

**Delegated discretion:**  
**A call for reasonableness in surrogate decision-making**  
**and clinical judgment**

**Kristine Bærøe**



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## **Contributors**

**This PhD project has been a co-operation between the following units at the University of Bergen:**

**Department of Public Health and Primary Health Care (ISF)**

ISF has provided supervision of the candidate through professor Ole Frithjof Norheim, and has administrated the project.

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## Summary

In a democratic welfare state, how should individual judgment be exercised and constrained when someone is making decisions on behalf of another who is not considered competent to make his or her own decisions? How should we expect individual judgment to work when a physician makes a particular claim for just health care on behalf of his or her patient? These are the general questions this thesis attempts to answer. As a result of theoretical discussions, I outline two frameworks as a basis for new policies to ensure the quality and accountability of the discretionary decisions called for in these circumstances.

The first framework I propose challenges a well established procedure for surrogate decision-making. Personal autonomy is a concept of self-governance that concern individuals' ability to set ends for themselves and to choose their acts according to their aims and values. The practice of requiring informed consent is closely connected to this version of autonomy as it is a way of respecting individuals and their ability to decide for themselves. From this point of view, a logically organised sequence of events follows: we are considered competent to make our own decisions until this competence is doubted by someone else, we then might have our competence considered and may potentially be assessed as not competent to make certain decisions about our own well-being. Then surrogate(s) will be appointed to make the decisions on our behalf. This sequence of events allows for exploitation in a way that could be avoided. Moreover, as I have tried to clarify, this sequence of events allows for what I have called 'structural arbitrariness' in how potentially not competent vulnerable people are treated: 1) it is up to others to initiate an assessment of competence, potentially for more or less arbitrary reasons, 2) it is up to others to proceed with an assessment process that I have shown relies on individual variables which can influence the arbitrariness of the outcome. To this we have to add the possibility that: 3) if a person is found by an assessment to be non-competent, he or she is deprived of credibility and is prevented from correcting or appealing on the presumption he or she does not understand his or her best interest. Since treating vulnerable people *arbitrarily* cannot be seen as a respectful way of treating others, I suggest a procedure to ensure reasonableness in the decision-making process by involving several people other than just the appointed surrogate(s). This process is supposed to safeguard against exploitation and against insufficiently justified decisions made on behalf of those assessed not competent to make their own decisions.

The second framework I suggest uses a novel way of thinking about the relation between macro- and micro-level decision-making in terms of *legitimacy*. There has been much discussion about how to obtain legitimacy at macro-level priority setting in health care by using fair procedures. Despite the fact that just health care totally hinges on the decisions of individual clinicians or health workers at the micro-level, surprisingly little attention seems to be paid to the legitimacy of these decisions. Assuming that guidelines are legitimate, what are the conditions that have to be met in order to ensure that individual claims on health care are aligned with an overall concept of just health care? I argue that macro- and micro-level decision-making belong to different contexts of legitimacy so that legitimacy does not automatically transfer from legitimate guidelines to individual clinical decisions. Using considerations about the relation between authorised discretion and regulating guidelines in terms of horizontal and vertical equity, I suggest conditions that have to be met in order for micro-level distribution of health care to be legitimate and fair. These conditions add up to a framework for reasonable clinical judgments. In addition, this framework also addresses and incorporates theoretical conditions affecting clinicians' motivation to meet the requirement of fairness in distribution. I argue that the proposed framework must be taken as a supplement to a framework that has legitimate guidelines at the macro-level, and that macro- and micro-level frameworks must work together to ensure fair distribution within a just health care system.

This thesis is organised along an important line of reasoning: Both surrogate decisions and distribution of health care at the clinical level are based on *delegated discretion*. Certain normative constraints are thereby passed onto the individual judgments of surrogates and clinicians. I approach these constraints by two different epistemological strategies. On the one hand, in the articles which form the basis of this thesis, I argue in favour of the mentioned normative frameworks mentioned above. The arguments provided here in crucial ways seek support by appealing to intuitions; intuitions about respectful treatment of other people and intuitions about equity, according to each framework respectively. On the other hand, I have followed another structure of argumentation in the Introduction part of the thesis. I have approached the specific topics of this thesis by considering how, in general, the normative constraints on delegated discretion are linked to principles derived from moral, personal and political versions of autonomy. These concepts are taken to represent central values of a democratic welfare state. The frameworks I propose are shown to be substantive realisations of these general conditions for exercising discretionary judgment. They are accounted for by

appealing to political theory and social values. In this way, I have tried to clarify the project I originally categorised as 'bioethics' by looking at its inherent political structure as well. I consider the two-way justification of the suggested frameworks to strengthen the results of the theoretical discussions provided in this thesis.

## List of papers

I: Bærøe, Kristine. Patient autonomy, assessment of competence and surrogate decision-making: a call for reasonableness in deciding for others. *Bioethics*. (early view): Jul 17 2008 12:02PM, DOI: 10.1111/j.1467-8519.2008.00672.x

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III: Bærøe, Kristine. Priority setting in health care: On the relation between reasonable choices on the micro-level and the macro-level. *Theoretical Medicine and Bioethics*, Vol. 29, No. 2, 2008: 87-102

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## Preliminary remarks

My work on this thesis started with the assumption that I would discuss ethical concerns within the field of medical ethics. I was prepared to set out my arguments within the framework of well-established doctrines of patient autonomy and ‘state of the art’ clinical practice. However, I realised that I would also have to look outside this field to find theoretical resources to articulate and justify my intuitions. After attending a course on Theories about Professions at Høgskolen i Oslo, I gained an outside-in perspective on the medical profession and was inclined to differentiate the power structure from the ethical regulation of clinical practice. At the same time, I attended a Priority-setting group led by my supervisor Professor Ole Frithjof Norheim. Here, I gained knowledge about macro-level approaches to the just distribution of health care. This made me realise that the normative aspects of physicians’ clinical judgments cannot be properly understood without going into the relationship between macro- and micro-level decision-making.

At this time, however, I was not aware of the call for broadening the field of bioethics to reflect the normative implications of the huge body of literature on social determinants within the field of epidemiology. So I wrote about reasonable clinical judgment and supposedly legitimate clinical guidelines using an argumentation which stretched and partly adopted political theory in order to widen the frame of justification. My argument in support of maintaining professional discretion was based on intuitions about fairness. I tested this argument by appealing to constructed examples demonstrating the need for improving the conditions for those worst-off. Then, when I recognised that inequity in health should not be considered to be isolated cases of bad luck but rather more directly related to issues of social justice, I realised I needed to place the argumentation into a wider framework of political philosophy and political theory than that initially set out in the field of medical ethics.

I had a similar experience working on my other topic, patient autonomy and care for people who lack decision-making competence. I started out with a strong intuition that there is something wrong or insufficient about the way decision-making on behalf of incompetent individuals is justified. I soon felt trapped within the frameworks or doctrines which traditionally appear in the field of medical ethics. I needed an outside-in perspective on the political values which underlie the practice of promoting patient’s autonomy. I then realised that my intuitions about the problem were related to the way ‘promoting the patient’s

autonomy' only mediated a disconnected part of the political values in our society. In order to support my arguments for a new type of surrogate decision-making, I needed to place the issue into a wider framework of political philosophical justification. This was too large an issue for a single article.

For these reasons, the Introduction to this dissertation plays a more important role than just providing a sketch of the background for my papers. It should rather be read as part of the whole argumentative structure leading towards the practical suggestions of my papers. While the papers represent arguments structured partly from the context of clinical practice, this introduction provides an outside-in, theoretical approach to the issues of individual discretionary judgment within an organised state. I try to clarify the bioethical approaches by referring to political philosophy and theory. I hope these different approaches to the topics in this thesis are not only compatible, but also in a deeper sense confirm each other when they are considered as parts of a greater justification process. To support this overall epistemological point of view on the thesis, I have included some meta-methodological considerations of bioethics as a separate section within the introduction.

# INTRODUCTION

## **PART I: BACKGROUND**

### ***A democratic welfare state: normative presumptions***

In a democratic welfare state, how should individual judgment be exercised and constrained when someone is making decisions on behalf of another who is not considered competent to make his or her own decisions? How should we expect individual judgment to work when a physician makes a particular claim for just health care on behalf of his or her patient? These are the general questions this thesis attempts to answer.

This introduction is organised as follows. I will start by clarifying the kind of state within which individual judgment is assumed to be exercised, that is, a democratic welfare state. Against this background, I outline the two particular topics for this thesis. I then provide a general framework for the normative regulations which are imposed on individual judgment when it is exercised by individuals trusted with discretionary powers within the structure of a democratic welfare state. These regulations concern people entrusted to make surrogate decisions on behalf of people who are assessed as incompetent to make their own decisions and physicians who are entrusted to make claims for health care on behalf of their patients. Apart from these shared meta-regulations, the contexts for exercising judgment as surrogates or physicians are quite different from each other. I therefore continue to account for these contexts separately, by presenting distinct frameworks.

### **Welfare state**

A welfare state has been described as “a state that ensures individuals life, health and welfare by a system consisting of (1) social rights provided to the citizens by virtue of their citizenship, (2) distribution of resources according to social goals (health, education, insurance, social security, childcare, etc.), 3) institutions and officials, especially professionals, who promote the rights of the citizens and carry political decisions into effect

[the author's translation] (Eriksen 2001, pp 12-13). Historically, states develop by different organisations and movements driven by diverse motives. Welfare states may present themselves in various forms. In the following, my concern is not to highlight a certain kind of a welfare state but rather to draw attention to some basic values on which modern states are organised in general terms. I suggest a combination of values which may be considered to constitute modern, democratic welfare states.

