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Autonomy and Distributive Justice at the End of Life

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AUTONOMY AND DISTRIBUTIVE JUSTICE AT THE END OF LIFE

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Abstract:

Discussions of autonomy at the end of life in health care contexts is no new phenomenon. However, what seems to have changed in issues of autonomy is cases where patients want to refuse a treatment to cases where patients are demanding more treatment when medical professionals may not agree or be able to provide them with the medical treatment. Some key competing interests impacting patient autonomy include beneficence-doing what is in the best interests of the health or well-being of the patient- and resource limitations. Here, I will explore distributive justice theories that impact the end of life and how they constrain autonomy.

Chapter 1

Introduction

As an undergraduate student intern in the Center for Ethics at the Washington hospital Center, I was given the opportunity to witness health care at the end of life from the perspective of patients, families, and medical teams in critical care departments. Families would plea for “everything to be done” to save or sustain their loved one, to ward off death for longer than medicine was able. What I had learned up to that point focused on a patient’s right to assert their autonomy to refuse treatments. Yet a lot of the cases I saw in the hospital were just the opposite; many patients and their families were requesting more treatment from medical teams rather than asserting their right to deny treatments. This piqued my interest. How did this happen, and how did the role of autonomy at the end of life change?

Case study:

Mr. K is a 77-year-old man with end-stage colon cancer that has metastasized to several areas of the brain. He recently underwent a craniotomy, and then nearly completed his radiation treatments. He was admitted to the intensive care unit (ICU) after suffering from a stroke due to metastases to the brain despite undergoing radiation intervention. The medical team believes that the aggressive radiation treatment is not providing benefit to the patient and not improving his prognosis with regards to his underlying disease. When the patient is awake (i.e. not sedated), he is alert and lucid. However, Mr. K and his family would like

Mr. K to continue to receive aggressive treatment against the recommendations of the medical team because they believe that to stop aggressive treatments, which includes artificial feeding, would be starving Mr. K and that would be wrong (Center for Ethics Staff 20).

Cases like Mr. K's are all too common in hospitals and illustrate an intersection of tension in modern medical practice: respecting patient autonomy versus managing resources. For the past few decades, end of life ethics has focused on how to protect patient autonomy from doctors forcing them to undergo certain treatments or take certain medications that they did not want (Jonsen 40). These kinds of cases may include, for instance, a Jehovah Witness patient who does not want blood transfusions under any circumstances because receiving blood from another goes against their beliefs. However, when the patient goes in for surgery and has complications resulting in the surgeon having to decide between letting the patient die or give them the blood transfusions they did not want, the surgeon feels pressured to give them a blood transfusion any way to prevent their death (Mann et al. 1992). Here, the patient does not want a medical resource, even if that means risking their health. Respecting the patient's autonomy means respecting their wish to not be given that medical treatment, and this is weighed against beneficence, making choices for the well-being and health of the patient.

More recently, however, patients have been fighting against healthcare practitioners and administrators for treatments and therapies. In a 2013 case, Jahi McMath, a 13 year old girl from California was pronounced dead by neurological

criteria following complications from a surgery. McMath's family, however, claims that she is not dead, but rather severely brain damaged, and requested that the hospital keep her on life support to allow her time to recover. The hospital claimed that McMath was dead, meaning they would not provide her with medical care. This led to McMath's family, as Jahi's surrogate decision makers, pursuing legal action, suing the hospital for malpractice and filing a civil suit against the state and several county officials on the grounds that the brain death criteria for death is unconstitutional (CBS News, 2015). After the legal battle at the end of 2013, the McMaths won and were able to move Jahi to a healthcare center in New Jersey. Because New Jersey state law allows religious exemption from death by neurological criteria, Jahi is able to be recognized as a living person receiving life support and health insurance coverage (CBS News, 2015). Although at the time of this news report and according to the most recent updates on the "Keep Jahi McMath on life support" community Facebook page, Jahi has yet to regain consciousness, Jahi's family reports that she moves on command at times and, "that her body remains in good condition and has even entered puberty," (CBS News, 2015).

In another recent case in Texas with a different outcome, George Pickering III became a patient on life support at Tomball Regional Medical Center after suffering from stroke in January 2015. After determining that George was dead by neurological criteria, the medical team was preparing to wean George off of life support and allow cardiopulmonary death. However, George's

father, George Pickering, disagreed based on “intuition” and knowing his son (Wang, 2015). To give his son more time and get the attention of the medical staff to allow his son to have more time, Pickering pulled out his gun in the hospital room, threatening to kill the hospital staff (Wang, 2015). Despite his other son taking away his gun, Pickering only surrendered to SWAT after feeling his son squeeze his hand multiple times, which he was holding throughout the standoff. Though Pickering served jail time for aggravated assault with a deadly weapon, George III made a full recovery, proving the father’s intuition correct and that the medical team’s decision would have taken the potential for a full life away from a young man (Wang, 2015).

Autonomy

McMath’s and Pickering’s cases are just a couple of examples, albeit extreme cases, of how the climate has shifted in end of life care from patients asserting their rights to refuse medicine towards patients asserting their rights to demand medicine, and that medicine has limitations to its certainties and guarantees. At the heart of these issues lies the issue of respecting the autonomy of those at the end of life. Here I hope to discuss the reasons that we value autonomy, how health care resource shortages impact patient autonomy, and a potential resource allocation method to address the tension between resource shortages and respect for autonomy.

Philosophers have begun to grapple with patient welfare and patient autonomy and justifications of medical paternalism, a field that I am interested in

thinking more about in the future. Two different conceptions of autonomy and some reasons for valuing autonomy have been proposed by John Stuart Mill and Immanuel Kant, which will be explored here.

John Stuart Mill, in On Liberty, known for his contributions to modern utilitarianism, argues autonomy is intrinsically important. Mill argues that a person knows himself or herself the best, and navigating life does not have a “one size fits all” path. By knowing oneself best, one can determine which “size” fits best for oneself (Mill 56). Mill offers the analogy of getting a pair of boots: not all feet are made the same width and length, thus not all feet can wear the same shoe and be most comfortable. Each individual needs a unique pair of shoes to allow them to be comfortable walking. And just like a pair of boots, the individual can decide what works best for themselves. Then according to Mill the most beneficial decisions for the individual are ones that are made by that individual because they are original (Mill 56). For example, even if a pair of boots appears to be a half size too long for someone, but they say are just right and they want them, then those shoes, according to Mill, are the best fit for that individual.

