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The assumptions of ethical rationing: an unreasonable man's response to
Magelssen et al.

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The assumptions of ethical rationing: an unreasonable man's response to Magelssen et al

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Abstract:	Contributors to the debate on ethical rationing bring with them assumptions about the proper role of moral theories in practical discourse which seem reasonable, realistic and pragmatic. These assumptions function to define the remit of bioethical discourse and to determine conceptions of proper methodology and causal reasoning in the area. However well intentioned, the desire to be realistic in this sense may lead us to judge the adequacy of a theory precisely with reference to its ability to deliver apparently determinate answers to questions that strike most practitioners and patients as morally arbitrary. By providing ethical solutions that work given the world as it is, work in clinical ethics may serve to endorse or protect from scrutiny the very structures that need to change if real moral progress is to be possible. Such work can help to foster the illusion that fundamentally arbitrary decisions are "grounded" in objective, impartial reasoning, bestowing academic credibility on policies and processes, making it subsequently harder for others to criticise those processes. As theorists, we need to reflect on our political role and how best to foster virtuous, critical practice, if we are to avoid making contributions to the debate that not only do no good, but may even be harmful. A recent debate in this journal illustrates these issues effectively.

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3 **The assumptions of ethical rationing: an unreasonable man's response to**
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5 **Magelssen et al**
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10 Short title: Assumptions of ethical rationing
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Abstract

Contributors to the debate on ethical rationing bring with them assumptions about the proper role of moral theories in practical discourse which seem reasonable, realistic and pragmatic. These assumptions function to define the remit of bioethical discourse and to determine conceptions of proper methodology and causal reasoning in the area. However well intentioned, the desire to be realistic in this sense may lead us to judge the adequacy of a theory precisely with reference to its ability to deliver apparently determinate answers to questions that strike most practitioners and patients as morally arbitrary. By providing ethical solutions that work given the world as it is, work in clinical ethics may serve to endorse or protect from scrutiny the very structures that need to change if real moral progress is to be possible. Such work can help to foster the illusion that fundamentally arbitrary decisions are “grounded” in objective, impartial reasoning, bestowing academic credibility on policies and processes, making it subsequently harder for others to criticise those processes. As theorists, we need to reflect on our political role and how best to foster virtuous, critical practice, if we are to avoid making contributions to the debate that not only do no good, but may even be harmful. A recent debate in this journal illustrates these issues effectively.

Keywords

bedside rationing, clinical ethics, bioethical methodology, critical practice, virtue, priority-setting, politics, social progress, causal reasoning/responsibility, justice

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3 “The reasonable man adapts himself to the world; the unreasonable one persists in trying to
4 adapt the world to himself. Therefore, all progress depends on the unreasonable man.”(GB
5 Shaw)¹
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11 All questions contain assumptions: this is uncontroversial. If we ask a particular British
12 celebrity whether or not he has stopped abusing children then we risk being sued, as our
13 question logically presupposes that he once abused children. The more complicated or
14 nuanced the question, the more difficult it may be to spell out its assumptions. Clinical
15 bioethicists will agree that the sort of questions they ask about how to ration 'realistically' and
16 'ethically' contain assumptions, but may regard those assumptions as reasonable, because they
17 reflect the realities of the health care systems and practices they aim to affect.^{2,3}
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29 I have argued that academics, including economists and moral philosophers, need to identify,
30 and subject to careful critical scrutiny, their own assumptions when they theorise about such
31 practices.⁴⁻⁶ Our goal may be to provide methods of argument or analysis to improve the
32 decision-making processes that determine practice. But in the real contexts we aim to affect,
33 our work may fail to do any positive good, and may even be harmful.⁴(p158) In some cases,
34 the attempt to 'solve' a particular problem 'ethically' may serve to endorse or protect from
35 scrutiny the very structures that need to change if real moral progress is to be possible;
36 unchallenged (because apparently reasonable) assumptions can function to distort the process
37 of moral reasoning, thereby discouraging virtuous and critical practice. (*op cit.*) By providing
38 certain 'realistic' solutions to practical problems, meaning ones that work given the world as it
39 is, theorists advising governments, local authorities and professional bodies can help to foster
40 the illusion that fundamentally arbitrary decisions and constraints have the support of, or are
41 grounded in, “objective, impartial reasoning informed by experts”. (*ibid.* p182) This in turn
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3 can promote a mentality I characterised as “formalism”, (*ibid.* pp199,232) whereby
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5 practitioners with context-specific knowledge are encouraged to think of their own moral
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7 intuitions, developed via an interaction with their patients, as merely “subjective” reactions, in
8
9 contrast to such impartial reasoning. Whether intended or not, the political role of the
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11 theorist, I argued, was often to “bestow academic credibility” on policies and processes,
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13 making it subsequently harder for others to criticise these processes – where “others” included
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15 patients demanding the best care available, and professionals attempting to “defend their
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17 corner”, to protect their traditional values and practices from random transformation to suit
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19 the prevailing political currents and economic agendas.
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25 The debate in this journal between Wyller^{7,8} and Magelssen et al³ suggests to me that these
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27 concerns are still very relevant to on-going debates in clinical ethics. Wyller's attempt to
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29 “defend his corner” as a clinician leads to his being perceived as either ignorant or in denial of
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31 certain realities; as unreasonably refusing to change his practices in the light of those realities;
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33 or as wedded to theoretical approaches that are in fact not adequate for sound practical
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35 reasoning. In other words, he is either insufficiently realistic, or insufficiently
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37 practical/pragmatic, or both. So, for instance, his insistence that “scarcity in healthcare” is the
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39 result of political factors and not simply “a given” is taken by his critics to reflect an
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41 ignorance of, or refusal to admit (“let on”) the true, “pervasive” nature of the “phenomenon”
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43 of rationing.³(p2) His scepticism about the attempt to apply universal moral principles to
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45 determine “fair” decisions in particular cases, and his claim that the outcomes of any such
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47 reasoning process are likely to be morally “arbitrary” (Wyller⁷ p258, cited by Magelssen et
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49 al,³ p6) provokes an answer that is helpful in revealing his critics' own fundamental
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51 assumptions about the proper role of moral theories in practical discourse. As we will see,
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53 they effectively stipulate that a “sound ethics of physician-patient relationship” must
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3 “accommodate” the fact that rationing is “unavoidable”, where “accommodating” this fact
4
5 includes providing practical guidance – non-arbitrary answers – to questions about how to
6
7 ration in particular cases.
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10 11 12 **The unreasonable man**