## **Moral autonomy**

Crucial for the organisation of a welfare state is normative regulation based on the idea of the equal moral standing of all individuals. This calls for respectful treatment of every human being. This idea can be explained in terms of Kant's concept of *moral autonomy* (Kant 2002). The core meaning of 'autonomy' is usually understood as some form of 'self-governance', self-regulation, or self-direction (Paul, Miller Jr. et al. 2003). Kant's theory about how our practical reason is constrained by *the categorical imperative* is an account of our individual appreciation of *moral rights and obligations*. The categorical imperative is considered to be a universal law formulated as two directives. On the one hand, the law demands that we treat other people as ends in themselves and not only as means to an end. On the other hand, the law dictates that we shall only act in ways that we would wish to become a universal law. Moral autonomy constitutes human dignity as humans can be seen as both the 'authors' of and the obedient subjects of the self-imposed moral law. In this respect people are considered to be free and equal individuals.

Individuals are not only considered free to impose universal laws upon their own actions, thereby fulfilling their moral autonomy. They can also be considered free in the sense of possessing *individual autonomy*. Individual autonomy does not require any objective end for all of our actions and for any rational being. Rather, *individual autonomy* characterises the individual's general capacity to set ends for themselves in accordance with their subjective desires, and to pursue these ends by appropriate means according to what Kant called hypothetical imperatives. Individual autonomy allows individuals to plan their lives according to motives and reasons that are their *own* in the sense of not being externally manipulated or forced upon the individual. This freedom was emphasised by John Stuart Mill in his influential work on utilitarian liberalism (Mill 1998). Mill's concern about individual freedom was related to its role in the development of personal character, its contribution to cultivating



appropriate feelings and thus its contribution to forming the well-developed human being. This development was considered to be grounded in the basic interest of man as ‘a progressive being’. Mill’s attempt to give a naturalistic account for normative constraints on individual moral development in psychological terms sees individual autonomy as existing prior to morality. This results in a naturalistic upside down version of how Kant considered the relation between autonomy (freedom) and reason in his metaphysical account for the pre-conditions for mortality.

## **Personal autonomy**

Recent accounts of individual autonomy mainly seem to follow the naturalistic version vindicated by Mill. The role of freedom in self-governance is to self-reflect critically on one’s desires, decide on one’s own goals and make choices in accordance with one’s own plans and conceptions of the good in the absence of external control (Dworkin 1988; Frankfurt 1988). In this way, individual autonomy becomes a character ideal (Gaus 2005). We can distinguish this version of individual autonomy from Kant’s moral version by calling it *personal autonomy*. Recent versions of personal autonomy explain freedom in terms of first and higher orders of desires, the choice between which forms the character and motivates actions (Taylor 2005). These versions of autonomy are not solely aimed at explaining moral responsibility, although they attempt to account for how the fundamental idea of individual responsibility links with autonomy in general.

Against this background, we can see that considering autonomy *from a moral point of view* implies an individual responsibility for the respectful treatment of others. Respectful treatment, understood as the realisation of the duty to treat others as ends in themselves, involves respecting an individual’s ability to set subjective ends for themselves, allowing them to form who they are and what they value (and thereby enacting their personal autonomy). Moreover, treating others as ends in themselves also involves the obligation of helping those who cannot help themselves. Let us see how the structure of moral autonomy forms the basis for the organisation of a modern state of citizens.

*From a political perspective*, the fundamental characteristics of individuals as moral equals with the freedom to set their own goals also applies to the concept of *citizens*. Modern, political, social contract theories reproduce the structure of moral autonomy when describing

the relationship between the state and the citizens. According to the influential work of J. Rawls, people are seen to subject themselves freely to the governing power of the state, which represents the collective power of equal citizens (Rawls 1993). In this way, individuals are aggregated into the unifying term *people*, who freely constrain their own actions by the regulations they impose upon themselves as duties mediated by the state.

The core tasks for states, organised in accordance with citizens' self-imposed regulations, are to administrate the distribution of social goods such as education, health care and protection and to ensure that the distribution is just. A state structured like this can organise just distribution in many different ways depending on substantive views about distributive justice. As the citizens are expected to subject themselves freely to the state power, the basic political institutions which ensure distribution of social goods according to rights and duties must be based on *fair principles*. Fair principles are principles that would be accepted by everyone affected by them. The substantive content of principles for fair distribution of social goods, however, is widely discussed (Rawls 1971; Daniels 1985; Frankfurt 1987; Arneson 1989; Cohen 1989; Dworkin 2000; Sen 2006).

In a modern state, the state's distribution of goods is typically structured and institutionalised as the state's *obligations* towards the people and the corresponding *rights* and *duties* of the citizens. In this way, citizens are respected and their autonomy maintained by rights that give them freedom to pursue their own ends. However, state administrations ensuring citizens their rights can be organised to respect the autonomy of citizens in different ways. Let us consider two general models of distribution to see how this can be so.

### **Models for distribution according to versions of autonomy**

*Equal concern*, considered the sovereign virtue of political community, can very generally be interpreted in two distinct ways (Dworkin 2000). These ways can be captured by the question "What does it mean to respect people as moral equals?" As one answer, we can imagine a society where fair distribution is understood in general as a kind of distribution that provides every citizen with rights to make exactly the same claims on the common resources. This type of distribution could be aligned with the idea of personal autonomy. It could be considered fair to distribute an equal share of the good to everyone and then leave it up to each individual to make the best of their opportunities. Given that there are huge variations in the initial conditions in which individuals find themselves, this distribution would be expected to result

in great inequality between people with regard to how successfully they pursue their own ends. Still, the organised distribution can be said to allow for, and even protect, the personal autonomy of individuals. But can this type of distribution be seen as treating individuals as *ends in themselves*, understood as the other version of respecting people as moral equals accounted for above?

Let us consider the other model of distribution where the rights of people do not involve getting exactly the same share of resources, but rather the aim is to achieve equality in the outcomes of resource use. According to this model, distribution should allow unequal shares of resources to make up for the initial disadvantaged conditions. This model allows for redistribution in accordance with individual needs (generally understood).

These two, very abstract and schematic ways of considering the alternatives for distribution that respect equality, leave us with a trade-off. If distribution does not correct for initial conditions which individuals cannot be expected to control, then the distribution does not represent an equal opportunity for everyone. Thus, the distribution that ensures equality in resources discriminates between citizens and gives them unequal potential for realising their ends. This means they are treated as ends in themselves to an unequal degree. On the other hand, ensuring that everyone is treated as an end in themselves implies compensating for the conditions that prevent some people from the opportunity of reaching their ends. This would discriminate between people in the sense that resources are not distributed equally. The two different ways of understanding 'equal concern' in distribution, and the two distinct distributive strategies which result from this ambiguity, both undermine one of the aspects of respectful treatment of moral equals inherent in the concept of moral autonomy.

This crude distinction between putting weight on the welfare outcome on one side and equality in distribution of resources on the other corresponds to two different versions of egalitarianism, equality in welfare and equality in resources. Philosophical approaches have attempted to combine these models, for example, by an idea of equal opportunity for welfare (Arneson 1989). Others have explicitly stated that they support resource-egalitarianism (Rawls 1999; Dworkin 2000).

Given the description of a welfare state above, we can start to flesh out the versions of autonomy the organisation of such a state might support. In this description, securing social

rights rather than promoting rights to an equal claim on resources was emphasised. This *welfare state* is characterised by its effort to ensure basic social conditions for all its citizens. Welfare is favoured at the expense of equal distribution of resources. This welfare state is based on the idea that people are considered moral equals, which here implies that people are to be treated as ends in themselves. Furthermore, it follows that an ideal welfare state would also allow people to exercise personal autonomy by the way it treats people as an end in themselves. This means the state must allow people opportunities to enact their personal autonomy by protecting them from coercion. Moreover, treating others as ends in themselves is also generally considered to involve an obligation to protect the interests of the vulnerable and thereby help those who cannot help themselves (Goodin 1985). So the concept of a welfare state must involve more than an aggregation of individually achieved welfare, since it must also encompass a duty to maintain the welfare of the vulnerable. An ideal welfare state must be organised to balance both the demand of treating people as moral equals in the sense of treating them as ends in themselves by providing opportunities and protect against harm (as one aspect of moral autonomy) and the demand of allowing individuals to set and pursue their own aims (personal autonomy). This is what I take 'welfare state' to mean in the following.

As *democracy* is also integrated into a welfare state, there is a third version of autonomy we will need to bear in mind.

## **Political autonomy**

Contractual theories allow us to see how a welfare state is connected to the idea of democracy. When the power of the state is organised so as to realise *rule by the people*, the state constitution can be described as a democracy (Held 1987). Democracy, then, is broadly understood as the collective power of the citizens maintaining the state through free endorsement. There are various ways to characterise democratic processes resulting in different constitutional regimes (Gutman 1993). In very general terms, we might say that in a *real* democracy, there will be freely running public debates within the state about how the constitution might be improved in terms of its democracy.