One issue with Mill’s description of autonomy is that it is slightly vague as to which group or groups of people are included in his theory. Mill limits the scope of original choices being good to pertain only to “[people who possess] any tolerable amount of common sense and experience,” (Mill 56) and, “to human beings in the maturity of their faculties. We are not speaking of children, or of young persons below the age which the law may fix as that of manhood or

womanhood” (Mill 8). So Mill is clear to exclude children, but it is less clear what constitutes “any tolerable amount of common sense,” and if people with cognitive disabilities who function at their highest capacity meet the requirement of being “in the maturity of their faculties.” Thus an elderly person facing the end of life would probably be considered to be at the maturity of their faculties and have a tolerable amount of experience, but may or may not meet Mill’s requirements for common sense depending on where the bar is set for common sense and the capacity of the elderly individual.

Mill also argues that respecting autonomous decisions of those who meet his criteria for being included in his moral theory, addressed above, is always the right thing to do, unless the individual’s will is to directly harm another (Mill 8). One reason Mill provides is that we, society, do not know with absolute certainty that the mainstream thinking or opinion is correct (Mill 14). So it is possible that a new or unpopular way of thinking may actually be the correct or more correct view. For example, prior to the sixteenth century, Europe believed that the Earth, rather than the sun, was the center of the Universe. However, German Renaissance astronomer Nicolaus Copernicus challenged this view and wrote On the Revolutions of the Celestial Spheres, defending heliocentrism, the view commonly held and taught today. This required Copernicus to think differently from what he had been taught and to stand up to his critics to defend his theory. Had Copernicus not had the freedom to express different views, students proceeding him would have been robbed of knowledge of the Universe. But we

are limited in what we can do ourselves by having to be respectful of others' autonomy. This may mean, for example, not running over a pedestrian with your car in order to make it to the theater as quickly as possible.

Additionally, Mill provides his own example of thinking outside of the norm. Mill was critical of the rigidity and socioeconomic expectations in Great Britain, and asked readers to challenge the confines of their class with him (Mill 51). He imagines that people, at the time, are asking themselves, "what is suitable to my position? What is usually done by persons of my station and pecuniary circumstances?" (Mill 51). Everyone should strive to challenge the mindsets they are ingrained to embody by society in order to be more consistent with their selves than necessarily consistent with society's expectations (Mill 51). In this way, Mill relates the importance of autonomy to all people on a more fundamental level than simply those who change the face of science, for example.

Autonomy, for Mill, is a good that leads to this increased individuality displayed by Copernicus' ability to think critically of and differently from the norm. Accepting the common opinion or common thought of those around you and those who have come before you without actively questioning these beliefs before internalizing the beliefs can be harmful (Mill 49). This can lead to the perpetuation of a wrong or bad belief (Mill 51). For example, if one is designated to a certain social status or class, they may begin to think that they are or should embody the expectations set by society for that particular social status. However, this, "narrow[s] the theory of life," and "[patronizes] human character," (Mill 51)

by limiting the capabilities of persons to what is prescribed onto them by society without individuals questioning this status quo. Thus if people are able to freely think and express, they will be able to question common beliefs and decide for themselves if that is what they believe as well (Mill 50). This allows people to develop their individuality (Mill 52).

This individuality, thinking or acting in accordance with one's own nature and beliefs even when doing so is different from the majority (Mill 50 and 56), is good and should be fostered because individuality, when cultivated, allows individuals to be the best they can be (Mill 53). Mill briefly makes a distinction between individuality and autonomy, stating that he takes autonomy to be a requirement for individuality (Mill 47). Autonomy is needed to, "interpret experience in his own way," which will allow one to develop and foster their individuality, which is a necessary constituent of a good life for a human being (Mill 48).

Mill suggests that "best" is when one can make decisions for oneself that are consistent with one's true preferences (Mill 47). Thus each individual determines what is best for himself or herself. One can determine what is best for oneself by discovering what their preferences and interests are (Mill 47). This can be accomplished through practice, including being critical of one's own actions that are done passively and actively making decisions for oneself, exercising, "faculties of perception, judgement, discriminative feeling, mental activity, and even moral preference," (Mill 47).

Thus, paternalism, or the interference of one individual on the agent by making decisions for them or suppressing the agent's thoughts or actions without their agreement, is harmful to the welfare of a person so long as the agent's action does not interfere with the freedoms of others (Mill 63).

While Mill argues that we should not suppress what could be a claim closer to the truth or that is more truthful than the currently held opinion by any in society (Mill 14), he also acknowledges that an institution or an individual should engage with people who have differing views in an attempt to discern which view is more correct, if that is possible (Mill 16). He goes on to add that it is "cowardice" for people and institutions to not act on their opinions when they think the alternative opinions are "dangerous to the welfare of mankind" (Mill 16). These dangerous opinions include proposals spanning from bad taxes to unjust wars (Mill 16). The action that Mill believes individuals should take when others spout dangerous alternative opinions should be to not suppress the alternative opinion because that would be inconsistent with Mill's claim that each should be able to express their opinions due to the possibility of its truth and others' lack of authority to exclude some from discourse (Mill 16). When confronted by another who expresses an opinion differing from one's own opinion, should then engage with them, "to listen to all that could be said against him...by hearing what can be said about it by persons of every variety of opinion, and studying all modes in which it can be looked at by every character of mind," (Mill 17). By doing this, one can either see the truth in another's opinion and the

shortcomings of their own opinions, or they show others the truth of their opinion over other opinions. Therefore, if one is confronted with falsity, the one being confronted, with the more truthful opinion, should use it as an opportunity to make their argument stronger rather than disregard others' opinions entirely (Mill 18).

So in Mr. K's case, if the aggressive treatment Mr. K wanted had been tested, tried, and shown to not benefit anyone in Mr. K's state, Mill may actually be against the doctors providing Mr. K with the aggressive treatment, since that would perpetuate the message that this type of treatment can be beneficial for patients like Mr. K. This is a danger to society's welfare because it may cause patients to think they are being denied a treatment that would save their lives, but they are actually being spared the unnecessary pain and suffering of aggressive treatment.

If, however, the aggressive treatment had been seen to be effective for only a very small percentage of people in Mr. K's state, we may have a different situation with which to contend. With the treatment having a possibility for efficacy, if Mr. K does not receive the treatment then there are other influences at play competing with autonomy, including possibly beneficence and resource limitations.

