Applying Rawls to Medical Cases: An Investigation into the Usages of Analytical Philosophy

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Abstract. John Rawls's Theory of Justice has been widely and correctly recognized as a tremendous intellectual accomplishment. It has been applauded as a comprehensive and satisfying approach to the problem of defining justice. Health policy analysts and medical ethicists have thus been inspired to apply Rawls's principles to various health care issues. The result has not been greater coherence in approaches to issues of policy and ethics, leading the author to question the validity of Rawls's analytical approach.

John Rawls's theory of justice is widely accepted as an intellectual accomplishment of tremendous proportions. His is often accepted as the final definition of justice at this point in Western intellectual development. While Rawls has been extraordinarily influential, the exact nature of his definitive impact is not clear. Ultimately, we might hope that a theory of justice would influence political life for the better, that is, making our politics in some sense more just. Since disentangling philosophy from other factors that affect our political self-understanding is itself a complicated enterprise, it is obvious that discerning the definitive impact of one philosopher will also be very difficult. It may be, however, that philosophical concepts and ideas filter down into political life by a complex process that involves all our intellectual institutions. Therefore, uncovering the influence of a philosophical system upon philosophers or social scientists might allow us to draw some preliminary conclusions about the potential overall significance of a given theory.

Rawls is of a philosophical school that does not encourage speaking directly about policy issues. His principles are meta-ethical—that is, they are intended not to say so much what just action is as to establish a framework from within which just actions can be evaluated. The theory is highly abstract and leaves to others the task of matching real world circumstances to ethical principles consistent with the overall theory.

Rawls does not explicitly deal with health care issues; we therefore cannot appeal directly to his theory for help. It might seem odd that such a comprehensive theory has very little if anything to say about health care problems, and we might consider...
two explanations. First, health issues were simply not the focus of most philo-
sophizing at the time Rawls wrote. He could not foresee the importance that would
eventually be given such issues. On the other hand, it may be that Rawls’s apparent
neglect of health care issues is the result of his analytical perspective. Rawls’s
meta-ethical concerns directed him away from the grubby analysis of policy ques-
tions. This neglect may expose a flaw in analytical philosophy and in Rawls’s
approach to composing a theory of justice. While it is true that Rawls deals with
questions related to political obligation in A Theory of Justice, his discussion is
highly abstract and in need of further evaluation by Rawlsian theorists at the level
of individual action. In any case, the problem of applying Rawls’s theories to health
care will be more difficult due to his almost complete silence on the subject. More
will be said about the general problem of application as we proceed. For now,
however, let us merely note that the project of application is usually incomplete
and must therefore be left in the hands of others, be they philosophers or social
scientists. How then are these applications to be made?

Since we now have a sizable literature on the application of Rawls to medical-
ethical problems, it seems appropriate to survey it to see if we can discover con-
sistencies in the application of the theory. If social theorists are reasonably con-
sistent in the application of the meta-ethical paradigm to specific contexts, we can
point to progress in the field of ethics, for which Rawls deserves considerable
credit. If, on the other hand, attempts to apply Rawls’s theory are wildly inconsis-
tent, then we must begin to question whether we are getting enough direction
from the theory. As the reader will see, the latter seems to be the case. That leaves
us to consider whether there is something about Rawls’s theory in particular that
leads to inconsistencies in application, or possibly whether it may be in the nature
of moral philosophy to leave important practical questions unanswered. Whether
the problem of application is especially Rawlsian, or whether it is more general,
will be directly addressed at the end of this essay. My conclusion is that Rawls’s
theory is ultimately a revised and very sophisticated version of older liberal theories
of justice. As such, it builds on the strengths and suffers from the weaknesses of
that tradition. The major weakness, as will be shown, is that such a perspective
makes the application of principles to particular cases extremely difficult, if not
impossible.

Rawls has developed two principles of justice from his hypothetical original
position. The particulars of the original position are not important for the purposes
of this essay. It should be noted, however, that Rawls has been criticized for the
information that he allows into that position (knowledge of politics and econo-
emics), and that he excludes (knowledge of one’s own individual characteristics).
In other words, the original position has been criticized for being too hypothetical
and abstract. The first principle of the original position is the “priority of liberty.”
According to this, liberty is considered prior to all other goals. “Liberty can only
be restricted for the sake of liberty.” Second is the “maximin” or “difference”
principle, which states that inequalities will be tolerated only insofar as they benefit
the least well-off. "Social and economic inequalities are to be arranged . . . to the
greatest benefit of the least advantaged." Connected to the difference principle is
the notion that there is a fair equality of opportunity to different "offices and po-
sitions."3

One way to evaluate properly the substance of the principles is, as I have noted,
to conduct a survey of their use by others. The remainder of this paper represents
an attempt at such a survey of the literature related to health policy. There has
been a large-scale attempt to "apply" Rawls within this field. The result has not
been the creation of a consistent Rawlsian stance toward resolution of these issues.