Clearly, in order to realise democracy, citizens must possess individual autonomy in the sense that they are free from external forces or constraints upon their actions. This corresponds to negative, political freedom characterised as the absence of coercion on individuals' or

collective's actions (Berlin 2006). But a positive reading of the freedom presupposed by autonomy is also needed when we consider the preconditions for democracy. When someone acts according to the principles articulated in the categorical imperative, positive freedom is seen in the autonomously imposed constraints on one's actions. So the Kantian version of moral autonomy mirrors the idea of positive freedom in that reason is applied to reason itself in order to disclose universal principles. When people are seen in a political way, there is more to individual responsibility than defining and realising one's own conceptions of a good life in the light of higher-order desires. In order to realise a democracy based on the collective power of the citizens, the basic institutions of the state require recognition of the need for fairness. (Rawls 1993) Just as recognition of universal principles (Kant's moral autonomy) or higher-order desire (personal autonomy) constrains truly autonomous actions in an ethical perspective; recognition of the requirements of fairness truly constrains autonomous political actions within a constitutional democracy. We can refer to this as *political autonomy*. Political autonomy concerns citizens as they recognise the need for fairness in the basic institutions of the state in the same way as they freely subject themselves to the principles of fairness in their individual actions. According to the concept of a welfare state, such principles have to be compatible with the interpretation of people as moral equals implying they are to be treated as ends in themselves. This means that citizens living in a democratic welfare state have institutionalised rights to receive treatment according to their relevant individual needs (whatever fair principles suggest these to be) and these rights are equally distributed among all citizens.

### **Basic principles for a democratic welfare state**

Against this background, a *democratic welfare state*, as understood in this thesis presupposes the following ideal principles based upon our different interpretations of autonomy:

- I) The state has a duty to respect all humans as moral equals, to treat them equally by distributing social goods in accordance with citizens rights and to redistribute social goods according to relevant needs (moral autonomy)
- II) The state must allow individuals freedom to a) reflect upon, adopt and endorse their own ends and b) make their own decisions concerning their own lives in accordance with their own values (personal autonomy)

- III) Citizens, when involved in developing political principles for distributive institutions, are subject to requirements of fairness when reflecting and endorsing ends for their actions (political autonomy)

These principles will serve as the general framework within which individual judgment is used to assess individual needs. I have striven to formulate these ideals broadly enough to be uncontroversial and to allow for various interpretations. But I also hope they are narrow and substantive enough to allow the discovery of any internal tensions between them. This is not meant as an exhaustive list of principles needed for a successful democratic welfare state. However, I see these three principles as sufficient to frame the particular issues I wish to discuss in this thesis.

Theoretical discourse is occupied with principled ways of interpreting the conditions and the ambiguity of such ideals. Practical, political discourse can be seen driven by disagreement about the substantive content and practical consequences of these kinds of ideals. When institutions are developed to support a democratic welfare state, considerations must be made to avoid bringing these principles into conflict with each other undermining the superior intentions. This idea has formed the basis of individual papers in this thesis where I discuss two specific contexts within the structure of a democratic welfare state where *individual judgment* is exercised. More precisely, I consider two different practices which, in their current form, address tensions between the ideal principles of democratic welfare states. These practices are:

- i) surrogate decision-making on behalf on individuals who are assessed as not competent to make their own decisions, and ii) discretionary judgments concerning the just distribution of health care in clinical settings.

### ***Outline of the topics***

A democratic welfare state cannot be represented by institutions which promote paternalistic decisions when meeting the individual needs of the citizens. Paternalism has been characterised as “*the intentional overriding of one person’s known preferences or actions by another person, where the person who overrides justifies the action by the goal of benefiting or avoiding harm to the person whose preferences or actions are overridden*” (Beauchamp and Childress 2001, p 178). Paternalistic actions would undermine one of the basic ideals of a

democratic welfare state, namely personal autonomy as described in principle II. But it would also undermine the first principles about respectful treatment of moral equals; individuals are respected by being treated as ends in themselves and this must involve considering individuals to have the primary basis for recognising their own best interests.

The need to respect personal autonomy in health care is fulfilled by requiring informed consent when the patient is to receive treatment or be involved in a clinical trial. However, it has been much debated whether this actually works according to the intention. It is not obvious what informed consent actually consists of, because there is no conclusive definition of what personal autonomy is (Faden and Beauchamp 1986; Christman 1988; Dworkin 1988; O'Neill 2003). There is, therefore, no obvious way to decide when a person is competent to make autonomous choices (Drane 1985; Beauchamp and Childress 2001; Buller 2001; DeMarco 2002; Kim, Karlawish et al. 2002; Buchanan 2004; Moye, Gurrera et al. 2006; Appelbaum 2007). It is also unclear how informed consent and patient autonomy as theories actually capture how patient autonomy is integrated in real-life practice (Pellegrino 1994; Schneider 1998; O'Neill 2002; Tauber 2003; Struhkamp 2005). Furthermore, it is not obvious that leaving patients with the responsibility for making the decisions is necessarily a respectful way to treat patients (Quill and Brody 1996; Beach, Duggan et al. 2007). All of these issues show us that *patient autonomy* is not a simple concept. A well justified understanding of patient autonomy has to address all these theoretical and practical concerns.

It is possible to trace an influential doctrine of patient autonomy based on the work of Beauchamp and Childress (Beauchamp and Childress 2001; Beauchamp 2003; Gillon 2003). This concept is most usefully seen as *a doctrine of ideals and practical solutions* addressing the various aspects of exercising, or failing to exercise, personal autonomy in health care. The ideals of treating competent individuals, assessing competence and treating those who lack competence are connected. The doctrine provides us with an organised way of handling personal autonomy issues sequentially from the point where the clinician starts to doubt a patient's capacity to exercise this right. The sequence of events is as follows. Normally, an individual's capacity to make their own decisions about their own welfare is taken for granted (Buchanan and Brock 1990). If this capacity has come into doubt for some reason, the decision-making competence is (should be) assessed formally. If the person is found to be not competent, a guardian might be appointed by the court, or informally, it might be left to a proxy (proxies) or health care personnel to make decisions on behalf of the incompetent

person. Whether the appointment of a surrogate is formal or informal, it can be a heavy responsibility and challenges the surrogate's individual judgment to work out what would be the right thing to do.

In this thesis, I question whether current practices for treating those assessed not competent is really in line with the principles we established above as a basic requirement for a democratic welfare state. The whole process of doubting an individual's competence, assessing their competence and making surrogate decisions on their behalf can be seen as arbitrary in a fundamental way, which allows the possibility of exploitation and manipulation. Is it respectful to treat the most vulnerable people in an arbitrary way, when they cannot, as a result of the assessment, defend themselves and their preferences to those who consider them incompetent? This dilemma is inherent to the established way of respecting individual autonomy as it is practised around the world in modern liberal societies, but it might not be compatible with the requirement of respectful treatment of *all* human beings, including the most vulnerable.

With regard to just health care in a democratic welfare state, the involvement of individual judgment relates to a wide range of issues. Central to thesis is the individual judgment of clinicians presented as 'clinical judgment'. This term is used in rather ambiguous ways. It is used to describe the reasoning constituting the practice of medicine as art, science or a compounding of the both (Gorovitz and MacIntyre 1975; Widdershoven-Heerding 1987; Pellegrino and Thomasma 1993; Eddy 1996; Davis 1997; Kenny 1997). Clinical judgment, considered one way or another as an essential part of medical practice has an important role to play in several challenging issues that have to be dealt with within a health care system. These issues concern clinical autonomy and trust placed in physicians (Hall and Berenson 1998; Bloche 1999), confidence placed in the distribution by the profession of medicine and the derived request for accountability of the medical practice (Mechanic 1996; Pellegrino and Relman 1999; Cruess, Cruess et al. 2000), the quality of care in relation to evidence based medicine (Hurwitz 1999; Hampton 2002; Parker 2005), the political implications of allowing physicians' extensive discretionary authority (Klein 1998; Lauridsen 2008) and the role of the physicians in call for rationing (Mechanic 1992; Hunter 1995; Pellegrino 1997; Kassirer 1998; Ubel and Goold 1998; Mechanic 2000; Ubel 2001; Hurst and Danis 2007).



My concern about physicians' individual judgment is how their delegated discretion can affect just distribution of health care, how their judgment can and should be regulated under the requirement of fairness within a closed system of distribution and redistribution (Daniels 1987). Just distributions have been extensively dealt with at an aggregated level of health care needs (Daniels 1985; Statens offentliga utredningar 1993; Norges Offentlige Utredninger 1997; Cookson and Dolan 2000; Daniels 2007). Fair distribution considered on an aggregated level has been taken as ensuring equitable distribution at the individual level by imposed guidelines (Rawlins and Culyer 2004). Moreover, the issue of legitimacy has been brought into the process of developing guidelines by making the actual process accountable (Norheim 1999). Others have tried to incorporate issues of equity into guidelines (Aldrich, Kemp et al. 2003; Oxman, Schunemann et al. 2006; Dans, Dans et al. 2007). I question this transfer of justice from one context of justification to another; from a context of aggregated needs to the context of individual needs by compliance with guidelines. I also question whether guidelines or rules are able to promote the aspects of justice that calls for unlike treatment of cases that are unlike in relevant respect. I ask what is needed to justify the individual clinical judgment when rules or guidelines alone cannot do the job of promoting justice. In this case, individual efforts to achieve just distribution must be in accordance with the three principles set out above as characterising a state of both welfare and democracy. The practical solutions I will suggest will have to address the theoretical and practical challenges involved when individual judgment needs to focus on particular needs and at the same time to promote democracy by acting on what would be considered fair but without expectations that everyone enacting their personal autonomy will come up with the same answer to what should be considered as fair.