On the other hand, in Fundamental Principles of the Metaphysic of Morals, Kant argues that autonomy is important because it is vital for the construction and upholding of morality. Kant assumes that all beings with the

ability to reason, also have freedom (Kant 80), and those who have freedom and use reason are autonomous (Kant 82). The ability to generate universal imperatives through reasoning is contingent upon using one's own reason and rationality (Kant 40). Reason is important to Kant because only rational beings can use laws and principles to determine their actions; therefore, only rational beings can be moral agents (Kant 40). While Kant claims that rational beings can only use rational means for moral decision making, he clearly restricts moral reasoning to rational reasoning, saying that nothing could, "be more fatal to morality than that we should wish to derive it from examples," (Kant 36). For example, if we roll a fair di (a di with 6 sides containing a number between 1 and 6) multiple times and 6 is face up every time, we may, based on our previous experiences, expect the next time we roll the di to turn up with another 6. But if we had an understanding of the rules of statistics, we would know that we cannot expect a 6 to turn up in the next roll any more than we would expect integers 1-5 to turn up. Thus if we followed the results of prior experiences to claim that a certain idea is true (i.e. the 6 will be face up on the next di roll), we may be correct (the next roll may give a 6 because there is a 1/6 chance of this), but we also be incorrect (the next roll may give any other integer from 1 to 5 because there is a 5/6 chance of this). It would be irrational, according to Kant, to base moral decision on this process of relying on prior experiences alone. A better process of moral decision making is based on rational reasoning, using rules for guidance.

Following only inductive reasoning, while encouraging for continuing actions that potentially coincide with guiding moral principles, can lead to a shallow understanding or practice of morals, or, as Kant phrases it, “a disgusting medley of compiled observations and half-reasoned principles,” (Kant 37). As a result, we do not end up with a better understanding of morals, but merely actions that, at best, lead to good by accident, and at worst, lead to evil (Kant 38). This may be, for example, like someone seeing an object made of wood with four legs and call it a table. And they may very well be right. However, Kant may say that without using a set of objective rules telling us what constitutes a table, one being correct in naming a table when they see one is happenstance. They may just as likely, or even more likely, incorrectly identify an object as a table that is not a table or miss an opportunity to call an object a table.

Even though Kant warns against abstracting moral principles from examples, he does allow a deduction of morality from objective principles (Kant 40). Through reason, exercising our autonomy, we can determine if something is moral by imagining if it would be possible to rationally will everyone to do the action in question. If it is possible, then this action is consistent with the categorical imperative, making that action a moral action. For example, consider coming up to a series of stop signs, and as you get closer to the first intersection you notice there is no one around for miles. You could run the stop signs and make it to work on time, so the proposed rule that you might will everyone to follow would be that one can run stop signs. However, according to Kant’s

categorical imperative, we need to think about this action as applied to everyone in order to determine if you should run the stop sign or not. If you were to will running stop signs to universal law, everyone would be able to run stop signs, which could lead to more crashes at these intersections and places drivers' lives at risk. This, running stop signs knowing that it leads to fatal car crashes, would be irrational. So running stop signs should not be taken as a categorical imperative, universal law, because it is irrational to will all rational beings to adopt it.

Moreover, for Kant, morality constitutes not only actions that are neither prohibited nor required, but also the actions that we should and must do (Kant 41). For example, as discussed earlier, if it is a categorical imperative that we not run through stop signs, then we should stop at the stop signs to do the moral thing. Thus Kant believes exercising one's autonomy is a duty because it is the only way for an individual to shape morality and act morally.

One important objection to Kantian ethics is that Kantian ethics ignores the consequences of actions when determining what is and is not moral, which can have paradoxical results from agent-centered restrictions (Scheffler 409). Agent centered restrictions are restrictions under agent-centered theories including Kant's, which suggest that since Kantians do not acknowledge the cost-benefit analysis and the illustration of consequences that cost-benefit analysis provides, there are situations in which one would be forced to make a choice that results in the avoidance of a certain Kantian harm only to cause more of that same harm. Thus it is paradoxical that always avoiding the first harm

should be required because if one occurrence of that first particular harm is bad, more of that particular harm occurring would be worse (Scheffler 409). For example, if one had to decide to kill one innocent person to save more other innocent people or not kill the one and let all the other innocents die, Kant would say we must not kill the one because killing the one to save the many is sacrificing an individual as a means to benefit others. Killing the one is contradictory to Kant's requirement to treat persons as ends in themselves, which is also a categorical imperative. Scheffler points out how this can be confusing in this, claiming that if it is wrong to kill one person, it would seem to be even more wrong for many to be killed.

Though this objection points out a weakness in Kant's view, the perspective suggested by this objection also seems to treat people as objects that can be put together and evaluated. Robert Nozick argues that one reason that Kantians cannot choose to harm one to prevent harm done to multiple others is that people are valuable as ends in themselves and therefore have separate values. Since people are separate, they cannot be aggregated to create something more valuable than one person (Nozick 33). Thus in situations where someone asks another to choose to kill one to spare several others, Nozick would maintain that the numbers of lives lost from each of the options are not of central importance here because most importantly the one is being used as a mere means to save others, violating Kant's rule of respect for persons (Zwolinski 154). The summing

of multiple lives as compared to the one does not negate the requirement to respect persons and not use them as means to an end (Zwolinski 154).

In end of life cases such as Mr. K's, Mr. K still has the capacity to reason rationally and is considering requesting to continue to receive aggressive medical treatments. Autonomy, as described by Kant, then is limited by the agent's ability to rationally reason and the generalizability of the outcomes of their decisions (Kant 44). Mr. K's family stated that they did not want aggressive treatment to be stopped because they were afraid that Mr. K would feel starved by not being artificially fed. First, the reason for wanting the aggressive treatment in Mr. K's case was actually proposed and defended by Mr. K's family, not Mr. K himself. Additionally, medical research suggests that end stage, terminal cancer patients eating and drinking can actually result in more pain, discomfort, and hastening of cancer growth (McInerney 1272). If artificial feeding is not typically physically helpful for people in Mr. K's state, another plausible reason for the family requesting to continue artificial feeding may be the innate intuition humans have in the value of food, and the symbolism we have attached to food to signify life (McInerney, 1273). We can see this symbolism in phrases like: *You are what you eat* and *An apple a day keeps the doctor away* (McInerney 1274). By taking away one's ability to eat, either on their own or through artificial means, one feels that they are not showing compassion and that they taking away one's ability to live (McInerney 1274). This symbolism and the lack of physical health improvement from food, however, suggests that Mr. K's family may want to continue the

aggressive treatment and artificial feeding not primarily for the benefit of Mr. K, but rather to avoid feeling like Mr. K would think they are not being compassionate. Kant may say that this would be Mr. K's family using Mr. K as a means to an end, and so fear of starvation, if it is carried out for symbolic meaning for the living, would not constitute a reason to continue aggressive treatment.