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14 In fact, it seems to me, Wyller's role in this exchange is that of Shaw's “unreasonable man”.
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16 However well intentioned, his critics' attempts to get him to conform to the project of 'bedside
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18 rationing' are part of a process that stifles protest and undermines complaint on the part of
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20 those either working within health systems, or users of the systems who feel disadvantaged by
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22 being on the losing side of a given resource-allocation decision. Hence their somewhat
23
24 disparaging comments about “sentimentality spurred by heart-wrenching stories of individual
25
26 patients or groups”, in contrast to the rationality of an overall system founded on “general
27
28 principles... decided upon through a fair and transparent process.”(p5) While they do not
29
30 deny that there can be a “tragic” aspect to the outcomes of rationing decisions,(p5) the very
31
32 existence of developed theories of just rationing, accompanied by evidence that the rationing
33
34 process was “performed explicitly and in line with justified moral principles”(p2) serves to
35
36 break the link between that sense of tragedy, the patient's feeling that her current situation is
37
38 “unfair” and any conclusion to the effect that she has suffered a genuine injustice. When all
39
40 the ethically and pragmatically endorsed policy calculations have been performed, there is a
41
42 remainder, a 'left-over' feeling that injustice at the personal level has been defined out of
43
44 existence to enable the ascription of 'justice' at the impersonal, societal level. This is what
45
46 frustrates and distresses the quite properly compassionate professional.
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54 Magelssen et al recognise this sense of unease and concede that rationing procedures may
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56 “mask the residual dimension” of regret at the “loss of the very real goods”(p4) that were
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3 promised by the de-prioritised possibilities. Even so, the logic of their position dictates that
4
5 they regard this outcome as “unfortunate” rather than unjust. While we might kindly overlook
6
7 the patient's linguistic error in claiming that her preventable suffering is “so unfair”, if that
8
9 suffering is the outcome of a “systematic approach to priority setting”(p4) then in the sense
10
11 that matters (the sense that determines action) she is (on this view) strictly incorrect. It's
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13 regrettable, unfortunate, even tragic – but not unjust. For if we were to admit that an outcome
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15 was at once unjust and unavoidable given the system as it is, then this would have the radical
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17 implication that that system needed changing as a matter of the utmost moral urgency,
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19 because it *necessitates* injustice – and this possibility seems to be one ruled out as beyond the
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21 scope of a 'pragmatic' debate meant to inform practitioners in the real world.
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27 Defenders of 'bedside rationing' believe that reasonable practitioners will operate with a
28
29 realistic sense of what is affordable given the resource base for the system as a whole, and
30
31 will not demand more for their patients merely because they are their patients. From their
32
33 perspective, clinicians like Wyller are being partial in a morally problematic sense elicited by
34
35 the characteristically Kantian question: 'what if everybody did that?' If the outcome of
36
37 everybody's refusal to 'ration at the bedside' would stretch the health system's resources
38
39 beyond its politically determined limits, then Wyller is either being unreasonable (or indeed
40
41 unjust) in asking for more for his particular patients than for others, or he is simply being
42
43 unrealistic regarding what the system can sustain. What this approach to clinical ethics takes
44
45 as “given”, then, is the fact of “scarcity” in the sense of the particular, finite limits allocated to
46
47 health care in the economic system within which the practitioner must operate. These
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49 economic facts effectively provide the moral framework for the debate: they form the basis
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51 from which all thinking about what it is reasonable to ask for on behalf of one's patients
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53 should begin, thus marking out the remit of the debate about bedside rationing.
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5 Other questions (crucially including, how much of a society's economic base should be
6 devoted to providing health care) are not illegitimate; they are just part of a different debate.
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10 Magelssen et al see no contradiction in Wyller agreeing to 'ration at the bedside', while
11 remaining one of those clinicians “who decry what they perceive as the underfunding of
12 healthcare”(p4). Indeed, he should be “eager to support efforts to instigate transparent
13 priority setting based on morally justified criteria and procedures... *until* he succeeds in
14 convincing the electorate and the politicians that healthcare funding must be increased
15 dramatically.” (*op.cit*) It is not that they want to dismiss his political views about the
16 underfunding of healthcare, or any other views he might have about the irrational, wasteful
17 and grotesquely unequal distribution of resources and expenditure within the developed
18 national economies of the world and the global economy. It is just that those questions are
19 beyond the remit of the debate about rationing in clinical ethics, where the question is: given
20 the resources in fact available, how do we set priorities ethically?
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36 What is not clear is why, given these limitations, any non-arbitrary answer to the question of
37 how to ration justly should be possible in the sort of controversial cases where the authors
38 regard guidance from ethical theory as being needed. To take an example considered by
39 Magelssen et al (p3) and discussed at greater length below, suppose some health policy-
40 makers have to decide whether to prioritise spending on reconstructive surgery for breast
41 cancer patients who have undergone mastectomy or surgery for children with cleft lip and
42 palate. To suggest that one can use some theoretical device, be it Kantian moral theory,
43 Rawlsian conceptions of distributive justice or the health economists' Quality-Adjusted Life
44 Year (QALY) to determine the answer is to assume that there really is a correct answer here,
45 that the choice is not morally arbitrary.ⁱ Why should that be the case? This at least needs a lot