There are gaps in the literature with regard to the meta-regulations imposed on individual judgment when it is exercised as *delegated discretion* within the framework of a democratic welfare state. In this thesis I explore how individual judgment is constrained and how it should be exercised when surrogates make decisions on behalf of individuals who are assessed not competent to make their own decisions and when physicians make particular claims to fair health care on behalf of their patients.

## **PART II: FRAMEWORKS**

### **GENERAL FRAMEWORK**

In this section, I will consider in more detail the structural constraints imposed on individual judgment within a democratic welfare state by stressing the crucial distinction between ‘discretion’ and ‘judgment’ and by explaining the link between these concepts. This discussion about the formal constraints on individual judgment forms a shared framework for the specific topics I discuss in the articles. I will then look specifically at each of the two areas I have considered: surrogate decision making and just claims on health care.

#### ***Judgment versus discretion***

Individual judgment, when it is exercised within institutions designed to sustain the ideals of a democratic welfare state, is subject to formal constraints. It is important to clarify the distinction between ‘epistemic judgment’ and ‘structural discretion’ (Grimen and Molander 2008) (in Norwegian: ‘epistemisk skjønn’ and ‘strukturelt skjønn’.) ‘Judgment’ is relevant when we assess an act without determinate standards, when we are trying to discern the right from the wrong thing to do or decide what is valuable art and what is uninteresting and so forth. Exercising judgment is considered to be an epistemic activity. ‘Discretion’, on the other hand is visualised as ‘the hole in a doughnut’ by R. Dworkin and ‘a lacuna in a system of rules’ by R. Goodin, suggesting an empty space for unconstrained decision-making compared to the surrounding space of constraining regulation which usually determines the outcome of decisions (Dworkin 1978; Goodin 1986). The open space represents the relative freedom of being able to choose how to act or being able to assess a situation using one’s own justification in the absence of pre-determined standards. Dworkin stresses that this understanding of discretion presupposes that decisions are normally subject to restrictions settled by authorities other than the agent himself. He also distinguishes between ‘weak’ and ‘strong’ discretion. The weak version of discretion represents the kind of individual judgment that is at work whenever someone tries to apply general knowledge (or standards) to particular instances. This version of discretion also operates when there is no-one reviewing

the decisions. The strong version of discretion is present when there are no standards to determine the decisions so the individual decision-maker can rely completely on his own, independent standards of justification. However, as Goodin pointed out, it will not make sense to state that in such a case there is no rule at all. Discretion presupposes a 'meta-rule' indicating the objective of the decision to be made. This could be *a need* or someone's *best interest*. 'Discretion' does not describe judgment in contexts where an individual is supposed to decide freely, such as the colour of one's own bathroom. In this sense, discretion can be seen as already regulated in some way by another authority. This also makes sense if we see a decision-maker as 'empowered with discretion', which would, of course, be a strange way to describe someone choosing the colour for decorating their walls.

Goodin, who is occupied with discretion in relation to the distribution of social goods in a welfare state, provides a more detailed analysis than Dworkin of various kinds of discretion. According to Goodin, the discretion an individual possesses can be categorised into different types depending on whether the decisions are constrained by rules, how binding any rules are and whether the individual's decision is likely to be reviewed or potentially overturned by any other official. In general, however, discretion must be related to the fact that it is delegated and not 'given'. 'Discretion' denotes delegated authority relative to other authorities.

*"Logically, the opposite of enjoying discretion is being bound by a rule"* writes Goodin (Goodin 1986, p 250). At the same time, he stresses that discretion arises in two ways, even when a decision is bound by rules. First, discretion is needed in order to choose the rule that the specific context requires. Someone must have the authority to make that choice where there are different rules to consider. Second, discretion is also involved *"in the act of bringing particular cases under the ambit of general rules"* (Goodin 1986, p 238). This means that when an authority has decided on a general rule, discretion is needed to identify the cases this general rule applies to. Discretion is at work even in a system of rules, so rules cannot totally undermine discretion.

Being empowered with the discretion to make certain kinds of decisions gives the decision-maker power. This power can represent a threat in so far as it could be misused to manipulate or exploited others. Misuse can be prevented at one level by having decisions reviewed by another, superior, authority. But as Goodin has pointed out, the review process has to end somewhere (Goodin 1986). So the threat of misuse is not eliminated but may just be transferred further up the hierarchy of authority.

In a democratic welfare state, bureaucrats typically prepare and translate political aims into practice on behalf of the state. The state is, however, in accordance with democratic theory, to be considered as a representation of the power of the people (Held 1987). Legislation and policies which regulate the distribution of common goods are usually voted through by elected representatives, or sometimes directly by the citizens. Principles supporting democracy are needed for more than just how to count the votes. These principles also have to follow through the whole bureaucratic system in order to support the will of the people in the distribution of common goods. Requirements of openness and a clearly structured system of authority and responsibility for decision-making is an important way to promote democracy (understood as the will of the people) throughout the distribution of social goods.

To sum up: 'Discretion' is used to describe the power structure at work when someone makes decisions within a state structure of delegated authority and responsibility. 'Judgment' on the other hand, denotes the epistemological activity of assessing, evaluating and filling out indeterminacy in general, and by those empowered with discretion in particular.

### **Street-level bureaucrats and distribution according to need**

A welfare state can be characterised by the emphasis put on the citizens' *rights* that promote equality by levelling up the conditions of the worst-off citizens in order to secure everyone a certain standard of living. In this respect, states seek to distribute certain social goods in accordance with need. At a collective level, this kind of targeted distribution hinges upon interpretations of needs, both regarding what kind of goods should be distributed to promote equality and more specifically how to measure the need which is to be compensated for. At the individual level, the person's situation is taken into consideration when needs are assessed. As part of the process of determining needs, certain characteristics might be identified and agreed upon outside the person-specific context. For example, citizens with incomes below a certain level are entitled to pay less for their children's kindergartens than those with higher incomes. In such cases, there are clear rules to follow when particular needs are considered. However, needs might be composed of various factors that, taken together, represent a much more complex picture which is difficult or impossible to capture in rules established to determine need. Moreover, to fulfil the aim of compensating for disadvantage and inequalities, measuring the compensation needed in the particular case by discretion might be the most effective way of reducing the needs. If the aim is equality, reached by

compensation, there must be a balance between levelling up the conditions for the worst-off without at the same time leaving the rest of society comparably worse-off. Consequently, it is not only limited resources that speak against overcompensation of individual needs, but also inherent logical constraints in the structure of a welfare state. In order to ensure that any compensation is neither too small, nor too large, individual need assessment is necessary. This means that someone has to assess individual needs which are not completely predefined by a set of specific characteristics, which lead to specific compensation. This assessment is fundamentally based on someone's *judgment* about the need in the specific case.

The distribution (or 'redistribution' as it might be called since social and economic compensation in accordance with needs comes in addition to the public distribution of goods that all citizens are entitled to within a welfare state) of social goods heavily depends upon the judgment of individual officials who face those in need of some kind of help. These officials represent the mediating instances between the politically, more or less generally defined needs and compensations, and the people who will receive this compensation. In this work, the officials have to transform political ideals, rules and particular concerns into concrete claims for compensating services. These officials fall under the description 'street-level bureaucrats' (Lipsky 1980). 'Street-level bureaucrats' are defined as "*[P]ublic service workers who interact directly with citizens in the course of their jobs, and who have substantial discretion in the execution of their work*" (Lipsky 1980, p 3). This definition is wide enough to cover a lot of occupations which mediate welfare goods to citizens without necessarily focusing upon and determining individual needs in particular. The definition goes for all those who distribute common goods such as education and security, provide classroom tuition or preserve law and order. But it also goes for those occupied with identifying more specified needs for publicly funded compensation such as health care workers. Characteristically, democratic control over the discretionary work of street-level bureaucrats is very limited. Their decisions about how to distribute welfare are usually not open to public review and it is hard to find ways to make street-level bureaucrats accountable for their discretionary work because of the particularity of needs they consider. These facts amount to what has been called 'the black hole of democracy' (Eriksen 2001). Although the work of street-level bureaucrats allow for discretion to a varying extent depending on the kind of work they do, the following points about the relation between discretion and judgment goes for all of them.

## **The relation between judgment and discretion in terms of *best calculated***

Goodin writes about discretion: “‘*Discretion*’ admits of two types of characterization, one positive and one negative. On the positive characterization, an official can be said to have discretion if and only if he is empowered to pursue some social goal(s) in the context of individual cases in such a way as he judges to be *best calculated*, in the circumstances, to promote those goals...These two characterizations, one positive and one negative, perhaps give a different flavour to discussions of discretion. Formally, however, I take them to be extensionally equivalent.” (Goodin 1986, pp 233-234) It is reasonable to see the positive description of discretion to fill up the lacuna (according to Goodin’s negative characterization), or the hole in the doughnut (Dworkin’s characterization), with epistemological activity externally unregulated in the absence of explicit rules. It would not be right, however, to conclude that judgment is totally unconstrained. First, according to Goodin’s description above, the judging process is normatively constrained by being considered the *best calculated* way to promote the goals in question. Obviously, if this normative constraint on the considerations of someone empowered with discretion was inherent in exercising discretion, discretion as such would not represent a threat of manipulation and exploitation. A more plausible way to link the positive and negative description is then not to see them as extensionally equivalent, but to say that when someone is empowered with discretion, they are also *expected* to consider how to promote the actual goals in what *they judge to be the best calculated* way. In the following, we will first consider *the expectation* that someone will promote the goal one judges to be best calculated in terms of *trust* and *confidence* and then consider what *judging something to be best calculated* actually amounts to in terms of meta-regulations imposed upon judgment.