If we had a way to know what Mr. K's motives were in requesting aggressive treatment, he may have relied on emotions and feelings such as sadness from eventually leaving his family, and fear from death and the possibility of the afterlife as opposed to following guiding moral principles as Kant would prefer. However, it is possible that he favors aggressive treatment because of objective reasons such as the possibility that he is part of the one percent of patients who will benefit from aggressive treatment and his cancer will go into remission, so we should give the benefit of the doubt and accept the possibility that Mr. K's decision was based on the objective reasons. If Mr. K used rational, objective reasoning, this would meet Kant's first requirement for the duty to respect autonomy and warrants Kantian respect for autonomy. Reliance on objective reasoning and having the capacity for rational reasoning are requirements to have autonomy respected, so if Mr. K did not use or did not have the capacity to use objective reasoning then his claim to the right for autonomy would not be as strong.

We now see Mill's and Kant's views on the importance for respecting autonomy. Mill, on the one hand, argues that autonomy is not only important for

one's society but also for the individual. When individuals exercise their autonomy, they are able to think critically of the norms of their society and determine if they are right or wrong, regardless of the popular thought of that time and place. By questioning norms, benefits such as improvements in knowledge may ensue. On the other hand, we see that Kant values autonomy because it is fundamental to morality. Exercising autonomy is crucial for rational beings to reason if an action is moral and carry out moral actions through determining if the action is a categorical imperative.

Competing Interests

Although that we can see that autonomy is important, other competing interests and limitations can make it difficult to decide what to do in particular cases. Two of these other limitations are beneficence and resource shortages. Beneficence requires action or inaction that promotes the patient's health, benefits the patient's well-being, or reduces pain and suffering (Gavrin 887). Beneficence and autonomy can conflict in several ways. One famous case in which autonomy and beneficence are at odds occurred in 1973 when twenty-five year old Dax Cowart suffered severe burns to 65% of his body in a gas explosion. His face was severely burned, and he had fingers amputated and an eye removed, but managed to make a recovery after spending two-thirds of the year in the hospital. Throughout this stay, however, Dax, who was declared to have capacity to make medical decisions, continuously expressed to his medical team that he did not want the treatment he was receiving and that he would like them to stop

treatment, allowing him to die (Jonsen 40). Dax's family and medical team pressed on and continued with the skin grafts, which allowed him to leave the hospital and live a full life, become a lawyer, and get married. Despite the successes Dax has seen in his life following his recovery from his burns, Dax maintains that his wishes to stop treatment should have been respected (Jonsen 41). In Dax's case, his autonomy, his wishes to stop receiving medical treatment, was disrespected by his family and medical team because they wanted to do what was best to promote his health status, act beneficently.

Another form of conflict between autonomy and beneficence can involve a patient's family as the subject rather than the patient. For example, Mr. J was recently diagnosed with an untreatable cancer. Mr. J's wife was with Mr. J when he got the results back from the oncologist. They decided to not tell their two daughters, one in high school and the other just about to finish her degree in engineering, so that they could focus on their work and studies and hearing of this news would be too upsetting for them to be able to continue with their studies (Latimer 1742). Here, the parents are disrespecting their daughters' autonomy by making a paternalistic decision because they believe withholding information from their daughters will most benefit their well-being.

While beneficence is a major and important factor that weighs on one's autonomy, I will focus only on resource shortages and the just distribution of resources in health care decision making at the end of life in this thesis.

Resource shortages in health care have given rise to several crucial and widely debated fields in medical ethics surrounding issues such as organ distribution and donation, and combating burn out in health care professionals (Persad et al. 423). In situations where resources are short, in which I mean that there is a greater demand for a resource than there is a supply of that resource, not all of the individuals can nor will receive the resource that is in demand. Thus some people will be denied access to that resource, meaning not only will they not receive that resource but they will also not be offered that resource.¹

For the people who are denied access to that resource, they have lost an option available to them from which to choose (Blake, 270). This option has been taken away from them by the institution or person(s) who decided that others and not they should receive access to the resource, which results in the inhibition of the ability to make and act on one's own decisions i.e. one's autonomy (Blake, 270).

In the following section I will further explore current examples of resource shortages in US health care, how resource shortages affect autonomy and theories of distributive justice concerned with balancing a patient's autonomy and use of society's finite and depleting health care resources.

¹ The difference between the two groups, I suppose, is important because those who are offered, for example, a scarce medicine can opt to not take the medicine after it being offered. Therefore, the group who is given access to the scarce resource and the group who takes the medicine are not necessarily the same population.

Chapter 2

Access and allocation

The autonomy of individuals should be respected, but there are limits to what having autonomy respected can bring to the individual. In other words, even those deemed autonomous have limits to what they can do and can have due to limitations of the finite resources available to allow autonomous individuals to exercise their autonomy and have it respected. In the US, there is a common thought that anything can happen if we work hard enough. A 2013 YouGov poll reported that over 60% of Americans agrees with the statement that if one, “is willing to work hard and put the effort in,” can be successful, and that nearly half of Americans believe that society has greater socioeconomic mobility recently as compared to several decades ago (Henderson 2013).² However, this hopeful frame of mind lets us down at times in the end of life. While hope and effort may affect prognosis for some, this does not mean that one can or will receive the necessary resource. If a resource is unavailable, then it cannot be given to a patient. This occurs regardless of whether the individual is autonomous or not.

² Despite YouGov’s findings in the beliefs of Americans, in 2013 Richard Fry *et al.* with the Pew Research Center found that economic mobility in the US has actually decreased in recent years (Fry, Taylor, and Pew Research Center 2013). Fry *et al.* compared changes in the net worth of households of the top 7% and lower 93% over the years following the Great Recession in 2008, and found that over this time period wealth disparity increased between these two groups, suggesting decreased mobility over the same time period that many Americans reported optimistic sentiments towards mobility.

Ezekiel Emanuel describes the tension between what one should receive and what one may actually receive in terms of access and allocation. According to Emanuel, access is one's ability to receive health care resources that they should receive, and allocation is determining who should obtain a health care resource (Emanuel, 8). Access and allocation are overlapping but distinct concepts (Emanuel, 8). Ideally, access and allocation populations overlap. For example, if someone falls and breaks their arm, ideally they would have the ability to access a hospital or urgent care center, afford the care at the health center, see a physician to cast their arm, and that physician would have the materials required to cast their arm. Of course, less ideal would be a situation lacking any one of the above steps; someone falls and breaks their arm but when they arrive at the urgent care center, there are no available physicians because they are tending to a large group of people who were injured in an overturned bus accident. In summary, just because you should receive a certain resource (allocation) does not mean that you will be entitled to receive that resource (access) (Emanuel, 8).

This, I believe, is the essence of situations where resources limit one receiving what one wants, or more critically, needs, and applies to any situation in which you want or need something that you cannot have, including situations at the end of life. For example, when you go to a grocery store in search of apples only to find that the store is all out of apples, it does not matter what you need the apples for, how loudly you complain, or who you are; you will not be getting any apples from that store at that time. Similarly, when a patient is suffering from

heart failure and requires a transplant, patient complaints or being a good person does not mean that a heart will become available to the patient at that time.