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3 of argument – it should not be an assumption of the discourse. There is a danger, as we'll see,
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5 that if we participate seriously in the rationing debate, we may end up judging the adequacy of
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7 a theory precisely with reference to its ability to deliver apparently determinate answers to
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9 questions which, our sound moral intuitions tell us, should not have any such answer. In such
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11 cases, the theory functions to enable those making policy decisions to claim an authoritative,
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13 rational status for choices that would otherwise be perceived as arbitrary.
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19 Should literally any question about what one ought to do admit of a determinate answer,
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21 whatever the options presented and whatever the background conditions restricting the
22
23 options? Bioethics discourse has produced its share of bizarre discussions of what one should
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25 do in imaginary cases, that in fact only served to illustrate the absurdity of some questions
26
27 beginning: “What should you do if...?”⁴ (p6) Years ago I was asked what I should do if a
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29 James Bond villain tells me to shoot five delegates at a bioethics conference – or else his
30
31 associate will set off a bomb in the main lecture theatre killing many more, perhaps all the
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33 delegates. When I refused to answer, I was made to feel like the celebrity mentioned in my
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35 first paragraph, confronted with an insistent request for a 'straight answer' to a question that
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37 does not admit of one. For clearly, there is no non-absurd, non-offensive way to reason my
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39 way to an answer as to which delegates I “should” kill. Should I target the old, those who
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41 look ill, or maybe even the disabled, making all manner of assumptions that many would
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43 regard quite rightly as utterly offensive, as to how we measure the value of a person's life? Of
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45 course not. If the death of at least five of the delegates really was unavoidable (and if I
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47 regarded myself as responsible not only for what I did but for what my actions and omissions
48
49 led to others doing) then I should admit that the choice as to *which* people I select is random,
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51 morally arbitrary.ⁱⁱ But surely, my reasoning would be better employed in considering ways
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53 that I might avoid the problem altogether and get the better of the villain. Similarly, in the
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3 real case of the choice between the two groups of patients, might not our reasoning faculties
4 be better employed in thinking of ways to arrange our social order such that the needs of both
5 the thoroughly deserving groups in the example could be met – ie engaging in the sort of
6 political discourse that is ruled beyond the remit of the rationing debate?
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14 In contrast to his critics, Wyller sees his primary obligation as to the patient in front of him,
15 not to the politician whose job it is to make the whole system 'tick over' effectively.⁷ (pp259-
16 60) Utilising the insights of Aristotle and Levinas in his search for a “moral framework” for
17 the role of caregiver, he argues for a form of “moral nearsightedness” exemplified by the New
18 Testament's Good Samaritan:
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27 “The Samaritan did not consider whether part of his limited resources should be reserved for
28 another individual or spread among all the poor in Palestine. His moral obligation was
29 awakened by the particular individual in need.”(p260)
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36 According to Wyller's version of the “ethics of proximity”(p257), for each of us it is true that:
37 *my* moral remit is determined by the needs of the person the New Testament would identify as
38 my “neighbour”: “every human being who incidentally comes in my way deserves my
39 compassionate care”.(*op.cit*)
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47 Far from viewing this mentality as socially irresponsible, I think Shaw would point out that it
48 is in fact this sort of “unreasonable” refusal to make the system tick over that creates a
49 political imperative for change. If a system prevents us from giving people the care they
50 *deserve*, then that system represents not a starting point for ethical thinking, but an arbitrary
51 barrier to moral practice. Of course, we need to recognise its reality and to understand its
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3 workings, but our attitude towards it should be strategic – it is something to be negotiated,
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5 challenged where possible, but not willingly and routinely accommodated. The more people
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7 who think like this, the more we have a 'bolshy' workforce and critical citizenry,⁹ the more we
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9 have a population prepared to call its political leaders to account. The 'reasonable' clinician,
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11 perhaps prepared to “decry” an underfunded system, but only on his days off work, is likely to
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13 prove less of a challenge to underfunding and arbitrary restraint than one who, like Wyller,
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15 states openly that he will not “try” to accommodate demands incompatible with his own,
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17 thought-through ethic of care. If workers who do the jobs that really matter do start to
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19 demand, en masse, to be properly resourced, and if they win the support of the public in doing
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21 so, then perhaps we could see some genuine social progress. In the meantime, if Wyller
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23 manages to win better treatment for his patients then he will not repent or see himself as 'the
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25 cause' of other patients losing out – as though he were responsible morally for the economic
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27 constraints on the system which he did not create.
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34 **Causal reasoning in the rationing debate**