### **Trust and confidence**

If a democratic welfare state is to allow this kind of discretion, we must look at the role of *trust*. First, we must distinguish between the collective (or public) and individuals as who give trust, and institutions or individuals who are potentially trusted. Second, we must distinguish between ‘trust’ and ‘confidence’ (Luhmann 1988; Seligman 1997; Checkland, Marshall et al. 2004; Dibben and Davies 2004; Harrison and Smith 2004). It is argued that ‘confidence’ relates to the general sense of safety and reliability that we routinely invest in abstract systems”, while ‘trust’ on the other hand, is essentially considered to be a moral issue, and

“[T]he moral nature of trust derives from the characteristic involvement of risk (of disappointment/damage), vulnerability, individual agency *and* the absence of regulatory mechanisms of coercion. Trust cannot be demanded or forced; it depends upon voluntary reciprocity in those interpersonal relations that are not governed by confidence.” (Smith 2001, p 295)

Individuals empowered with discretion within a state structure are potentially subjected to both confidence and trust. They can be considered part of a collective entrusted with the responsibility for bearing certain institutions. In this regard they could be considered subject to confidence rather than trust, according to the distinction above. So, from a political, public point of view, delegation of discretion within a state structure must be based on collective confidence that those empowered with discretion will exercise judgment and sustain the institutions, according to ways they *judge to be best calculated*. And from a moral point of view, when individuals trust other individuals who are empowered with discretion, they trust them to be able and willing to judge the *best way to respond* (Baier 1986; Smith 2001). At the same time, confidence and trust also mirror asymmetric relations of power. This becomes clear when we recognise that institutions and trusted individuals are in a position to bring about actions that are simply not aligned with the moral expectations. There is no guarantee that power is always used in the other’s best interest (Grimen 2001).

Both confidence and trust are fundamental for democracy as they allow individual discretion to represent the ‘rule of the people’ and to pervade bureaucracy and the organised distribution of rights and common goods. O. O’Neill emphasises that trust (and, I add, confidence) enables democracy, rather than the other way around (O’Neill 2002). Confidence placed in institutions can be weakened. The media plays an important role in reporting on officials’ decision-making that can undermine confidence. Reports might be biased or even incorrect and can lead to a distorted version that challenges the confidence of the citizens (O’Neill 2002). Nevertheless, continuous questioning of whether public institutions are worthy of confidence can be seen as fundamental in sustaining democracy. This leads us to the requirement of accountability.

## **Accountability**

In order to ensure that humans can develop as free and equal members of democracies, coercive powers, and arbitrary power, must be reduced to a minimum. The only way this can

happen is to subject the state to accountability (Held 1987). In order to maintain confidence (or rebuild it, if lost), there is a need for accountability not only in political decision-making processes but also in the institutions involved in the distribution of rights and social goods.

Accountability presupposes that 1) there is someone to be held accountable, 2) that there are ways to hold someone accountable and 3) there is someone to whom one is accountable (Emanuel and Emanuel 1996). Welfare institutions, represented by collective discretionary decision-making, can be accountable to substantial goals that are recognised and accepted. In general, accountability presupposes transparency so that all stake-holders are able to judge the collective performance in accordance with accessible standards. At the level of welfare institutions, accountability can be seen to be related to procedures which measure the outcome of discretionary decision-making in terms of objectively measurable standards of performance. As regards point 3), the public institution has to answer to stake-holders in the distribution system, that is to local management, higher governmental authorities and to the public it is supposed to serve. Accountability of institutions, represented by substantive standards for the assessment of performance, gives people some *ways* to evaluate institutions and not just leave the attitude as a matter of blind confidence.

What about the accountability of particular discretionary decisions within an organised distribution system? First, we must note that the *aggregated* discretionary decisions of individuals can also be subjected to standards of performance, for instance by monitoring the rate of referrals of a general practitioner. In this respect, accountability does not concern the particular decision but rather the *pattern* of decision-making which corresponds to the accountability of the individuals as part of the organised welfare institution in question.

Individuals who realise the rights of others by their decisions are, of course, subject to *externally imposed* laws and institutionalised procedures which make them accountable for their work. When exercising discretion, however, they are not, by definition, subject to any accessible rule which explicitly indicates what the given situation requires. This of course, does not exclude the possibility that they judge according to *internally imposed* standards. These are standards imposed upon their judgments by the individuals themselves and these standards justify their decisions as *best calculated* based on the reasons they find the most important. In this sense, individuals empowered with discretion might also be made accountable by requiring their decisions to be accompanied by a *justification*. However, if the



justification is not automatically subjected to review by some other authority, the decision-maker still possesses discretionary power.

If there is a lack of accepted standards to justify the judgment, the decision-maker must provide a justification based on his or her personal normative principles or intuitions. The concept of personal autonomy allows for disagreement on such personal standards. Consequently, the receiver and the street-level bureaucrat might disagree about the rightness of a decision. This is something we have to live with in a democratic welfare state. What we cannot live with, however, are discretionary decisions that fail to be as *best calculated* to the decision-maker. Therefore, accountability at the street-level should be (as it often is) supported by institutionalised procedures for complaints so that decisions that are badly or arbitrarily justified, can be reconsidered by some other authority empowered with discretion. Indirectly, this is a way to reduce an authority or individual's arbitrary power to make badly justified decisions when distributing social goods on behalf of the people and it is a way to protect the vulnerable against this kind of maltreatment. Moreover, when this kind of *indirect accountability to the clients and citizens* is required, people are offered reasons to be confident that distribution is being appropriately carried out at street-level.

Decisions about individual cases contain sensitive personal information. The first principle of a democratic welfare state discussed above, respecting individuals, cannot allow public access to sensitive information about their personal welfare. This would not be treating individuals as ends in themselves. Public access to personal information about someone's welfare needs could be stigmatising, and it would also undermine their personal liberty to decide themselves about who knows their personal circumstances. One could wonder what is the point of providing justification for discretionary decisions if, normally, (when no one complains about the decision) there is nobody else to review the decisions concerning people's privacy? At the end of any organised distribution chain, there are the *receivers* of the distributed good. Although they may have no right to overturn a decision, the receivers of distributed goods represent moral equals with claims to respectful treatment. They also represent the people by being a citizen. Individual, discretionary decisions at street level therefore require accountability, both morally and politically. Morally, those who are empowered with discretion in street-level distribution owe their clients justification for their decisions if the clients ask for it. Politically, they are also accountable for their decisions to the clients considered as citizens as they distribute a common good (Lauridsen, Norup et al. 2007).

We must note that the standards used to measure aggregated discretionary decisions within a distributive institution might help to maintain people's confidence. But this kind of performance accountability in terms of measurable aims might clash with moral accountability needed to maintain the interpersonal trust between street-level bureaucrats and their clients (Smith 2001; Checkland, Marshall et al. 2004; Harrison and Smith 2004). For example, if the clinicians are focusing on fulfilling measurement aims it might affect their ability to hold on to what should be the focus, i.e. the patient best interest, and this might undermine the patient's trust.

### ***Meta-regulation of discretionary judgments***

What more there is to say about Goodin's point that those to whom discretion is delegated are supposed to arrive at conclusions they judge as 'best calculated'. What could this actually mean in practice, given the need to maintain the public's confidence in institutions and trust in individual street-level bureaucrats? If it is not left to individuals with discretionary power to assess this in a completely arbitrary manner, what more can be said about it? I will present below two different ways in which individual judgment might be regulated internally by those who themselves are making the judgments; 1) by recognising normative contexts in accordance with some overall aim of the discretionary work and 2) by recognising the different levels of justification.

### **Normative frames for individual judgment**

Dworkin has pointed out that "Almost any situation in which a person acts...makes relevant certain standards of rationality, fairness, and effectiveness. We criticize each other's acts in terms of these standards, and there is no reason not to do so when the acts are within the centre rather than beyond the perimeter of the doughnut of special authority." (Dworkin 1978, p 33) Considered as standards, these particular standards must be of a kind other than those imposed by an external authority which originally defined the body of the doughnut.

H. Grimen and A. Molander follow Dworkin in his assumptions that judgment is subject to formal normative regulations. Assuming that judgment works under the same conditions as practical reasoning in general, judgment is constrained by standards of rationality. In addition to the norms of rationality, they suggest there are 'normative contexts of judgment' that

impose yet other constraints on judgment. Judgment is exercised within the context of normative expectation derived from “the most general requirements imposed on the occupation or the system within which judgment is exercised” [author’s translation] (Grimen and Molander 2008, p 188). Such formal constraints on individual judgment could then also include what Dworkin refers to as ‘standards of fairness and effectiveness’.

Grimen and Molander discuss three different kinds of idealised ‘normative contexts of discretion’ which can potentially frame discretionary judgments; the principle of equal treatment, the principle of reproducibility, and the principle of individualisation. Individual judgment is constrained by the principle of reproducibility when judgment is required to bring forward features of the context or a case which could be explained by some kind of knowledge that is accessible to others as well. Such knowledge could be specialised, professional knowledge and this would be a pre-condition for making a good judgment for instance in a health care situation, and it will be knowledge that others in a similar role would recognise as valid. The principle of equal treatment is at work where the resulting judgment is affected by and has implications for cases that are equal in relevant respect, i.e., how have other been treated before and how others will be treated in future. When discretion is exercised under this constraint, knowledge about how similar cases are treated is a pre-condition for exercising good judgment, for instance, in law cases. These two principles are both categorised as principles that occur in contexts with a requirement of strong comparative consistency. The principle of individualisation calls for attention to the specific concerns of individuals. This principle is typically presented in contexts where the judgment is about how best to care for somebody. This principle does not presuppose comparison either to achieve consistency with other cases or to obtain consistency in how one person’s judgment of this case coincides with another person’s judgments of the case.