While these situations have a clear disanalogy in severity- not being able to buy apples from one grocery store does not usually mean that you cannot easily go to another market, whereas advanced heart failure patients cannot usually just move to a different hospital or different country to get a heart, and not receiving apples is usually not of fatal consequence, whereas not receiving a heart when needed has fatal consequences- the underlying problem in both scenarios is that you cannot have something that is not there, and it does not matter what the other circumstances of the story are. In these examples of the complete lack of a resource, it does not seem that one not receiving what they want is limiting because no one else has the opportunity to receive the desired thing either.

However, when we move from situations lacking a resource entirely to situations where there is a resource but not enough to meet its demand, distributive justice issues come into play, as those who control allocation of the scarce resource must determine if the people who should receive the resource, who will actually get it because the demand exceeds the supply. These are situations in which some people will have the ability to choose to take advantage of a resource that they want and others will not.

Examples of scarce health care resources

Though an unlikely view, it is possible one could claim that our society need not be critically concerned with health care resource shortages. Even if we are not facing a scarcity of organs, for example, healthcare is still a limited resource with regards to doctors, nurses, equipment, hospitals, and money. For instance, for patients who can afford the costs of seeing doctors and going through exams at multiple organ transplant locations, many but not all locations allow patients to be placed on transplant lists at multiple centers at the same time (Miller, 46; UNOS, 8). This cross listing of patients could contribute to inflated waitlists at organ transplant sites. The Hastings Center also reports that approximately 10% of organ transplant waitlists consist of people who are listed at multiple transplant locations (Caplan, 130). But patients going to great expense (thousands of dollars) to get on multiple waitlists at a time seems to be a result of the preexisting high demand and low supply of organs, rather than creating a sort of artificial demand that could be suggested. The patients waitlisted at multiple sites are simply trying to increase their odds of receiving an organ and receiving it quickly, and thus would not be listing at multiple sites if their initial transplant location provided them with access to the necessary organ (Miller, 47; UNOS, 8).

Additionally, some may be concerned that non-US citizens and residents can receive organs in the US from US donors, since up to 5% of any single waitlist for a transplant location in the US can consist of people who are not US citizens

(Caplan, 130). Thus this could create an additional demand that could arguably be mitigated by restricting US organs to only US citizens or US citizens, despite financial or other incentives, receive priority to the organs. However, the US is also a major organ importing country, according to a report by Organs Watch, a medical human rights group founded at the University of California, Berkeley (Shimazono 2007). So while excluding foreigners from making up a small fraction of the organ waitlists in the US may seem like it could alleviate some stress on the demand for organs here, it could result in losses in the significant importation of organs from which many Americans benefit.

Though there are some reasons that we have seen above that could cause some to think that US health care resource shortages are not as dire as made out to be, I think there are examples that can be made more explicit, showing that we are facing resource shortages in health care and that we should be concerned with not only these instances of resource shortages, but also with how we ought to handle future situations of resource shortages, should they arise. First, hospital beds in intensive care units (ICUs) periodically face overcrowding, and are thus one example of resource shortage in health care. In an observational study of one ICU in 2014, researchers found that of the patients evaluated to be admitted to the ICU, 67% were admitted to the ICU, 39% percent of the study period there were ICU beds available, and 69% of the duration of the study period only one ICU bed was available (Orsini et al. 2014). There is a clear shortage of ICU beds causing triaging to occur to determine which patients should be prioritized for

ICU admission, meaning that not all patients who are brought in to the hospital who want or need ICU level care can receive it (Orsini et al. 2014).

Next, organs, as seen in the hypothetical heart example earlier, are a resource that is limited in society. Not everyone who wants, let alone requires, an organ transplant to survive will receive an organ. For example, in 2006 it was reported that approximately 95,000 Americans were on the waitlist for organ transplants, while approximately 6,300 of these people died that year waiting for an organ to become available (Abouna, 34). More recently, from 1980 to 2010 the US has seen a 1000% increase in end-stage renal disease prevalence from 60,000 patients to 594,000 patients, for which the most effective, life prolonging, and life improving treatment is the renal (kidney) transplant (Bastani, 105). With this rate exponentially and continuously increasing, kidney donor numbers have not quite kept up. In the US, 16,487 kidneys were transplanted in 2012, which is a combined number of 10,868 and 5,619 kidneys from deceased and live donors, respectively (Bastani, 105).

Furthermore, overall donor rates have plateaued since 2006 (Bastani, 105). With these low donor and transplant rates, only 16% (16,487 patients / 101,630 patients on waitlist) received transplants in 2012. In that same year, 7% (7,363 patients / 101,630 patients on waitlist) were taken off of the waitlist due to their death or no longer being a good candidate for transplantation because their prognosis was so poor (Bastani, 106). In summary, these statistics illustrate just one example of current organ shortage in the US.

If you do not think that there is a current shortage of healthcare resource now, there is still reason to care about the just distribution of resources because action or inaction now can determine our resource status in the not-so-far-away future. The statistics above not only show the immediate trauma that can occur when there are fewer medical resources available than are needed, but also allude to the domino effect that can occur. The endangerment of one resource is not a micro-event. The shortage of kidneys for transplant causes more patients to be dependent upon dialysis machines to do the work that fully functional kidneys should do, but that kidneys of end-stage renal disease patients cannot do (Bastani, 106). This places increasing pressure on hospitals and dialysis centers to provide dialysis to not only patients who need it in acute situations, but now an increasing numbers of patients with chronic and probably irreversible end-stage renal disease without a transplant.

Additionally, the Association of American Medical Colleges predicts that in 2025 the US will face a physician shortage (Dall et al. 2015). The steps to become a doctor typically include 4 years of undergraduate study, 4 years of medical school, 3 years of residency training, and then possibly a 1-3 year fellowship that allows doctors to specialize in a certain field like geriatrics, palliative care, and cardiologists. Together, this process is at least 10 years long, which means that if we fail to encourage grade school students to pursue medicine now, we will have an even smaller class of fully trained and certified doctors in 2025. So if one does not believe that we currently have a resource

shortage now, irresponsible action in the present can create a foreseeable resource shortage in the future.