Generalizable health care rights

Questions related to the just distribution of health care goods often boil down
to a question of entitlements. Are people entitled to a certain level of health care
(or even some level of "health" itself)? If so, how does one distinguish between
levels? What are the connections between health care and health? Is there a min-
imum standard of health in the same sense that there is a minimum income standard
beneath which no one must fall? For how much of each individual’s health or health
care is one responsible? Does post-hoc treatment hurt the incentive for preventative
care? By considering these questions, it should be apparent that issues of health
care distribution tend to mirror general questions about distributive justice.

I would argue further that the significance of distribution issues tends to be
magnified as we talk about health care, because as we discuss the distribution of
actual goods, we are moving closer to making decisions that affect people in real
circumstances. Since resources are limited, hard choices must be made. The more
these decisions are made concrete, the more we realize the political significance
and ethical difficulty of actual schemes. Presuming that a just distribution is de-
sired, how can we go about obtaining that outcome? Can Rawls’s theory help?

Norman Daniels has done much toward adapting Rawls to health care rights.
It would be instructive, therefore, to begin with his analysis. Daniels believes that
Rawls "at first sight is amenable to generating a right to health care." Recognizing
health as a precondition to experiencing and enjoying other rights and goods, the
distribution of which would be determined from the standpoint of the original po-
sition, Daniels reasons, correctly I believe, that health care issues are closely
bound to issues of social justice. They should therefore be connected to (even if
not explicitly covered by) a comprehensive theory of justice. "After all," he states,
"the process of providing adequate food, clothing and shelter is not explicitly men-
tioned by the theory but it is clearly intended to have implications for their just
distribution."4

Daniels argues that basic needs, like food and shelter, are easily incorporated
into the theory because the need for them is roughly equal. If one is developing
a floor of needs (and Daniels understands Rawls to be doing so), then it will be
easy to specify the floor for certain basic needs. That will not be the case, however,
with health care because the need for it varies widely. "It is the unequal needs it is most expensive to secure." Health care needs are "especially unruly," according to Daniels, and therefore difficult to include under a general theory. Rawls's enterprise is justifiable "to produce principles of justice" acceptable for the "ideal case" in which we assume people are "normal, active and fully cooperative members of society over the course of a complete life." Once the ideal has been determined (by Rawls or others) it "may be extended, modified, or supplemented to accommodate unruly health care needs."5

Daniels notes four preliminary possibilities. First, we could put health care into the index of primary goods. An individual's share of the primary goods would include some predetermined amount of health care. Second, health care could be considered a primary good (like food) to which everyone would receive equal access. Third, we could "use the fair equality of opportunity clause of Rawls's Second Principle and its priority, to put health care service on par with education" (treating it as a "background" institution). Fourth, we could leave it as something to be purchased. The theory itself, it should be noted, does not direct us to use one strategy or another.

This "narrowing down" process is actually quite ambiguous. It leaves us able to choose from nearly every distribution scheme considered by responsible people as a serious option. The first and second options would be compatible with an egalitarianism ranging from national health insurance to socialized medicine to a massive health care lottery. The third would incorporate various social welfare schemes as well as modified (or even possibly pure) market approaches. The last is an explicit affirmation of a pure market strategy. Can all of these schemes fit the requirements of "justice?" In some abstract sense, this might seem plausible. To turn to actual cases, however, consider the following: Would forcing someone to choose between needed nursing care and decent housing be as "just" as entitling someone to a minimum standard of each? A comprehensive theory of justice might help us to answer questions such as these. Rawls, however, does not seem to help.