All these principles might regulate judgment depending on the context. There might also be contexts where these regulating principles are brought into conflict with each other. Within the context of distributing a common welfare good, such as social services, scarcity of resources might bring judgment concerning what a client really needs in terms of economic support in order to manage may come into conflict with the requirement that everybody in a similar situation thereby has a claim on that kind of treatment. There will simply not be the means available for such a fair distribution. Moreover, in order to ensure strictly fair distribution across a population where everyone in a comparable situation with equal needs

gets the same, we would have to presume that every street-level bureaucrat was educated and trained to consider the same kinds of needs and would make identical judgments on particular needs. This suggests that the principle of reproducibility is called for under the demand for equality. Unfortunately, that discretionary judgments should work under the principle of reproducibility is an unobtainable ideal. Theoretically, there are good reasons why this must be expected. I will touch upon some of the reasons below, when I discuss the ‘burdens of judgment’ according to Rawls’ account. Here, however, we need to recognise that being empowered with the discretion to judge about particular claims on common goods might be subject to normative requirements that work against each other, and also to requirements that can come into conflict with what individual judgment can realistically be expected to provide (Grimen and Molander 2008).

The normative constraints on individual judgments presented here are thought to be at work in various settings and constellations. How can the individuals making discretionary decisions know which formal principle or principles they should apply to the situation in hand?

## **Normative contexts of judgment and the ideals of a democratic welfare state**

Those who are empowered with discretion within the distribution of common goods within a democratic welfare state will have to see their judgment restricted by the formal principles which follow from the ideal principles constituting this kind of state. I will now show how normative contexts of judgment might be derived from the three ideals (themselves derived from assumptions about autonomy) which I have set out to constitute a democratic welfare state above.

The first principle (I) derived from the concept of moral autonomy, tells us that all are considered moral equals with equal claims on the distribution of common goods and that those who are worst-off in relevant respects have an additional claim on resources to have their needs met.

The requirement for equal treatment can be seen applied to the distribution of goods within a democratic welfare state in a three-stage model. Firstly, all individuals considered on an aggregate level with the characteristics shared by all citizens are ensured the same share of the goods by the rights attributed to all citizens. Secondly, everyone with common conditions that make them worse-off than others are treated equally by being attributed the same rights to

compensation. Thirdly, when the rights concerning redistribution are implemented, the individual discretionary judgment of street-level bureaucrats becomes central. Discretion is needed to identify who has a right to redistributed goods and to measure out the level of compensation whenever these factors are not explicitly written into the rights. Discretionary decisions about individual needs are also, at this level, subject to the requirement of equal treatment of what would, if individual cases were compared, be considered equal sets of relevant conditions that constitute the same need. According to the first principle of a democratic welfare state requiring that people are treated equally to maintain their moral standing as equals, it follows that discretionary judgments about individual needs will also be subjected to the principle of reproducibility. This means that in order to ensure equal treatment of equal cases, discretionary judgment should be used so that others would be expected to come to the same conclusion and equal cases across the population would be identified and treated equally by the judgment of different street-level bureaucrats. As I will discuss below, this requirement is unlikely to be met because of what Rawls has called the 'burdens of judgment'. Nevertheless, it remains a normative context of judgment within the structure of a democratic welfare state. So to summarise so far, the first principle of a democratic welfare state implies that discretionary judgment works within the normative contexts of judgment requiring equal treatment of similar cases and, implicitly, the reproducibility of individual judgments.

Further, the second principle of a democratic welfare state (II) stresses the individuals' right to set their own ends freely and endorse their own values. This must be compatible with an understanding of individual need. Individual needs will partly be created by the person acknowledging their situation as constituting a need. This depends on the ends they have set and the values they hold. It follows that those empowered with discretion to make decisions about people's needs must also exercise their judgment under the constraining principle of individualisation. Individual conditions might occur in infinite combinations so that a condition which appear disadvantageous for one person might very well be unimportant to another person even when it is present in his or her situation. Needs (for compensation) cannot in general be adequately determined prior to assessment of the whole situation and predefining single conditions as disadvantageous might lead to mistakes. The principle of individualisation constrains the discretionary judgment of street-level bureaucrats in that they must identify the needs in accordance with the particular situation of their clients.

Finally, we must consider the third principle of a democratic welfare state (III) which tells us that individuals involved in developing political distributive institutions are subject to the requirements of fairness when they reflect over and endorse the ends or goals of their actions. Street-level bureaucrats who are supposed to realise the democratic principles for fair distribution will also be subject to this requirement when they exercise discretionary judgment in the absence of explicit authoritative rules. When someone is acting on behalf of the state's authority, he or she is still responsible for maintaining fair distribution even where there are no principle-based rules to lean upon. For street-level bureaucrats working in a democratic welfare state, this means that they are already within a normative context of judgment that calls for fairness based on principles I-III. They are, by implication, also in the *normative contexts of judgment* derived from the *principles*, namely contexts that call for equal treatment, reproducibility and individualisation. Fair judgments, then, involve balancing the different requirements according to what the particular situations call for.

### **The internal structure of fairness within a democratic welfare state**

As we saw above, Dworkin referred to a standard of fairness according to which it could be relevant to criticise people “when the acts are within the centre rather than beyond the perimeter of the doughnut of special authority” (Dworkin 1978, p 33). Now, we have established the connection between this standard of fairness and the normative contexts of judgment discussed by Grimen and Molander. This connection hinges on a trade-off between interpretations of how equal moral standing should affect general principles for distribution (welfare egalitarianism versus resource egalitarianism), resulting in particular principles for a democratic welfare state. My point here is that a substantive standard of fairness frames judgments at this superior level of a state regime, but as we will now see, a new substantive standard of fairness is also called for *within* the particular organisation of a democratic welfare state. The need to make new substantive trade-offs in the interpretation of equality reappears as a result of the tension between the normative context of judgment calling for equal treatment and the normative context of judgment calling for individualisation. This conflict occurs at the level of policy-making within a democratic welfare state, when it is decided whether distribution would be carried out most fairly by using strict rules or by delegating discretion. In the first case, *equal* treatment based on specified conditions will be ensured. In the other case, a better targeted individualisation of interpreted needs might be the result of discretionary considerations but at the expense of less equal treatment across the

population. This would be expected because of the burdens of judgment that undermine the reproducibility of discretionary judgments (I will soon elaborate more on this point). Deciding on policies to deal with this conflict, involves trade-offs corresponding to interpretations of which practical policy of redistribution (discretion or rules) is the most feasible way to ensure the standing of individuals as moral equals. The justification of this trade-off will be related to the particular good that is to be distributed as well as a clearly defined aim the distribution is intended to achieve. At this point, however, we should note that derived standards of fairness will be based on new trade-offs that must be made at the level of policy-making, where the aim is to realise the formal principles of fairness in a world where different kinds of need require compensation.

### **Interpretations of ‘need’**

The requirement of fairness in discretionary judgment has several implications. Practically, it means that those empowered with discretion must ideally understand the formal principles for distribution which constitute the basic institution of the state as well as the derived normative contexts of judgment which constrain the actual distribution. These form the background for making discretionary judgments about *fair distribution*. But the normative contexts of judgment constituting the idea of fairness would not be of much help without knowing the specific aim of the distribution of the good in question. Those who assess needs on behalf of the state must be able to answer: What is the objective of this distribution? This question implies i) an answer to why is *this* good a good for organised distribution. But it also involves ii) an interpretation of what actually constitutes a *need* for this particular good. The concept of ‘need’ might be interpreted in different ways. For instance, if a good is very scarce, ‘needs’ might be considered comparatively so that those with the lowest level of welfare will be considered in greatest need. Alternatively, ‘needs’ might be considered in relation to who has the greatest potential to benefit or the greatest increment in welfare (Elster 1992). Resources might be distributed quite differently depending on how ‘need’ is interpreted.

If a distribution of a given good is supposed to be fair, the aims of the distribution, as it relates to a given interpretation of ‘need’, should be clarified on a political level so that interpretations of need for that good can be based on equal treatment of citizens. However, predefined needs cannot always handle cases of inequalities that call for interpretation under the requirement of individualisation, as would often be the case in health care. We will

continue to consider the internal structure of fairness all the way throughout the organised state. Briefly, we will now prepare for considerations about fairness in relation to the judgment of street-level bureaucrats by looking into a model of the conditions that trigger individual judgment.

### **A general model of judgment**

Grimen and Molander make use of Toulmin's model of general argumentation to get a grip on the general contexts that trigger judgment (Toulmin 2003). Their assumption is that exercising judgment should be understood in accordance with how practical reasoning is carried out in general. Practical reasoning is reasoning about how one should act in a given situation. To put it briefly, practical reasoning involves data about the concrete context one is about to act upon, and 'warrants' or norms that justify the conclusions reached about what to do. The 'warrants' might be of different kinds. They might be *norms of duty* pointing out what one has to do in certain circumstances. They might be *instrumental norms* telling us what to do if we want to achieve a certain goal, and they might be *teleological norms* that require us to strive for a certain goal by finding the appropriate means. Taken together, the descriptions (data) of the situation and the norm are our reasons for acting. These reasons might themselves need to be subject to justification that calls for new warrants. The warrants used to justify a description of a context (so that the decision about what to do can be related to that context), are called rules of identification. The norm that justifies an action might also be justified. This happens by arguing that the norm is valid, that is, by arguing that it ought to be applied, or by arguing for its compliance with the situation in question. Against this background, Grimen and Molander conclude that on the presumption that warrants present themselves with various degree of strength that can be arranged on a continuum, judgment is most at play in those situations where the warrants are the weakest. Weak warrants are the causes of uncertainty about the actions different situations call for. Judgment is required to bring the situation to a practical conclusion (that is action, on the assumption there exists no weakness of the will) by bringing this indeterminacy to an end.