John Hardwig and the duty to die

To address these issues of medical resource shortages, theories on how to justly distribute resources have been proposed. One view that stirred much debate surrounding resource distribution was proposed by John Hardwig in, “Is there a duty to die?”. Hardwig argues that people who aged and lived a full life and now pose an immense burden on their loved ones and society’s resources have a duty to die in order to allow the caregivers to live full and enjoyable lives (Hardwig, 36). Hardwig has many reasons leading him to this view, one of which being that we should recognize that we are not hermits, meaning that we do not live as isolated individuals. Rather we usually live in societies and families, and thus, the things we do and the decisions we make affect both our own lives and the lives of the people around us (Hardwig, 36). Hardwig extends this to all decisions. The decisions that affect those around us could be as basic as, for example, when I was deciding between getting put under anesthesia or just the local anesthetic for my wisdom teeth removal. If I had decided to get knocked out for the procedure, my mom would have come to the oral surgeon’s office with me so that she could drive me home. If, on the other hand I opted for the local anesthetic, I could drive myself home and my mom could go on the hike she was planning with her friends. My decision impacted how my mom would spend her time that day. My wisdom teeth removal only demanded a few hours of my mom’s

time, and thus, did not pose an immense burden on her, and having my wisdom teeth removed with only a local anesthetic may have had a significant impact on my day. Hardwig though is primarily concerned with bigger decisions than wisdom teeth removals.

Hardwig further argues that because we are interconnected people, we should not make decisions that would result in great burden for others. Hardwig wants us to imagine ourselves as elderly, ill, and dependent upon our loved ones to serve as our caregivers (Hardwig, 36). In this situation we see that we will pose an immense burden on our loved ones, which could require them to quit their jobs, possibly lose their careers due to dedicating a lot of time and energy to taking care of us, help pay for our medical bills, and sacrifice time and energy away from other members of the family in order to prolong our lives (Hardwig, 36). So when these immense burdens arise, we, the burdensome individual, can alleviate these burdens by fulfilling our duty to die (Hardwig, 37).

Hardwig elaborates on this idea via an analogy between Captain Oates and the ill, dependent elderly. Captain Oates was an explorer, who was on an expedition to the South Pole with his crew. Oates fell ill and became very burdensome to the group: he would require extra care by his crew, and not be able to perform functions for the crew like carry heavy items or complete physically intensive tasks. Without being able to do these things, Oates would slow the crew and likely prevent them from covering as much area as they had set out to, and possibly slowing them down so much that they would run out of

resources before being able to return home, thus placing the lives of the whole crew at risk. Knowing this, one night Oates left the group, walked out into the cold, and did not return (Hardwig, 34). According to Hardwig, Oates not only did a brave thing, but he also did the morally right thing. Forcing (or even allowing) the group to continue to care for him would have been considered wrong (Hardwig, 35).

This is analogous to the burdens people at the end of life place on their loved ones when they request life sustaining therapies according to Hardwig's argument, and because of this, burdensome people at the end of life have a duty to die (Hardwig, 35). Similar to the crew, though not quite as dramatic as perishing in the Arctic, caregivers could be faced with financial troubles, loss of resources available to dedicate to their own children, and a loss of free time available for the caregiver to spend destressing or spending time with friends. Thus one being a greater burden results in a greater loss of the caregiver's freedom. This invasion of the freedom of the caregivers is one reason warranting the duty to die, and becomes a bigger and better reason as one becomes a bigger burden.

Additionally, Hardwig argues that one's duty to die also becomes stronger as one grows older. As one grows older, there is less of a future to benefit from by prolonging one's life, and as we grow older we have also had more life experiences that would have allowed us to live fulfilling lives (Hardwig, 39).

Hardwig acknowledges that it is unclear when someone exactly has a duty to die, but he offers some factors that increase one's likelihood of having a

duty to die. These factors include how burdensome one is, how old they are, and how much one can contribute to loved ones and society if life is continued (Hardwig, 38). Thus Hardwig is proposing a distribution of resources away from elderly and the chronically ill.

According to Hardwig, the duty to die aligns with the intuitive feeling, “moral wisdom,” that we do not want to be burdens to our families when we age and become ill because this would greatly affect many aspects of our loved ones’ lives; and if we loved them, then we would not put our burdens on them (Hardwig, 34). While it is possible that this reflects moral wisdom, it may also be a reflection of the lack of respect and reverence we have for the sick and elderly in our society (Ackerman, 173). Felicia Ackerman draws a compelling analogy in, “For now I have my death,” between the bias against the sick and elderly and bias against women wanting to have careers. Not too long ago³, women felt that they should not get jobs outside of the house in fear that this would burden their families by leaving the housework. We now see that this strain of thought is unjustly biased and devalues women’s rights (Ackerman, 173). Similarly, Hardwig argues that the elderly should not ask to continue living when falling ill because this would be a burden to their family, and he fails to see that this is a biased thought against the elderly (Ackerman, 173). College-bound students are both financial burdens and burdens on parents’ time, but Hardwig does not want to include them in the duty to die, as he would include the elderly (Ackerman, 173).

³ or arguably still today

Furthermore, I think he underestimates the amount of burden families would willingly endure for a loved one. Hardwig agrees that having family and friends around gives meaning to our lives and that having these people in our lives is important when going through rough times, including illness, growing old, and dying (Hardwig, 36). This, I think, makes it more confusing that he would ignore the love that family members may have towards their ill and elderly loved one. Mutual love should provide a family member the ability to request some support when they are old and ill without being called selfish and immoral because when one asks for help from a family member the family member would know that the other would help them in a situation of equal importance if the situation were to arise.

Hardwig may reply that this may be an exception to the duty to die if the loved one's continued, albeit burdensome, living provides some kind of benefit to the caregiver. Hardwig concedes, "caring for the sick or aged can foster growth, even as it makes daily life immeasurably harder...If my loved ones are truly benefiting from coping with my illness of debility, I have no duty to die based on burdens to them," (Hardwig 36). In this case, the caregiver may benefit from taking care for their loved one by getting peace of mind in knowing that subsequent loved ones will care for them, the caregiver at present, as they are caring for the ill, elderly now.

Moreover, I do not think that the types of burdens that the sick and old pose are burdens that necessitate the suicide or killing of the burdensome

individual. For example, Hardwig claims that being a caregiver could entail a decreased social life causing one to lose touch with outside friends and family (Hardwig, 36). First, there are many ways with modern technology to actively keep in touch with friends and family that a caregiver may no longer have time to go and see, including cell phones, e-mail, and video chatting (Ackerman, 175). Also, a loss of a social life is not a valid reason to ask a loved one to kill themselves or for someone to kill them, even if it is a nuisance or burden to not have a social life.

Margaret Battin and age rationing

Seeing that Hardwig's resource allocation theory does not seem acceptable or plausible, we turn to another theory proposed by Margaret Battin, who argues that the chronically ill elderly utilize more than their fair share of society's resources, and when resources are scarce, these resources should be redistributed to younger people suffering from diseases that, "cause death of opportunity-restricting disability earlier in life," to provide them with a better chance to live a normal lifespan and to improve their prognosis with less resources than the elderly (Battin, 322).