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36 In response, Magelssen et al might protest that he *is* responsible. He did not create the
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38 constraints within which he must practice, but he is responsible for being aware that the
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40 system is resource-constrained. It follows, logically, that any additional benefits he secures
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42 for his patients will be achieved at a cost to patients elsewhere. As Alan Williams, the health
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44 economist and inventor of the QALY used to say, “in a resource-constrained system 'cost'
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46 means 'sacrifice'.”¹⁰ (p223) They give an example which they believe illustrates this point
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48 effectively.
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54 In Norway, “breast cancer patients who had undergone mastectomy bared their scars at a rally
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56 outside of parliament, in order to protest the long waiting lists for reconstructive surgery”³
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3 (p3) as part of an ultimately successful campaign on the part of these patients to improve their
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5 lot. Far from congratulating the campaigners, the authors report that it was later
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7 “acknowledged” (by the Norwegian Ministry of Health and Care Services) that “this
8
9 allocation of healthcare resources at the macro level had the very unfortunate side-effect of
10
11 increasing waiting lists for surgery for children with cleft lip and palate”.(p3) In other words,
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13 the politicians who made the concession chose not to increase the overall health budget – not
14
15 to charge a little more in taxes to the super-rich or large corporations, not to cut spending on
16
17 armaments, on their own salaries and perks or indeed the inflated salaries of game show hosts
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19 and other socially uselessⁱⁱⁱ celebrities (no doubt because they understood that such options
20
21 were 'beyond their remit'). Instead they transferred the money from somewhere else in the
22
23 health system and the children became what Williams would call the “sacrifice” in this case.
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30 Magelssen et al describe this as a “side-effect” of the campaigners' actions. It's worth noting
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32 that this is a *causal* claim: to say X is a “side-effect” of Y is surely to attribute causal
33
34 responsibility to Y for X. So they seem to be attributing responsibility for the suffering of the
35
36 children to the women who bravely campaigned for an end to their own suffering, and to all
37
38 who supported them. If this is not what they are doing, then what exactly is the point they are
39
40 making via this example?
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46 How do they arrive at this causal claim? The manner of reasoning here seems straightforward:
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48 they consider a counter-factual statement that 'had that money not been spent on the one group
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50 of patients, it could have been spent on the other,' note its truth and promptly conclude that the
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52 spending on the one group caused/rendered inevitable the cuts to spending on the other. But
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54 in that case, any number of other counter-factual propositions could provide an equally
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56 credible basis for the attribution of causal responsibility. Had the politicians made a different
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3 decision resulting in one of the alternatives listed above, then both the breast cancer patients
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5 and the children awaiting surgery could have been funded, while (for instance) the profits of
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7 the makers of *Norway's Got Talent* could have been taxed more heavily. So the profits of the
8
9 makers of that particular exploitative pulp entertainment show could equally be characterised
10
11 as the cause of the children's suffering. (As could expenditure on armaments &etc.) The
12
13 point is, it is all a matter of which counter-factual you are prepared to consider, and the range
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15 of counter-factual possibilities the authors are prepared to consider is quite simply a result of
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17 their *stipulation* that they will only consider possibilities delimited by the health budget as it
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19 so happens to be fixed. There is no more 'objective' reason for this stipulation than the fact
20
21 that this is the declared remit of their discourse. The question then arises, for Wyller and
22
23 others: what rational grounds have you given me to want to be part of that discourse? Why
24
25 not be part of a less restrictive discourse, that allows us to consider broader social factors in
26
27 our analysis of the causes and what is/is not "avoidable"? The question is not which realities
28
29 we are aware of, but the moral significance we accord to them in determining our own
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31 thinking and actions. While it might well serve the interests of the minister for health to wish
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33 to restrict all thinking to the options available given 'the system as it is', it is by no means clear
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35 why that is a useful or even morally acceptable starting point for clinicians or indeed for
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37 citizens. It must sometimes be part of our role to do all we can to challenge the limits
38
39 imposed upon us. To consider another counter-factual possibility: the citizens of Norway
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41 could have had as vociferous a campaign for the children with cleft lip and palate as the one
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43 launched for the breast cancer patients. It need not have been restricted to the citizens of
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45 Norway – I could have joined the campaign. So we all bear responsibility for the failures of
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47 the system, every time we tolerate injustice, every time we rationalise the suffering of another
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49 human being.
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Making progress