### **Discretionary judgment and individual needs for compensation**

When it is considered fair on an institutional level to allow distribution by using the discretion of street level bureaucrats (thereby avoiding pre-defined needs handled by applying specific



rules) the political aim of the distribution is formulated vaguely precisely so that individual adjustments can be made. As we saw above, judgment is typically called for in order to fill out indeterminacy in *teleological* reasoning (Grimen and Molander 2008). Those empowered with discretion to make individually adjusted redistributions within a democratic welfare state, are required to exercise judgment to bring to an end the indeterminacy of both the aim and the appropriate means when they are considering the conditions of particular cases. This illuminates the core structure of interpreting needs. Interpreting needs presupposes an understanding of: the aim of the good in question, specific occupational knowledge about means that accord with the good, and information about specific cases under consideration. The aim of the good forms the basis for the *relevancy* of the case and the means or action required.

The ambiguity of a formal interpretation of ‘need’ might cause different interpretations of what there actually is a need for in a particular case. If it were possible to decide at an institutional level which formal interpretation of need street-level bureaucrats are supposed to comply with, would equal treatment across the population then be expected? Because of the requirement of individualisation, judgment is needed to decide about what is an *acceptable level of welfare* and what *increment of improvement* should be reached for particular clients. This kind of assessment might be given some objectivity or inter-subjectivity if they are based on practice developed by tradition or consensus among the members of an occupational collective. Nevertheless, the aspect of fairness with regard to the requirement of reproducibility will only reach as wide as the community of shared practice. Thereby, the requirement of equal treatment is only partly ensured in the whole population. Let us now consider how street-level bureaucrat’s judgments about *acceptable levels of welfare* and *increment of improvement* needed might come about.

### **Conditions for interpreting individual needs**

When fair distribution is carried out, it is left to those empowered with discretion to reflect over the aim of the distribution when they are facing individual cases. A need for a distributed good can be defined as a condition-treatment pairing (Hasman, Hope et al. 2006). The interpretation of the aim of distribution must be fair in the sense that what is seen as ‘appropriate means’, i.e., what is needed, is subjected to the formal political conception of fairness allowing for equal treatment, reproducibility and individualisation. This indicates that

the aim of the distribution and the potential, available means in a given situation might affect each other reciprocally which again affects what comes out as a considered need in a particular context. The fact that the aim of distribution has been vaguely formulated higher in the process and that potential means are already known as occupational knowledge, allows for balancing a condition-treatment pairing which constitutes a need for a certain good under the requirement of fairness. How can “balancing a condition-treatment pairing which constitutes a need under the requirement of fairness” be brought about? To clarify this, we will consider the method of reflective equilibrium and the idea of the reasonable versus the rational.

### **Reflective equilibrium**

The method of reflective equilibrium has been considered both as a philosophical and as a more general method of epistemology (Daniels 1996; Daniels 2003). Rawls made use of the method in a philosophical sense when he discussed how people could be expected to agree on a set of principles of justice (Rawls 1971; Rawls 1993). The same methodological principles are well suited to describe how we justify and establish our beliefs as individuals in general. N. Daniels states that searching for a reflective equilibrium is an everyday practice we all engage in when we reflect over and revise our beliefs (Daniels 2003). The search for a reflective equilibrium is more precisely described as a search for coherence between considered judgments about particular situations (i.e. our ‘intuitions’), beliefs about the principles we use to govern our judgments and the theories we assume make these principles acceptable. Because of the influence of Rawls’ theory about justice, the method has been attributed particularly to works in ethics and political theory although, in initial works, it was considered appropriate for justifying logical principles (Daniels 2003).

A crucial feature of the method is that reflective equilibrium “...includes our considered convictions at all levels of generality; no one level, say that of abstract principle or that of particular judgments in particular cases, is viewed as foundational. They all may have an initial credibility” (Rawls 1993, footnote 8, p 8). In this way the method distinguishes itself from theories which presume that the direction of justification moves downwards with “ready-made” principles being applied to particular situations. It is also different from views which assume that the direction of justification is upwards, from particular situations into principles, represented by theories such as particularism and casuistry (Toulmin 1981; Jonsen

1991; Callahan 2000). However, this does not mean that reflective equilibrium rejects these two distinct structures of justification; rather that it encompasses them both. The method of reflective equilibrium allows justification to run along and across different levels of justifying generality represented by judgment, principles and theories, with the aim of achieving *coherence* in all (relevant) beliefs. By ending up with a coherent system, we will not only have achieved consistency between our beliefs, but they will mutually support and explain each other.

There is an important distinction between *narrow* and *wide reflective equilibrium* (Daniels 1996). *Narrow equilibrium* describes the process when particular moral judgments about a particular situation are justified according to moral standards and vice versa. Moral judgment about particular situations might challenge a moral standard which has been applied quite adequately in other similar situations, thereby leading to revision of the standard. Likewise, consultation of moral standards might affect moral judgments which initially seemed intuitive. Starting out with a considered judgment, which is a judgment we initially feel intuitively convinced by, we seek confirmation in the principles or rules we believe support the judgment. Working back and forth between judgments and principles, we search for coherence between our particular and our more general beliefs, yet we might ask: Why should we accept the exact pairing of reciprocally affirming judgment and principle we end up with? We need further support for our beliefs and this can be found in various theories, moral as well as non-moral, which bring a higher level of generality into our justifying process. When we obtain coherence between all the judgments, principles and theories we have considered, we have brought our reflection into a *wide reflective equilibrium*.

This method goes for anyone trying to ensure solid ground for his or her normative beliefs and this, of course, includes street-level bureaucrats. The bureaucrat, however, are also subject to the requirement of maintaining the assumed fair principles of a democratic welfare state in the way they consider and meet inequalities while distributing a common good. Is there anything more that can be said about how *best calculated judgment* of those empowered with discretion should be constrained in this regard?

To explore this issue further, I will present Rawls' distinction between a rational and a reasonable person and his concept of 'the burden of judgment'. I also introduce Scanlon's idea of a *reasonable person* in order to map more adequately the normative constraints on

individual discretionary judgment. Against this background, I sum up the hierarchy of levels of justification which might explain individual judgments as *best calculated*.

### **Rawls on the rational and the first basic aspect of the reasonable**

Rawls bases his distinction between the rational and the reasonable on W.M. Sibley's work about these concepts. (Sibley 1953) A *rational* person deliberates over his or hers own ends, interests and life-plans, their priority and how to achieve them. The ends might be selected and ordered in many different ways and are not necessarily only of benefit to the self. They might well also concern the well-being of others. Even so, the solely rational person is distinguished from a *reasonable* one, by the lack of "*the particular form of moral sensibility that underlies the desire to engage in fair cooperation as such and to do so on terms that others as equals might reasonably be expected to endorse*" (Rawls 1993, p 51). The reasonable person will be a rational person, but is also characteristically moved to "...*desire for its own sake a social world in which they, as free and equal, can cooperate with others on terms all can accept*" (Rawls 1993, p 50). Rawls does not take this particular willingness of the reasonable person to be all that there is to moral sensibility. However, he takes moral sensibility to include the part about fair social cooperation (Rawls 1993). Moved by this particular sense of justice, reasonable people, among equals, "... *are ready to propose principles and standards as fair terms of cooperation and to abide by them willingly, given the assurance that others will likewise do so. The norms they view as reasonable for everyone to accept and therefore as justifiable to them: and they are ready to discuss the fair terms that others propose.*" (Rawls 1993, p 49). In more concrete terms, reasonable people take into account the effects of their actions on other people's well-being. It also follows that we enter the public world and engage in social relations as 'reasonable people' by proposing or accepting fair terms of cooperation with others.

So far we have considered one basic aspect of the reasonable, but Rawls emphasises that reasonable must also be understood in another way. This is related to Rawls's specific aim of discussing the conditions necessary for deliberating legitimate institutions based on the idea of justice understood as fairness. Briefly, justice with regard to the construction of basic institutions is not arrived at simply by applying what might appear (for someone) to be an appropriate principle. Just institutions are based on principles arrived at by processes of collective deliberation by reasonable people.

## **The burdens of judgment**

We have considered the particular motivation to engage in fair cooperation, but why should we believe this willingness would be all we need for reasonable persons to agree on matters of the state's constitution? Empirically, we find no evidence to justify such an expectation, rather the contrary. Disagreement about the deepest held values of reasonable people appears inevitable. The second aspect of the reasonable links to the recognition of this fact which is due to what Rawls calls the *burdens of judgment*. Let us briefly look into his account of these burdens as well as his account of *reasonable comprehensive doctrines* before presenting this second aspect.