Battin's theory was largely inspired Norman Daniels' ideas in Am I my Parents' Keeper. Daniels proposed that we reframe the way that we conceptualize age cohorts. Rather than separating people in into age groups (i.e. children, adults, elderly) and comparing the differences in access or needs of

these groups cross sectionally, we should recognize that we age along a continuum, meaning that we go through all of the stages of aging. Therefore, any inequalities seen between age groups does not mean that there is inequality in a person's life because they will transition to each age group (Daniels, 41). Age as an identity is unlike other identities like race; one's age changes but race does not (Daniels, 42). Moreover, if there is an inequality between races, we can see how that would result in a lifelong, unjust inequality; however, with inequality between age groups we can see that inequality one may face at one time can be rectified when they enter another age group.

So by reframing the way we think about competing age groups, we can reframe the way we think about how people in different ages utilize health care resources. Because we see people's lives as continuums, we move to thinking about how individuals require and consume health care resources over a lifetime rather than comparing different age groups at different points in their lives (Daniels, 43).

From this Daniels offers his prudential account, which dictates how one might best divvy up their health care resources over their lifespan. The prudential account requires that an individual make a plan for how they can allocate their share of resources over their lifetime. This plan need not be the same for everyone since some may face different health complications or lifestyles, or some may place different values on physical ability at different stages of life. A major challenge to this is that one will have to make a binding choice about their future

use of health care resources without knowing what the future holds for their health and longevity (Daniels, 64).

Battin builds on this initial framework proposed by Daniels to suggest a prudential account of how to allocate health care resources over a lifetime to promote longevity and quality of life. According to Battin, if we shift utilization of resources from the elderly, the stage in life using the most resources and money, equitably to the young, we will give all children a better chance at living longer without disease, which will lead to increasing the probability of these children living normal lifespans (Battin, 322). When these children reach old age, they will be on the other end of age rationing, forfeiting their claim to expensive healthcare services and resources to allow these services and resources to be dedicated to supporting the next generation's children (Battin, 324).

Rather than thinking of the distribution of resources to the young as being a competition between age groups, where the elderly, middle aged, and young are pitted against each other, we should think of this as a continuum throughout an individual's life (Battin, 324). As a person goes through life, they will have access to a certain range of scarce resources when needed, and that range of scarce resources will decrease as they grow older. For example, if someone had kidney problems, needed dialysis, and dialysis machines were scarce in the hospital, they would be more likely to have access to dialysis if they were in this situation as a child than a senior.

Battin's theory, theoretically, has the potential to greatly benefit members of demographics who typically have poor health outcomes. Impoverished children, who come from families usually lacking insurance, are at greater risk than middle- and upper-class children of receiving poor quality health care services and have a higher infant mortality rate (Andrulis 1998; National Academy on Aging 1997). Furthermore, Battin's theory can address health inequality that low income neighborhoods face with increased health risks from not only limited access to health care resources, but also from harmful living conditions as has most recently been brought to media attention in Flint, Michigan. In 2014, the state switched the water supply of Flint, a town where 57% of the population is black and 40% live at or below the poverty line, from the fresh water of nearby Lake Huron to Flint River, widely known for its filth and corroded metals (Ganim and Tran 2016; Goodnough 2016). Though the water from the Flint River was supposed to be filtered and drinkable, it was not being treated properly, resulting in high levels of iron in the tap water and turning the water physically brown (Goodnough 2016). Moreover, other metals such as lead was present in the water that Flint residents were expected to be able to use for their drinking, bathing, and laundry. Because of this, approximately 8,000 children under 6 years old in Flint have been added to a list Flint residents who may potentially develop symptoms of lead poisoning (Goodnough 2016). Some effects that have been linked to lead exposure include, "learning disabilities, problems with attention and fine motor coordination, and violent behavior," (Goodnough 2016).

Preventing or minimizing social inequalities that effect health, such as ones that can be seen in the elevated infant mortality rate in uninsured families and the Flint water crisis, is a major benefit to Battin's theory. According to Battin, if resources were tight, resources should be allocated from the elderly to children and preventative care measures. This would ideally help decrease the elevated infant mortality rate for uninsured and impoverished children and provide them with the quality of care comparable to children coming from families of higher socioeconomic status. If these children had better access to health care, we could expect to see their health and survival rates increase to levels comparable to those of the insured and higher socioeconomic status classes. This gives these children a better chance at living a full life. These preventative care measures would have allocated more money and resources to the children of Flint to have clean water and avoid lead poisoning, which would result in avoiding the future health care expenses of paying for the care and support of children who were exposed to lead. Thus implementing Battin's theory in the future would, ideally, prevent crises like that of the Flint water crisis, and reduce the cases where communities, mostly poor communities in this case, receive more harmful resources than other communities that negatively impact their health. In this light, we can see how Battin's age-rationing has the potential to equitably raise the quality of life across social demographics including class, race, and gender from the beginning to the end of life.

Additionally, Battin's proposal to allocate resources earlier in life and limit resources later in life is similar to other systems to which we already ascribe. For example, as members of society we have accepted all the benefits that come with society like education and socialization, similar to submitting to Battin's resource allocation proposal and receiving the health benefits at a younger age. However, a con to joining society is giving up some freedoms such as abiding by laws or giving up even more freedoms if a law is broken and a punishment is given. Similarly, future freedom to choose from a variety of health care options later in life are forfeited to receive better health care access at a younger stage. So the planned forfeiting of future freedoms that Battin proposed is not entirely new to us as members of society who must sacrifice to benefit in sharing resources.

While I like that Battin's theory allows people to forfeit resources for their future selves to give themselves the best chance they can to have a future self by being given priority to medical resources through middle age, implementing this could leave the generation that grows old during this transition period without access to use scarce resources when they may not have been given access to these resources when they were young to prepare them for old age. This means that if this theory is implemented, one generation will have to make big health care sacrifices to allow future generations to receive priority for scarce resources starting at a young age. Ideally, we would be able to provide medical coverage for both the older and younger generations during the transition time, but since this theory is meant to apply to situations of resource shortage, providing everyone

with coverage for the transition would not be likely. Even though this objection does not pose a threat to Battin's theory in itself, I think it is important to point out practical barriers to applying Battin's theory to our current society and existing health care system.