Daniels is thorough in exploring the logic of the theory. He attempts in a detailed and careful way to narrow the choices. Unfortunately, he finds himself stymied in each successive attempt. He seems aware that as he moves from abstract guidepost to particular application, he is appealing less to theory and more to "intuitions." He even finds himself doubting the usefulness of the entire theory. "If one must supplement the general distribution theory with extensive appeals to such intuitions in order to apply our distribution theory to health care, then it becomes less obvious what the real gain is from turning to the general theory."6

Daniels approaches a crucial, and, if correct, damning insight—that the theory really does not help. Applications cannot be abstracted from it in a logical (or quasi-logical) fashion. They can only be "intuited," which may or may not be helpful depending upon the theory. Still, Daniels is reluctant to make this final appraisal. He concludes that the general theory may still contribute to selecting special distributive principles, but "the grounds are quite unclear."7 This position
seems paradoxical; and it is reasonable that Daniels concludes with some expression of frustration.

I have taken a fairly simple intuition couched in terms of a right to health care, namely, that we ought to have access to adequate health care, regardless of our income level. I have shown that it seems surprisingly difficult to flesh out that right within the framework of a theory that should, more than most others be able to accommodate it.\(^8\)

Despite his difficulties developing a health care distribution scheme based on the theory of justice, Daniels attempts it in another context. In a subsequent article he argues that health care institutions ought to be included among “background institutions” involved in providing for fair equality of opportunity.\(^9\) Daniels attempts to use Rawls’s theory to defend equal opportunity as the primary consideration for the distribution of health care goods. He does this by relying on Rawls’s notion that inherited characteristics do not infer entitlements.

According to Daniels, just as we do not deserve the (health) advantages conferred by birth, we do not deserve to be hindered by the “natural disadvantages induced by disease.” This statement, however, should not be construed as a thoroughgoing commitment to the egalitarianism that comes from a strong adherence to demands for equal opportunity. We do not, according to Daniels, want to extend the principle to “the futile goal of elimination of all natural differences between persons.” He stresses the “limited contribution to guaranteeing fair equality of opportunity.”\(^10\)

Daniels’s position is that health care ought to be distributed recognizing its limited contribution to the goal of equal opportunity (a goal which itself may or may not be accepted as a strategy for redistribution). There appears to be a certain commitment to egalitarianism here, but it is not wholehearted. Not only is Daniels unspecific about policies, but it is doubtful whether Rawls presents a complete justification of equal opportunity, or whether his theory makes any advances over traditional liberal theories in this regard, and is therefore necessary for a justification of equal opportunity.

Daniels, even in light of a basic re-evaluation of Rawls, recognizes that when we must make hard choices, Rawls can offer little guidance. For example, he asks, “What does the restoration of normal opportunity range mean for the terminally ill, on whom we lavish exotic life-prolonging technology, or for the severely mentally retarded?” (This is another way of asking what to do when things get “unruly.”) Daniels admits that he is “not sure what the approach requires here if it delivers an answer at all.” He reasons that Rawls cannot help because we are moving “beyond the domain of justice into other considerations of right.”\(^11\) It is difficult to interpret this statement since Daniels does not detail the distinction. But we have now arrived at the conclusion that Rawls will not help with actual distribution problems. Moreover, if we were to credit Rawls with helping us to reaffirm a principle of equal opportunity, which in turn would move us toward an
egalitarian distribution of health care services, we are unable at this point to distinguish what ought to be subject to "normal" distribution. Distinguishing the "normal" from, say, the "supererogatory" goes to the root of the problem to which we have, relying on Rawls, no foundation upon which to build a solution. Schaefer states, "It would be impossible to show that . . . any institution violates the difference principle as Rawls has stated it."12

Nora Bell takes a different approach to applying Rawls to problems of health care distribution. She argues that Rawls's theory of justice defines the relationship of the individual to a given institution. A person has a "right to" or a "right against" certain expectations insofar as they are delineated by a given institutional arrangement. Once one determines that a given arrangement is just, one has an obligation to subscribe to the duties defined by the institution. She uses this reasoning to conclude that health care is not undeniable. When one enters into the institution, that person must "do what is required . . . by the rules [or] . . . no longer have a claim recognized as legitimate within the system as defined."13 Once the health care system is determined as just, the individual patient must follow its prescriptions. In other words, in a just arrangement, one must follow the doctor's orders.

Bell's key example is free hypertensive care. Free care here is assumed as "just" care, so that to be just in relation to the system of distribution one must "take his medicine routinely, show up on schedule for checkups, not smoke, avoid food high in fat, etc." This concept of justice raises some interesting questions. If a just system accepts a person provided they will follow the regime, and if following it is in turn just action, would it be "just" to terminate life-supporting systems to careless patients? For example, would a hospital be just in stopping (free) dialysis to a patient who did not adhere to the Giavanetti diet? Apparently so, since according to Bell, the institution's obligation to provide services ceases when its rights have been violated.