What concerns me about the view of Magelssen et al is the sense coming across from their paper that such broader political questions can be neatly ruled off from any discussion of the ethics of practice, and a subsequent lack of investigation of their own role as theorists. We all agree that sometimes professionals will not be able to 'defend their corner' in the way I have used this term, and the economic constraints upon them will force them to provide sub-optimal care to their patients. It is not clear that, when this happens, there need be any non-arbitrary answer to the question: who should suffer? To act as though there must be, to make it one's job to find this answer, may seem commendable, but it may serve to place a rational gloss on brute factors whose arbitrariness really should be made clear to all, such that people actually start to have the feelings of outrage that Magelssen et al seem, at times, to be disparaging (see the previous point about "sentimentality").

Historically, arrangements we would now regard as wildly irrational and patently unjust have been defended by those who noted that changing them was 'unrealistic' – where being unrealistic means calling for something that is simply not viable given background economic arrangements that are considered beyond the remit of the topic under discussion. Some slave societies are better and some are worse than others, and the same can be said of particular slave owners. So it might have seemed 'reasonable' at certain points in human history to develop an 'ethics of slavery', to encourage more 'ethical' slave owners for the benefit of slaves. The problem with this idea is that slavery is inherently immoral, so any such 'ethic' is patently untenable:

“If our starting point is a slave society and that ‘background context’ is outside the scope of our discussion, we simply cannot arrive at a solution to the problem of how to organise the

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3 production of life's necessities that is 'fair to all concerned'. Why should we just assume that
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5 our own place in history is so much more fortunate, that given this starting point we can find
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7 rational and fair solutions to our social problems without fundamental social change?"⁶ (p59)
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11 Is it not even possible that our current social and economic arrangements – with all of the
12
13 inequality and suffering they necessitate – are the real problem, in the same way that (most of
14
15 us readily accept) the underlying social and economic arrangements in many earlier human
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17 societies were the true obstacles to justice and social progress? In that case we need to be
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19 very careful, as theorists, about work we do that might serve to vindicate such arrangements:
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25 "By offering solutions to practical problems via rational methods, ethicists confirm that
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27 'rational' and 'ethical' solutions are possible within the present political environment: it is not
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29 that the environment must change radically if reason is to survive at all, but rather rational
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31 debate can flourish provided it accepts certain arbitrary limits placed upon it. By agreeing to
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33 work within the confines of 'realistic' assumptions, such theorists may find that their work
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35 functions to underwrite the very conceptions of reality and practice which must change if
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37 social rationality is even to be possible."⁴(p155)
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43 Consider the response of Magelssen et al to Wyller's claim that the application of universal
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45 moral principles to determine "fair" decisions in particular cases led to morally "arbitrary"
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47 outcomes, while his preferred "ethics of proximity" furnished the role of caregiver with a
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49 moral framework. Their answer reflects what I have elsewhere characterised as an
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51 assumption about proper *methodology* in applied ethics.⁵ They answer that, if rationing is
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53 unavoidable given the system as it is (which they believe they have demonstrated to be a fact)
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55 then "a well-developed modern professional ethic ought to be able to incorporate and justify
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3 notions of justice and rationing” and their concern about “proximity and care ethics
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5 approaches” is that they may be “simply unsuited to provide such an ethical framework for
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7 medicine”.(p6) This does suggest they regard it as the job of applied moral theorists to
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9 explain, given the world as it is, how non-arbitrary solutions are in fact possible, however
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11 intuitively unfair and arbitrary the rationing process might appear to the ethically untrained.
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16 Such theorists risk becoming implicit apologists for the political status quo. When one
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18 considers the sheer irrationality of the broader social order, that allows the salary of an
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20 individual CEO to exceed the entire health budget of a developing world nation, while
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22 something in the region of 29,000 children per day die in the developing world from poverty-
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24 related disease and malnutrition,¹¹ the desire to be “reasonable” in their sense, to frame one's
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26 moral thinking with reference to the need to keep the system as it is ticking over, might
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28 depreciate. It is by large numbers of people failing (or indeed refusing) to work within the
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30 current realities that we have the best hope of actually changing those realities.
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29 i Or at the very least, that the employment of the relevant theory somehow renders the whole process more
30 rational, more justified than one where decisions were made by some patently arbitrary process, such as a
31 lottery.
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33 ii A reviewer for this journal suggests this claim commits me to the view that “all moral decisions are
34 arbitrary”. It doesn't. The denial of the claim that “literally any question about what one ought to do admits
35 of a determinate answer” does not imply the assertion that “no question about what one ought to do
36 admits of a determinate answer”. Given the choice between not killing anyone at the conference and killing
37 five delegates, I should clearly make the decision not to kill anyone! (Anyone who purports to disagree is
38 either disingenuous or psychotic.) But if you insist on saying: “But suppose you simply have to kill five
39 people, how should you select them?” then there is no reason to assume that I must be able to supply a
40 non-arbitrary answer to that particular question. To assume that you can set up any situation you like, limit
41 the choices available in any way you like, then wheel in Kantian, utilitarian or some other moral theory to
42 provide a determinate answer to the question “so what should you do?” is to abuse these moral theories⁴ :
43 they were designed to consider fundamental questions about the nature of moral thinking, not to
44 rationalise any decision you may care to make or to prove that there just has to be a determinate answer to
45 literally any question you care to frame.
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48 iii A reviewer points out that this is a “value-loaded” term, as is my previous use of the term “bolshy” and my
49 later assertion that shows like Britain's Got Talent, America's Got Talent, Norway's Got Talent and (by
50 implication) all the other members of the “Got Talent” family are “exploitative”. Let's be clear, there is
51 nothing whatsoever to be ashamed of in being a “bolshy” worker: the whole point of this paper is to praise
52 the “unreasonable” worker who defends her/his corner in the sense I explain. So there is nothing pejorative
53 about this term. The same cannot be said for terms like “useless” and “exploitative”. My view is that a TV
54 show which invites desperate and often deeply misguided people to prove they “have talent” in front of a
55 panel of wealthy celebrities, to be routinely subjected to public humiliation (except in the rare cases where a
56 true “gem” is found, and instantly signed up to an extremely restrictive contract by the show's multi-
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millionaire founder) is indeed “exploitative”. If there were such a thing as the Platonic Form of Exploitation then this show would be it. Frankly, the term “useless” is far too moderate a characterisation of its founder and key presenter, known affectionately as “Mr Nasty” by his admirers for the hilarious way he “savages” the array of “flops” paraded before him while “earning” his annual income of something in excess of £50 million.