Battin says that the age that patients should stop receiving aggressive treatment should be based on the expected time until death rather than a fixed-age cutoff (Battin, 337). The fixed age cutoff, according to Battin, is not ideal because, "it is not old age itself which is medically expensive; it is the last month, six months, or year or two of life. Variations in costs and efficacy of treatment are not so much a function of time since birth as time to death," (Battin 338). Thus, for example a fixed age cutoff of 72 years old would result in providing a 30 year old with end stage terminal cancer with higher level medical care than a 75 year old with a highly treatable cancer that has high rates of remission. However, Battin would say this is not right because we would be giving limited medical resources to someone, the 30 year old, with a treatment that will not improve their prognosis, while that same resource, if it is the same resource, could provide a greater benefit in terms of longevity to another person. Thus choosing a fixed age such as the age one is considered elderly (65) or the average American life expectancy (72) creates a system that is biased towards people with a naturally shorter life span because those who are facing the end stage of a terminal illness will then receive futile, aggressive treatment (and potentially expensive medical

resources), which only provides the small possibility of a small extension to lifespan and not and improvement in prognosis (Battin 337-338).

Battin presents a graph that plots one's health status versus their age (Battin, 331). The slope of the graph remains relatively flat as one ages; however, when one goes through old age and nears the end of life, the graph's slope decreases towards the x-axis, the point of death, to show a decrease in health status and an increase in suffering (Battin, 331). Each person faces the decline in health status, the decreasing slope in Battin's graph, at different ages and with differing slopes. Because people will have different graphs, they will near death at different times. This is another way that Battin argued that level of care cannot be altered using a fixed-age cutoff, but rather should be tailored to each individual.

But this is reliant upon knowing or being able to predict when someone will die. Studies have shown how clinicians are usually poor predictors of the time someone has left before death. In a survey of physicians treating terminally ill cancer patients who had a median survival of 4 weeks at the time of physician clinical prediction of survival, physicians significantly over predicted patient survival (Glare *et al.*, 2003). For this sample of terminally ill cancer patients, physicians overestimated patient survival by 4 weeks in 27% of cases, meaning they overestimated survival by double the average survival time of the sample (Glare *et al.*, 2003). Glare *et al.* (2003) also found that in 12% of cases, physicians underestimated survival time by 4 or more weeks.

The prediction ability needs to be improved to accurately predict time left until death before we can use Battin's prediction suggestion to determine who will and will not have access to medical resources at the end of life. Without knowing how much longer someone has left when they are sick, not providing them with a limited resource that could treat (but not cure) their illness could shorten their lifespan more than it is already shortened from a normal lifespan that does not include a chronic illness. Overestimation of longevity could result in a procrastination of palliative care measures, resulting in possible misuse of aggressive treatment and underutilization of palliative medicine resources (Glare *et al.*, 2003). Improvements in medical technology though may be able to alleviate this issue in the near future to allow accurate predictions of longevity.

One may argue that the objection Felicia Ackerman raised about bias against the elderly with respect to Hardwig's argument may also apply to Battin's resource distribution theory. Is Battin's theory not simply another form of bias and discrimination against people at the end of life?

At the root, Battin's theory is a prudential contractualist account to guide us in determining scarce resource allocation. By this I mean that her account tells us that earlier in life, an individual freely chose to be a part of this health resource distribution system because it would provide them with quality health care in the earlier stages of life, while knowing that this meant a forfeiture of claim to these same resources later in their life. Battin's theory is similar to Odysseus, in Homer's The Odyssey, asking to be tied to the mast of the ship to hear the Sirens

and protect him from their dangers but then, upon hearing, the Sirens, demanding to be released. When one engages in the contract that Battin presents, they are benefiting from the initial terms of the contract to receive health care but then must follow through with the other terms of the contract despite losing access to certain scarce resources similar to Odysseus changing his mind when his situation changes. We must remember that it is the same person going through the earlier stages of life and receiving the benefits as if the person at the end of life and unable to access the resources they themselves once held. This recognition of each person going through each stage of life is important because it means that each of us goes through the end of life. Because each of us goes through this stage, we would not say that there is an inequality between a person at the end of life and a person at the beginning of life when we look at their lives over time (Daniels 45). Additionally, Battin's theory is not biased against people at the end of life like how we may conceive of bias against a racial demographic, for example, because there is an inequality generated over time between races when one is biased against. And again, Battin's account does not generate inequality over time.

Another problem that Battin herself alludes to is that if we are to deny the elderly with chronic diseases care for these diseases beyond resources like cheap and minimal pain relief, then we are somewhat dooming these people to a prolonged state of pain, suffering, and decline of health status decline before their

death (Battin 328). An alternative to this fate of prolonged suffering is assisted suicide (Battin 336).

Battin believes that the individual who is suffering at the end of life would be protected from feeling and being coerced to ending their life by their right to make free choices (Battin 337). But this does not seem like Battin is giving these people a real choice. She is asking them to choose between killing themselves and enduring pain, suffering, and potential disabilities. Though Battin does touch on what is so difficult about resource distribution decisions; not all the people who need a scarce resource can have that resource. That is precisely what makes it scarce. With this harsh reality, we need to make tough decisions that possibly can include tough end of life choices for people at the end of life. For Battin to make the claim that this is an un-coerced choice, one may think her theory needs to preserve adequate pain relief to claim that the theory offers a fair choice between suicide and continued living.

Battin may respond to this similarly to the response earlier against an Ackerman-like objection, which is by referring to the general nature of her theory as a prudential contractualist account. The individuals at the end of life had already made their free choice when agreeing to the terms of having access to health care resources earlier in life, and the health care system is following through with the terms of the agreement. Even though the individual is no longer in the beneficiary stage of life, they were previously greatly benefitting from the options of care they could receive.

We should keep in mind as well that while here I have focused on the redistribution of health care resources, health and longevity are influenced by factors beyond the scope of simply medical care access. Furthermore, various institutions such as the military, agriculture, and public education, to name a few, also use government funds for financing. So another possible way to alleviate scarcity of resources that are rooted in financial strains would be to redistribute government spending from these institutions to public health and health care. Questions of the justice, necessity, plausibility, and potential harms and benefits of expansion of redistribution policies to alleviate the strains of limited resources on the health care system, beyond the realm of redistributing health care resources from the end of life are interesting, relevant, and too large for the scope of this thesis question.

In conclusion, I think Battin's theory provides us with a much better theory of resource allocation than Hardwig's. People will be able to get the scarce resources that they want when it will give them the best probability of that resource being maximally helpful. While it is not perfect, requiring some sacrifice by the generation in the transition period and improvements in medicine to more accurately assess when one will die to minimize suffering periods and maximize the lifespan, it presents a reasonable approach to resource allocation that allows for resource equality. In situations where there is a higher demand for a resource than there is supply, of which I hope I have shown is an important current

problem in our health care system, there will unfortunately be some losses and sacrifices that some must take.

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