I introduce Bell's argument not for her substantive stand per se, but to compare her position to Daniels's. Her idea of justice, ostensibly derived from Rawls, justifies a minimalist interpretation of health care rights. In fact, her stated intention is to use Rawls in support of such a minimalist stance. "Right to health care may be limited to access to those services absolutely essential to the maintenance of life. In practice, this could mean that one has no right to cosmetic surgery, or that one has no right to avail himself of emergency room treatment for minor cuts and bruises."14 Of course, face-lifts and minor cuts are not the only non-life-threatening conditions that one can imagine. What about hernia repairs or cataract surgeries? We can only presume, from what Bell states, that such needs are not covered by demands for justice. Whether Rawls would intend his theory to be a justification for such minimalism may not ultimately be an answerable question—which is precisely the problem. We can at least note a significant inconsistency between applications by others. Daniels's position seems more egalitarian than Bell's.15
Ronald Green argues that prudential considerations of parties in the original position “would rule out agreement on the meritorious qualities a person must possess to be worthy of preferential treatment in a matter as vital as [medical treatment].” Therefore, Green interprets Rawls as justifying an equitable distribution of health care needs. “We can expect the parties finally to opt for a principle of equal access to health care”; each “would be guaranteed an equal right to the most extensive health services the society allows.”

It is worth noting that Green’s notion of “equality” is nearly as abstract as Rawls’s idea of justice. That is, Green does not move much toward explication of practical consequences. “Equality,” he asserts, “exists only in the health care system.” Therefore, “the problem of differing subjective needs can be handled by professional judgment within the health care system.” In practice, this would mean that some doctors would view hair transplants as a minimal right, while others would be reluctant to include kidney transplants.

The ambiguities inherent in Green’s concept of equality point to a possible consequence of Rawls’s mode of theorizing, which is the encouragement it lends to equivocation. In a short article it is impossible to relate the widespread presence of this tendency, but illustrations from the literature can be instructive. Cynthia B. Cohen, for example, attempts to “apply” Rawls in the emergency room (ER) context. Cohen’s is a general introduction to ER issues which she claims to substantiate from Rawls’s text. Yet she never arrives at actual practices. She does not, as she notes, “present specific guidelines for the use of an intensive care unit, regardless of kind, organization or size,” but addresses the “more general ethical questions that logically precede the development of such rules at individual institutions.”

If “normal ethicists” aspire to be “meta-ethical,” who will complete the project of application?

While Green’s notion of equality may be unspecified, it is nonetheless a notion of equality. But where Green sees equality, Veatch criticizes inequality. Veatch concentrates on the maximin principle, noting, as others have, that it does not necessarily compel an institution or a society much toward greater equality. As in Reaganomics, the least well off can receive a very small percentage of an increase in goods to satisfy the requirements of justice. Therefore, as Veatch notes, “the smaller the marginal increase to the least well off in comparison to the increase in goods to the elite, the less plausible is the Rawlsian formula of justice.” Veatch feels compelled to argue against Rawls on somewhat the same egalitarian grounds that Green is inclined to argue for him. Veatch is committed to an egalitarian distribution of health care goods. He therefore rejects Rawls and makes a straightforward pitch for egalitarianism “that finds equality of distribution per se as a just-making characteristic.”

Triage

Triage or “lifeboat” circumstances are of considerable importance in the health care field. In these unfortunate cases certain people need to be directly sacrificed
for the benefit of others. Suppose, in the simplest example, there are two patients and one bed, or two patients and one artificial heart: can Rawls’s theory of justice help in such cases? James Childress and Marc Basson have each attempted to apply Rawls in such situations. Each has arrived at markedly different conclusions.

Childress argues for a lottery as the most just method of distributing essential health care resources under conditions of extreme scarcity. He starts from a position that owes, as he notes, a great deal to Rawls’s original one (i.e., men are “self-interested and ignorant of their own talents, potential, etc.”). He argues that persons in that position would choose a lottery as the means of distributing scarce life-saving medical resources (SLMRs) because “this alone provides equality of opportunity.” Those persons would “consider selection by chance as relatively just and fair allocation.”

Basson, in an explicit counter to Childress, argues that membership in something like an original position would result in a collective desire to distribute on the basis of utilitarian criteria. He argues that those behind the veil would regard themselves as having an equal chance of either winning a lottery or being born with the high social worth guaranteeing their selection for SLMRs. Furthermore, if “they never turn out to be a candidate for scarce life saving resources (as is most likely the case), they will stand to benefit more from the social value-oriented allocation.”