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3 I thank the reviewer for these comments. I'll try to respond to them below, indicating where I have
4 revised the paper in response to the comments.

5 SUMMARY:

6 In this article, the author argues that by being “reasonable” and accepting the “unavoidability of
7 rationing”, health care ethicists are in fact neglecting important larger ethical and political issues, as
8 well as endorsing “the very structures that need to change if real moral progress is to be made”. The
9 author furthermore argues that certain lines of ethical reasoning, here illustrated by an article by
10 Magelssen et al, provide a false sheen of “non-arbitrariness” to (higher-order) priority decisions. Yes
11 that's a fair summary of the key claims of the paper.

12 COMMENTS REGARDING THE ARGUMENTATION:

13 Whereas I find the author’s claim that ethicists ought to scrutinize “the larger picture” relevant and
14 interesting, I am less convinced by the discussion on “arbitrariness”. The two are intrinsically linked: it
15 is the failure to consider the broader picture that renders the solutions offered morally arbitrary. All
16 in all, it seems that the author claims that all moral decisions are arbitrary (?), see especially pg 8,
17 lines 52-54. If so, the problem cannot be that “higher-order” priority setting decisions are arbitrary
18 whereas those made by the physician are not, but rather that any claim by anybody that their
19 decisions are “non-arbitrary” is invalid. This point could be more clearly spelled out. This is a rather
20 puzzling reading which must reflect significant differences in our intellectual starting points. I have
21 been criticised before by bioethicists who (correctly) identified my metaethical presuppositions as
22 realist. No-one thus far has thought my arguments presupposed that 'all moral decisions are
23 arbitrary'. I have added a footnote at the point you reference (p8, line 54) which hopefully makes it
24 clear why this is a misreading. (Actually it's an endnote so the text appears on p17 of the revised
25 document.) Hopefully the note is not too blunt (apologies if it is) but I am attempting to be succinct. A
26 full exposition of my own position in metaethics is not needed here and would lead the discussion
27 away from the main subject matter. You later raise concerns about too much 'autocitation', so
28 expounding further on what I have argued elsewhere would not, I take it, be welcomed.

29 Furthermore, the author claims (on pg 7, lines 50-57) that “to use some theoretical device is to
30 assume that there really is a correct answer here, that the choice is not morally arbitrary”. I do not
31 agree with this claim. For instance, considerations of procedural justice may apply. What precisely is
32 being claimed here? That you can employ a theoretical device such as the QALY, or a Rawlsian
33 conception of procedural justice, but admit that there is no correct answer, that the choice is
34 arbitrary? People can make arbitrary choices without the help of bioethicists, so what role, then, does
35 the theoretical device play – other than to give the *appearance* of a non-arbitrary solution? One
36 possibility is that you are appealing here to the Rawlsian idea of 'pure procedural justice' and the
37 distinction between the justice of processes and of outcomes. But to say that such considerations
38 'may apply' here is not to say that choices are 'arbitrary': a defender of pure procedural justice would
39 argue that, once the 'right' process has been adopted, whatever outcome ensues it is justified
40 precisely as the outcome of the right process – on such a view, that is the only justification it needs,
41 and to say it is justified is, precisely, to deny that it is an arbitrary choice. Again, I have added an
42 endnote at the point you reference (p7, line 57 – the text again appearing on p17) which hopefully
43 expands on this point, bringing in the possibility of a procedural approach.

