social contributions (past)
- A = B and C = D = E and AB = CDE
Rescher vs Childress

Rescher’s System (continued)

- First, inclusion criteria applied
- Second, comparative criteria selects a group about a third or half as large as group to be treated.
- Random selection of final group
  - Recognized no system is exact or optimal
  - Easier for those rejected to accept final outcome
  - (Least important) Relieves administrators of heavy burden.
- Element of human chance supplements life’s inherent natural chance (e.g., in who gets sick enough to need life-saving treatment).

Childress: Against Social Worth Criteria

- Impossible to quantify human social worth: engineer vs painter?
- Shatin: “discover the values most people hold”
  - Values change, there are regional differences, cannot predict future social needs
  - MORE IMPORTANT: the whole utilitarian approach is wrong. Reduces people to social roles.
  - “eliminates sense of person’s transcendence”

Childress: Value of Random Selection

- Preserves personal dignity and equality
- Preserves trust of physicians
- Rawlsian, p. 395-1: what procedure would we choose in original position?
- This method can be applied to other issues too
  - Organ transplantation
  - Macroallocation (next week)