We have here a good illustration of diametrically opposed approaches to the allocation of scarce goods, each relying to some degree on Rawls’s theory for justification. In effect, it seems that both authors are correct in their interpretations, because Rawls’s analytical approach does not allow making clearer distinctions that let others develop actual criteria for evaluating just policies or just actions. The problem is highlighted by Gerald Winslow’s analysis, which is written partly to resolve the opposition of Basson and Childress.

Winslow’s Triage and Justice is perhaps the most detailed and sophisticated work of application that has yet been done. Winslow engages in a kind of case analysis, applying Rawls to distribution of totally implantable artificial hearts (TIAHs) and to distribution of medical resources in the event of an earthquake in San Francisco. He carefully criticizes the two most widely accepted approaches to allocation of scarce resources—utilitarianism and egalitarianism. Utilitarian principles include those such as whether a candidate would respond favorably to treatment, whether the candidate might be valuable in terms of the immediate circumstances, or whether candidates have high social worth. Egalitarian principles include distribution on the basis of “general neediness” or chance. Winslow also argues that utilitarian or egalitarian principles can be valuable as principles of distribution depending on the circumstances of a given case.

According to Winslow, ethicists almost always use some “mix” of principles when working through the details of a particular triage problem. What we need is a general theory that helps to determine the appropriate mix and ranking of principles. Winslow states that discussions regarding allocation of scarce resources
"generally incorporate a mixture of principles . . . both utilitarian and egalitarian. But these ‘mixtures’ are generally weighted in the direction of either utility or equality." He looks to Rawls to tip the balance in favor of utility or equality. Rawls’s meta-theory helps us, he believes, to choose between these two sets of normative presumptions. Yet we must be sensitive that, within a utilitarian or egalitarian framework, principles from the category not chosen can be used for refinements.

Winslow argues that health care ought to be considered in Rawlsian terms as a social primary good. “Life saving health care would have to rank close to liberty as one of those primary goods that generally takes priority because, if needed, such care must be obtained before most other goods can be enjoyed.” His analysis of Rawls’s primary goods category leads to the following general principle:

The participants [in the original position] would subscribe to an equal distribution of social primary goods unless the inequality would be to the advantage of the least favored. The inequalities must bear a heavy burden of proof: it must be reasonable to expect that any inequality would maximize the minimum benefit. If this could not be demonstrated, the negotiators would opt for equality.

Applying this principle to allocation of the artificial hearts, Winslow reasons that a strong presumption of equality would be favored. He argues that members of the original position would seek to maximize the number of survivors; thus a minimum floor of medical suitability would be established. After the exclusion of the medically unsuitable, a lottery would be conducted to determine who would receive the hearts. Utilitarian calculations of social worth would be rejected since members of the original position would be unwilling to gamble that they would fall within the category of those chosen because of worth.

Winslow’s thoughtful analysis seems at first convincing. Unfortunately it does not “solve” distribution problems in Rawlsian terms. Winslow is arguing that members of the original position would be unwilling to gamble while in that position, but would be willing to take that same chance once they were a member of the “real world” needing life-sustaining medical care. From the perspective of the original position, these turn out to be precisely the same thing. Given that the number of positions is limited to the same degree, whether one gambles that they will be of high social worth, or takes part in a future lottery, the probability of receiving a heart will not change.

To clarify this point, momentarily place yourself into an imagined original position. You must decide which method for future allocation of TIAHs will be used, keeping in mind that you might need one at some future time, but not necessarily. You might imagine a hypothetical circumstance in which six hearts would be available with twelve applicants, all medically suitable. How will you maximize your chances of gaining a heart? Can you? Winslow argues that Rawls’s theory moves
you toward “maximining,” that is maximizing the chances for the least fortunate, because you might be among them. Social-worth criteria would not do this; a lottery would. You therefore might choose a lottery so you would have a 50 percent chance of gaining a heart no matter what your social position. But Winslow does not consider that from your present vantage point you also have a 50 percent chance of winding up in a social-worth category that would be allocated the heart if social worth were the criteria. Whether you choose a lottery (later) or social worth (sooner), you cannot increase your chances of obtaining a heart from the knowledge that you are allowed.