44 More importantly, any system of ethics is contingent upon accepting some sort of moral ground, be it
45 principlist, Kantian, or utilitarian. As soon as this is done subsequent choices are not in fact
46 “arbitrary”. So it seems you now agree with my claim that to employ such a device is to assume or
47 imply that the choice is not morally arbitrary. You surely are not saying that any evocation of
48 theoretical language guarantees that the theory is being legitimately employed and that its
49 employment really does provide an adequate justification of the conclusion reached? As I say in the
50 two sentences which immediately follow the one you quote, that is precisely the point that needs
51 arguing – it should not be an assumption of the discourse.

52 Equally, I do not agree with the author when he writes that “if a system prevents us from giving
53 people the care they deserve, then that system represents... an arbitrary barrier” (pg 9). The problem,
54 in that case, is not that the system is arbitrary but that it is ethically flawed. You could make a good
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3 case for saying the system is 'ethically flawed' but there is no logical incompatibility with that use of
4 language and my own. (But your preferred use of language encourages you to move to the point
5 below.)

6 Summing up, I feel that the reasoning about “arbitrariness” should either be developed further, or
7 downplayed. I would also like to know just what the author recommends instead of the
8 “arbitrariness” of the model proposed by Magelssen et al. I think it's here that the differences
9 between our intellectual starting points (what I call our conceptions about the proper 'remit' of our
10 enquiry and its effects on our assumptions about proper methodology) really come into play. You
11 already know that I support Wyller's view about doing the best for the patient in front of you, as
12 expressed in his 'Good Samaritan' argument quoted on my p9. But that strikes you as patently
13 incomplete, failing to answer the most obvious and pertinent questions. Your natural assumption is
14 that, if I think a particular overall system is 'ethically flawed', then I should be able to propose/
15 'recommend' a better model that can realistically be achieved given the world as it is. (Or else I am
16 not understanding 'the facts' or being 'realistic' – see your [mocking?] use of these terms in inverted
17 commas below.) Yours is a popular conception of the 'pragmatic' and the 'realistic', one with a huge
18 influence on debates in bioethics, but it is not mine. Pragmatic questions are ones which face real
19 people in their particular situations. This is precisely why I prefer the language of 'arbitrariness' to
20 that of a system being 'ethically flawed'. At any particular point in history, people can be faced with
21 systems constraining their behaviour that have simply evolved: they have not been designed as some
22 sort of overarching moral plan – there isn't a flaw in the plan but rather *there is no plan*. As I have
23 argued extensively in the texts and papers you suggest I cite too much, the best we can do in such a
24 context is, as Aristotle advised, to attempt to preserve our integrity in contexts which will tend to
25 corrupt us. The best way to bring about progress in the 'overall' system is for the Wyllers of this world
26 to continue to resist the arbitrary constraints of the system they have to work with – not to attempt
27 to bring work such as Kant's (which was in fact designed to understand fundamental philosophical
28 questions about reasoning) to find 'rational' or 'ethical' solutions to problems within contexts he
29 could never have envisaged. (This is arguably an abuse of his work, but again, to go into this in more
30 detail would mean more 'autocitation'. I've added a reference to this point to the second endnote,
31 appearing on p17. Beyond that, I'd like to trust any reader who wants more detail on this argument to
32 follow-up the references already in the article. I can't make anyone do this, I can't stop people from
33 simply assuming I'm wrong about something without even reading the work I cite in support of my
34 claims, but I naively hope that academics won't proceed in that way.)

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37 Regardless of “higher order” policy decisions, physicians will always be faced with priority setting
38 decisions (How long to spend with this patient? What ailment to treat first? etc). Given this “fact” (or
39 am I being too “realistic” here?), what indeed should inform the physician in such decisions? Non-
40 arbitrary decisions from within the physicians “defended corner”, that is: from close to the clinical
41 reality, perhaps influenced by the author's preferred “ethics of proximity”? Or should physicians'
42 decisions be informed by other, less arbitrary “higher-order” principles – if so, which are these
43 principles? Or should each physician embrace the “arbitrariness” of ethical decision-making,
44 prioritizing as he/she chooses? To my mind, this would inevitably lead to injustice and
45 unpredictability for the patient, as well as a lack of transparency regarding ethics in health care. The
46 author's developed view on this issue would lend further relevance to the present article. See my
47 previous response. If the only decision the system allows us is just plain arbitrary (eg either cut the
48 spending to the women with breast cancer or the children with cleft lip and palate) then we should
49 admit it, and get angry about it – not rationalise it by acting as though Kant's ethics can somehow
50 resolve a problem Kant never set out to solve. To bring in such theoretical language is not to create
51 transparency but the very opposite: to make an arbitrary decision seem non-arbitrary and to distract
52 attention from the social conditions that require that choice. There could indeed be a non-arbitrary
53 answer, even at what you call the 'higher order' level eg spend on both sets of patients by cutting the
54 money spent on WMDs or charging a higher rate of tax to Simon Cowell and his cohorts. But if you
55 tell me such alternatives are ruled out and I must choose between the two sets of patients, then the
56 choice in that case is arbitrary, and the transparent, honest response is to admit this. The very fact
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3 that in many practical contexts, practitioners may be able to make non-arbitrary choices does not in
4 any way imply that all choices about 'rationing' must be non-arbitrary.