It is important to remember that those in the original position are not kind to the least advantaged out of sympathy or compassion, but from rational self-interest. They want to maximize the benefits received if they find themselves in a minimum position. In the case of artificial hearts this dictates maximizing one’s chances of obtaining a heart and not dying. But choosing a system of distribution based upon social worth rather than a lottery would have no bearing on maximin calculations. In other words, members of the original position can make no rational distinction (the only kind to which they are entitled) between social worth and the lottery. The original position does not help us to narrow the choices in a significant way. This same argument, it should be noted, could be extended to using willingness to pay as a selection method. Participants would have the same chance of having enough money to buy a heart as they would to be chosen in a lottery. Thus Rawls’s theory leaves us unable to distinguish between the three conventionally accepted means of distribution of scarce medical resources. Winslow might now argue that given that no fair distribution can be determined from the original position, we must opt for equality. But there is no equality in the zero-sum circumstance of scarce health care distribution except to deny all applicants the goods, a solution that Winslow finds “preposterous.”

Since Rawls seems concerned most directly with questions of distributive justice, it is not surprising that his principles have been most widely applied to health policy questions about the distribution of scarce resources. But applications of the theory have not been confined to that area alone.

**Euthanasia**

Turning to the question of euthanasia, John Troyer has argued that Rawls (along with W. D. Ross and Robert Nozick) makes “the only significant steps . . . of which [he] is aware” toward “reducing talk about rights to talk about what ought to be done.” This is a claim which deserves serious attention. Unfortunately, it is not substantiated by Troyer. It turns out that, according to Troyer, we have “no way in general, to proceed from premises about rights to conclusions about what we ought to do.” While Rawls and the others make significant advances, these have apparently not been decisive. Troyer begins with large claims about the applicability of Rawls, but ends his discussion of euthanasia with the unsatisfying con-
clusion that "in many cases there is a great deal to be said for the principle that one should live and let live."  

We see here the repetition of a pattern. Rawls is invoked because he is widely presumed to have something important to say about difficult matters of ethics and justice. However, his opinions have not been fleshed out to the point that we can make particular judgments based on his work. After applying Rawls we are left in our original position. Troyer, finding Rawls less useful than he had hoped, closes on a disturbingly optimistic note. "After all," he tells us, "ethics is a young science . . . and there is little reason to suppose that it would have, at this point, even the right concepts for formulating its principles" (emphasis added). It is "logically possible," we are told, that "ethics is more like medicine in the 17th century than witchcraft in the 18th." In other words, we can hope that ethical science, which has been discovered so recently, will progress rather than atrophy.  

Rawls cannot of course be held strictly accountable for statements made in the name of his theory. He is certainly aware of classical, medieval, and modern ethical traditions. On the other hand, as Harold Bloom notes, "Rawls is the product of a school which thinks it invented philosophy."31 Troyer seems to believe that they at least invented moral philosophy. That misconception is itself unfortunate, since it shows a lack of understanding of the richness and diversity that exist within the tradition of moral philosophizing. An awareness, if not a detailed understanding of that tradition, would certainly aid in the development of an individual’s capacities for moral reasoning.

The emergency room

Tait and Winslow draw our attention to an interesting set of problems that arise regarding treatment in an emergency room, arguing that Rawls’s concept of paternalism can help. When medical personnel confront cases in which a patient is in excruciating pain and desires treatment terminated, the personnel are enjoined to act from the original position where "no one is able to act on personal biases." Those in the original position would presumably "not know whether in fact they might be a patient or physician." (We can presume that they would know what pain is.) Hence, a doctor, acting from sensitivity to the position, would "make choices with which a rational and prudent person would likely agree."32

Tait and Winslow admit that this stance provides no specific content, but assert that "it does give a basis on which emergency medical decisions can be made."33 But it is not clear what these authors mean by a "basis," especially since actual applications are not discussed. They assert that reasoning from the original position "protects" a physician from a patient who, because of idiosyncratic preferences, disagrees with the decisions which have been made. It also "protects" a patient from a physician who "adheres to norms different from those expected of a representative reasonable person."34 Yet the nature of the protection and the means of its enforcement are not clear. In fact, no actual conduct is either prescribed or
forbidden. Tait and Winslow, like Cohen and Ritao, are involved in meta-ethical concerns that supposedly precede application. But the necessary next step is again omitted.

**Defining death**

The definition of death is another health care issue that has become extremely problematical and important with the development of exotic life-sustaining technologies. Peter Black claims to have found Rawls helpful in this issue, arguing that Rawls’s conception of “reflective equilibrium” is useful in developing definitions of death. He emphasizes the significance of reflective equilibrium for resolving discrepancies between intuitions and a theory of justice when the two conflict. According to Black, after immersing ourselves in the project we will sometimes find our theory to be correct, and sometimes our intuitions.

Black states that this process can help us define death. In that case, “Perhaps what is needed is not so much individual reflection about theory as a kind of societal reflective equilibrium.” This is not such a new process after all; it merely involves weighing the consequences of utilizing various definitions of death. “Intuitions here would reflect decisions made as a society about the structuring of values a decision about what life is.” Repeating a familiar refrain, Black makes no attempt to decide which of the various definitions ought to be accepted. It is difficult to avoid the conclusion that “normal philosophers” reading Rawls’s “ethical paradigm” often take it as an invitation to non-commitment.

**Abortion**

Abortion has been an extraordinarily divisive ethical and political issue, an issue for which the guidance of philosophical thinkers should be useful. L. H. O’Driscoll makes a detailed Rawlsian argument for protection of the right of women to choose in these matters. She appeals to Rawls’s development of an idea of natural duties, the most important of which is the “duty of mutual aid.” It is “the duty to help another when he is in need or jeopardy, provided that one can do so without excessive risk or loss to oneself.” The duty of mutual aid requires us to take risks for one another to provide “some protection for the risk lover, the stupid and the weak.” But since those that make up the original position would not be inclined to take great risks, “the duty of mutual aid requires individuals to submit to relatively small risks and losses in order to provide aid to one in need. It does not require individuals to take grave risks or incur substantial losses.”

O’Driscoll combines her analysis of the requirement of mutual aid (relatively weak) with the privilege engendered by ownership of one’s body and the right to self-respect (relatively strong). On these grounds, she argues that women are not required to carry fetuses to term. “The fact that the bodies of adult females are uniquely capable of sustaining the lives of unborn beings does not impose a requirement on them to make their bodies available for such use. The duty of mutual
aid does not require one to permit the use of one’s body by the unborn, even if
the unborn have the right to life.”37 O’Driscol, in other words, appeals to Rawls
to defend free choice with regard to abortion.

Philip Abbot, on the other hand, invokes Rawls as a possible advocate of the
“right to life” position. He notes that “Rawls does not address himself to the abor-
tion question; but one can also note that while the original position can include
all generations, Rawls finds it necessary to add that ‘it is assumed that a generation
cares for their sons.’”38 Abbot argues that Rawls’s consideration for future gen-
erations could include fetuses. I see no reason to doubt that, based on what Rawls
himself writes; but neither do I see reasons to discard O’Driscol’s position from
a Rawlsian perspective. Again, Rawls’s theory could fairly support either side of
the controversy. Can both positions be considered “just”? That would seem to be
a logical impossibility.

Genetic engineering

Rawls’s original position is at least in part justified by a presumption that genetic
endowments are not fairly distributed. Rawls’s theory is in large measure designed
to correct for these “accidental” (and therefore unfair) genetic inequalities. With
this in mind, we can imagine a Rawlsian argument in favor of distributing them
more justly. We can imagine at least two ways of correcting for genetic maldis-
tribution. First, we could attempt to eliminate certain debilitating genetic traits
(such as mongoloidism or double Y chromosomes). Second, we could attempt,
through more ambitious genetics schemes, to create a pool of genetically superior
mutations. Since these creations would presumably be able to help the less ge-
etically well off (in a paternalistic sense), it would seem that this scheme could
also be justified from a Rawlsian perspective.

Mark Lappe argues that Rawls’s difference principle ought to move us away
from a moral/philosophical commitment to genetic determinism. He wants us to
consciously extend our “veil of ignorance” to the genetic process, so that we will
henceforth assume that environment, not genes, is most crucial for determining
development. He admits “that genes might be at work beneath the surface,” but
we should accept an “environmental hypothesis in spite of this knowledge,” be-
cause “it provides us with greater freedom in our action to institute therapeutic
options than does a purely genetic one.” If we follow this assumption, then ac-
cording to Lappe we will be more inclined to follow the difference principle. If
we believe that inequalities are not genetically determined, we will be more likely
to act as if “they should be rectified in favor of the least well-off.”39 Assuming,
for the moment, that the force of Rawls’s argument is very egalitarian, where would
Lappe’s application of the position leave us? We know for a fact that genetic dif-
ferences account for many significant distinctions among human beings. We also
know that genetic researchers are gaining an increased capacity to influence, if
not control, those differences. Is it wise to operate with ignorance of these de-
velopments? It would seem so, according to Lappe, since he wants to act as though genetic differences do not really matter. Such an exercise does not seem warranted.