5 I also wish to disagree when the author, on pg 11, claims that Magelssen et al "attribute
6 responsibility" by describing as a "side-effect" the transfer of money from somewhere else in the
7 health system (from the care of children with cleft palate) to "the women who bravely campaigned
8 for an end to their own suffering". Describing this transfer as a side-effect needs not necessarily entail
9 claiming that the women are responsible for the fate of the children – compare for instance the
10 "doctrine of double effect", or Schlomi Segalls insistence that responsibility hinges on whether the
11 outcomes (of an action) are such that "it would have been unreasonable to expect them to avoid"
12 (Segall: Health, Luck and Justice, pg 13). This matter could be explored further. This is a point of logic.
13 The section is entitled 'Causal reasoning in the rationing debate' and the paragraph you quote makes
14 it very clear that what is being discussed is a claim about causal responsibility: the claim that A is a
15 'side-effect' of B is the attribution of causal responsibility for A to B. Considerations of the Double
16 Effects Doctrine in no way contradict this straightforward point – and if Maelssen et al are not making
17 this causal claim, then their use of the example in context simply has no relevance to the point they
18 are making. The principle of charity suggests I should read them as making sense: I therefore read
19 them as making the causal claim I attribute to them. The DDE concerns attempts to avoid moral
20 responsibility for certain foreseeable and unpleasant consequences by construing them as 'side-
21 effects' of intended actions, not to alter the logic of the term 'side-effect'.
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23 COMMENTS REGARDING LANGUAGE AND STYLE:

- 24 • I would suggest substituting the word "remit" with limits or scope as these are more common in
25 the debate on priority setting in health care. For reasons suggested above, the word 'remit' seems to
26 me important here. My argument is that many contributors to debates about rationing still seem to
27 treat identifying 'the problems' as a fairly straightforward, empirical exercise, because their evaluative
28 'remit' is such that they won't consider the possibility that any serious changes to the overall political
29 system might be morally required. (Or they just don't see that as 'relevant' to the debate they are
30 having.) So they see no need to spell out, let alone justify, the moral assumptions underlying their
31 own picture of social reality and their 'pragmatic' solutions to 'the problems' they discuss. It's as
32 though their position is morally neutral, while it's only radical critics of the status quo who need to
33 explain and justify their moral presuppositions. The purpose of my arguments is, precisely, to
34 challenge that 'remit' as intellectually 'arbitrary'.
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- 36 • The author in several places uses what I perceive as value loaded terms. On pg 4: "protect their
37 traditional values and practices from random transformation to suit the prevailing political currents
38 and economic agendas"; on pg 10: "... the more we have a bolshy workforce"; on pg 11 "socially
39 useless celebrities"; on pg 12: "that particular exploitative pulp entertainment show". My strong
40 recommendation would be to replace all such value loaded terms with more neutral phrasings. I do
41 not wish to pretend my own position is morally neutral – given the nature of my criticisms of other
42 commentators, that would be grotesque hypocrisy on my part. I've added another endnote (p11, text
43 appearing on p17) owning up to the value-loaded nature of such phrases and suggesting possible
44 justification for the relevant evaluations. Obviously, I realize that such a recommendation may be
45 perceived as yet another way of "protecting from scrutiny" some aspects of the way the current
46 system functions, or indeed as lending legitimacy to "Norway's got talent". This is not my intention,
47 but rather I argue that any normative claims should be clearly spelled out in an ethics article. For
48 instance, if the author wants to push one of the above points, this can be done in a separate section
49 (or indeed a separate article) entitled "Why celebrities are socially useless and what to do about the
50 situation" rather than merely suggesting the "uselessness" of celebrities in a side passage. If you
51 seriously want me to submit a further article detailing the many ways in which mass culture degrades
52 human beings and impoverishes rational and moral discourse then I can submit it. (Not sure if it
53 would fit in with the stated aims and scope of this particular journal though.) I could add another
54 reference to a place where I present arguments on the general decay of popular debate, and its
55 effects on academic debate, but that would involve more 'autocitation'. For now see if the added
56 endnote does the job.
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- On pg 13 line 16 I think the text should read “there need be”, not “there need by”. **Many thanks! Altered as you suggest.**
- I feel there is too much autocitation in the last section entitled “Making progress”, pp 13-16. The same (interesting!) content can be brought out without reproducing bulky quotes from previously published work. **OK see my above points on this issue and my efforts to keep 'autocitation' to a minimum, compatible with actually communicating the points being made in this paper: hence the restriction of direct quotes from my own previous work to two in the pages cited.**
- I suggest rewriting the very last sentence (“It is by large numbers of people failing to work within the current realities that those realities change”), as this is making rather a steep empirical claim. Especially I recommend exchanging “failing” with some other term (refusing?) as the phrasing “failing to work within the current realities” to me rather suggest that they are unemployed or working in the black market. **OK I'll change the wording here: see p15.**

Proof