Lappe wants us to behave towards others not as they really are but as he wants them to be. He seeks to abstract from them those characteristics that are complicated, messy, and also very human. But genetic engineers do not think in such terms. They are looking at concrete aspects of human development and behavior. Some of those engineers are seeking to change them in important and sometimes frightening ways. The philosopher, I would suggest, must also be attentive to the concrete and particular aspects of life that are involved in shaping public policies. If the philosopher is unwilling to do this, he or she will become increasingly irrelevant to the political community, possibly at a time of crisis when the community most needs the clearheadedness of the detached and serious thinker. Rawls does not encourage philosophers to examine moral questions in all their concrete and unruly details.

Conclusion

The reader may at this point feel that I am being unfair to Rawls, or to those who conscientiously attempt to apply his theory to cases. I do not mean to imply that John Rawls is responsible for the inconsistencies and equivocations that one finds in much writing on health policy and medical ethics. There are certainly other philosophers, ranging from Robert Nozick to Emmanuel Kant, who might as easily have been the focus of this essay. Unfortunately, it often seems that philosophy itself leaves us without firm answers to hard questions involving competing claims of justice. This should not, however, lead us to condemn or abandon philosophy, but rather to take into account the problems that are encountered by those seeking to apply philosophical principles. With this in mind, I believe we can draw some tentative conclusions with regard to Rawls.

First, Rawls's impressive philosophical edifice encompasses the strength and weakness of any liberal theory of justice. The great strength of a liberal theory is the open-endedness that creates penumbras of toleration for competing claims of justice. Social peace and utilitarian demands for happiness require that no one individual, group, or class impose their view of "justice" upon the rest. A re-examination of the concept of justice which widens boundaries of just action (and by implication just policymaking) is a desirable corollary of this liberal ideology. Rawls's theory fits firmly within this tradition. The parameters of justice are quite wide within the theory.40

The major weakness of liberal theory is also demonstrated by Rawls, and that weakness should be clear from any analysis. The open-space created by a liberal theory of justice makes the process of applying principles to individual cases extremely difficult. The liberal paradigm of justice encompasses so many choices as candidates for "justness" that application tends toward inconsistency or equivocation, or both. It may be that over time increasing progress will be made toward
"closing in" on what constitutes just activity. The process may work itself out in the "marketplace of ideas," where academic journals and philosophical treatises have a central place. Rawls, however, does not introduce a clear historical perspective (as J.S. Mill does, for example, in On Liberty). Rawls does not indicate the dynamic which moves a society meeting his criteria of justness toward greater justice (or greater understanding of justice). If he had introduced such an historical perspective, we might be able to evaluate whether a society, just in Rawlsian terms, would eventually progress toward more refined forms of justness. We would have a standard by which future movements toward justice could be measured. Still, it is possible that the theory will be fleshed out as time goes on. Rawls's system should therefore not be considered mainly a theory of justice, but the intellectual framework in which competing theories of justice can flourish until one is strong enough to survive. The test of survival, however, will probably not be measurable (except in the most general terms) from criteria attributable to Rawls.

Notes
5. Ibid.
6. Ibid., p. 189.
7. Ibid.
8. Ibid., p. 190.
10. Ibid., p. 165.
11. Ibid., p. 171.
12. Schaefer, Justice or Tyranny, p. 57.
15. My reading of Daniels's work leads me to conclude that, while he is not radically egalitarian, neither is he a minimalist with regard to the distribution of health care goods.
17. Ibid, p. 118.
19. Robert M. Veatch, "What is a 'Just' Health Care Delivery System?" in Veatch and Branson, Ethics and Health Policy.
22. Gerald Winslow, Triage and Justice: The Ethics of Rationing Life-Saving Medical Resources (Berkeley: University of California Press, 1982).
25. Ibid., p. 126.
26. Ibid., p. 133.
27. Ibid., p. 88.
29. Ibid., p. 93.
30. Ibid., p. 90.
33. Ibid., p. 158.
34. Ibid., p. 159.
37. Ibid., p. 110.
40. In spite of what might be implied in the preceding analysis, however, there are parameters. While they may ultimately be overdrawn, they do exclude certain kinds of activities, such as deliberate cruelty and conscious attempts to hurt the least advantaged for no social good. Such actions are difficult to exclude from conventional forms of utilitarianism. If the pleasure of cruelty outweighs its corresponding pain, a utilitarian justification can be made for it.