The 'burdens of judgment' refers to the sources that may cause disagreement between reasonable persons. Reasonable persons are assumed to share a common human reason that enables them to "*draw inferences, weigh evidence, and balance competing considerations*", but the many hazards involved in the exercise of reason and judgment lead individuals to arrive at different reasonable conclusions (Rawls 1993, p 55). Rawls points out the six most obvious sources that might cause disagreement. These are; the difficulty of assessing complex empirical and scientific cases, the weighting of relevant considerations, the vagueness of concepts that imply exercise of judgment and interpretation might differ between reasonable people, the way assessment of evidence and weighting of values are, to some extent, shaped by individual experience, the difficulty in making an overall assessment when there are normative considerations of different force on both sides of an issue, and finally, the difficulty of setting priorities and making adjustments when one has to select between different values within systems of social institutions that cannot realise every cherished value (Rawls 1993, pp 56-7). Because of the burdens of judgment, pluralism of philosophical, moral and religious views cannot be avoided and deep substantive disagreements concerning these kinds of issues are to be expected.

## **Reasonable comprehensive doctrines**

Rawls uses the term *reasonable comprehensive doctrines* to describe the views held by reasonable people (Rawls 1993, p 59). Reasonable comprehensive doctrines are characterised by three main features: 1) They can be considered an exercise of theoretical reason in that they organise and characterise "...recognized values so that they are compatible with one another and express an intelligible view of the world" covering the religious, philosophical

and moral aspects of human life in a more or less consistent and coherent manner. 2) They are considered an exercise of practical reason in that they enable the reasonable person to distinguish between salient and less important values as well as balancing values when these are brought into conflict. 3) Reasonable comprehensive doctrines draw upon traditions and therefore possess some stability over time. They are not fixed doctrines, but there must be good reasons for the doctrines to change.

## **Second aspect of the reasonable**

Against this background of burdens of judgment and reasonable comprehensive doctrines, Rawls identifies the second basic aspect of the reasonable as "...the willingness to recognise the burdens of judgment and to accept their consequences for the use of public reason in directing the legitimate exercise of political power in a constitutional regime." (Rawls 1993, p 54). So a reasonable person is not only driven by a moral sense of justice to propose fair principles on the assumption that they are principles that anyone could endorse. A reasonable person is also willing to subject himself to the political principles arrived at by collective deliberation on the recognition that other people might hold different, but equally reasonable views. However, such a unifying political basis for a state does not require agreement on a comprehensive doctrine. That would be unreasonable in the light of the burdens of judgment (Rawls 1993). According to Rawls, there will be particular political principles concerning the basic institutions of a society, which might be agreed upon and justified according to different, incompatible comprehensive views. He sees the area of potential agreement between different comprehensive doctrines as the field where various comprehensive doctrines overlap each other. This *overlapping consensus* represents the goal for reasonable agreement about political principles. The reasonable political principles shared by people who have different moral and religious views are justified in accordance with divergent rationales constituted by opposing comprehensive views. Rawls considers overlapping consensus to be a precondition for stability. Stability of a democratic welfare state, for instance, requires that its political constitution can be the focus of an overlapping consensus of reasonable doctrines supporting the constitutional regime.

Leaving aside for a moment the epistemological consequences of being a reasonable person, I now consider the particular motivation this characteristic implies for a street-level bureaucrat.

## Reasonable street-level bureaucrat: Motivational aspects

First, we must recognise that whether street-level bureaucrats act as reasonable people is an issue that we can only try to affirm or deny empirically. Here, my concern is ideal theory and I will first question whether street-level bureaucrats ideally should be expected to be reasonable in one, both or none of the aspects outlined above. Here we must remember that discretion in this setting is delegated authority to determine individual needs for economic or social compensation (including health care) in order to maintain the idea of people as moral equals within a structured organisation of basic institutions, which are assumed to be fair. As I have tried to show, their discretionary judgment is situated in the normative contexts derived from the (assumed) fair principles which constitute a democratic welfare state. This, of course, does not guarantee that the street-level bureaucrats' are aware of these constraints. However, street-level bureaucrats educated to deal with specific distributional tasks would be expected to act under these requirements in some form as the result of a socialisation process running through their education and working experience. But again, ideally, how should we expect those empowered with discretion to be motivated to act in a way that maintains fair distribution?

In my approach here, I have considered discretionary judgment within a state based on fair principles concerning rights and liberties and I have then considered the general normative contexts of judgment these principles imply. With regard to the assessment of needs by street-level bureaucrats, I have not discussed the issues of substantive interpretations of which inequalities ought to be to be compensated for or how compensation should be carried out in order to be fair. These issues concern distributive justice, and in accordance with my exposition so far, I take the derived *general* normative contexts of judgment to frame the fairness of these distributive principles within a democratic welfare state. Considered in this way, if street-level bureaucrats enjoy vast discretionary freedom in determining needs for compensation, their decisions should hinge upon some substantive principles of distributive justice. These principles thereby play a crucial role in how the distribution is actually carried out and they cannot be considered a matter for street-level bureaucrats' private opinions. They must be of the kind that any reasonable person would be willing to propose on the basis that all other reasonable people would accept it. This is how principles become fair. Interestingly, Rawls comments that it is possible to hold reasonable views without being reasonable oneself. In other words, a street-level bureaucrat might act on fair principles without being concerned

about the social implications of so acting. However, I will claim that in order to become a *competent* street-level bureaucrat who lives up to the delegated responsibility of discretion, one must be expected to distribute fairly because one desires to do so, from case to case, not because one, by coincidence, happens to do so. So the first aspect of the reasonable, that is the distinct moral sense of justice, seems to characterise our *ideal* street-level bureaucrat.

Moreover, the second aspect seems to be required as well. In order to distribute fairly, the street-level bureaucrat must be willing to recognise that others might hold equally well justified comprehensive views, and public reason is called for to settle the basic principles by over-lapping consensus. Street-level bureaucrats are supposed to subject their action to this legitimate political power. This must involve forming their concepts of distributive justice when exercising discretionary judgment in accordance with the normative contexts of judgment derived from the legitimate basic principles. In order to try to map the terrain of motivation more adequately, let us briefly look into the idea of reasonableness as regarded by T. M. Scanlon.

### **Scanlon about reasonable**

Scanlon shares Rawls' idea about identifying the core structure of reasonable judgment in the willingness of the deliberator to provide justification that is acceptable to others who share the same aim of justification. Scanlon, however, has a different agenda. He applies 'reasonableness' in order to clarify the normative and motivational force of judgments about right and wrong. He holds the view that: "...*thinking about right and wrong is, at the most basic level, thinking about what could be justified to others on grounds that they, if appropriately motivated, could not reasonably reject.*" (Scanlon 1998, p 5). His theory concerns the part of morality "...*having to do with our duties to other people, including such things as requirements to aid them, and prohibitions against harming, killing, coercion, and deception*". (Scanlon 1998, p 6). Reasonable judgments are judgments "*about the suitability of certain principles to serve as the basis of mutual recognition and accommodation*" which expose the moral content of these judgment (Scanlon 1998, p 194). Scanlon has adopted the phrase "what we owe to each other" to label the part of morality he has in mind. He explains the special authority of requirements of justifiability to others by showing that this idea is involved in our relations with each other in aspects of life that matter to us. In this way, 'reasonableness' on Scanlon's account relates both to an appropriate way of justifying a



course of action and to the accompanying motivating reasons that emerge out of ‘what we owe to each other’. He does not only provide us with a psychological principle of motivation, but he also offers an answer to the fundamental question why anyone should care about morality at all. According to Rawls, his own two aspects of the reasonable can be seen as closely connected with Scanlon’s principle of moral motivation although he does not elaborate on this connection (Rawls 1993 footnote 2, p 49).

### **In between Rawls’ and Scanlon’s differently motivated calls for reasonableness**

The focus of Rawls’s account is how to reach fair decisions about basic political institutions of an organised state. He seems to take the motivation of reasonable persons to care about fair cooperation as a given, uncontested pre-condition. Scanlon’s project covers a wide field of morality constituted by judgments about right and wrong when he provides an account that connects the proper justification for moral distinctions between right and wrong with the required motivation of people who try to act morally successfully. People empowered with the discretion to decide on claims from other individuals within an organised democratic welfare state, will have to respond to the call for reasonableness as found in both Rawls’ and Scanlon’s theories. As agents who contribute to maintaining the political institutions of fair distribution, they must respond to the requirements of reasonableness in terms of reflecting on aggregated concerns appropriate to institutional models. This way of thinking corresponds to the way *reasonableness* was laid out by Rawls. Their moral equal standing with specific others whose needs they have to consider and whose share of the distribution they must claim, calls for *reasonableness* corresponding to the moral motivation Scanlon defends; reasonableness emerges from relations humans are involved in. Caught in between these slightly different demands for reasonable decision-making, those empowered with discretion will have to make their judgments according to constraints of reasonableness that potentially do not to coincide. This point about the different structural directions of justification can be yet another way to explain the conflicting demands street-level bureaucrats are working under.

## Reasonable street-level bureaucrat: Epistemological implications

What are the epistemological implications that can be drawn from both Rawls' and Scanlon's accounts for reasonable persons? On the assumption that street-level bureaucrats are reasonable people both in the moral and the political sense, we can now consider how we should expect them to justify others individual needs according to the idea of reflective equilibrium. We may do so by looking into what appears as a hierarchy of justification.

First, we must recognise the theoretical possibility that discretionary judgments might be *completely arbitrary* in the sense of being disconnected from any reflection of normative requirements at all. In that case, the judgment might represent what someone 'felt to be right', or 'the way one is used to consider such cases'. This sense of arbitrariness can be distinguished from the sense in which judgments will be *inherently arbitrary*. Because of the burdens of judgment, different reasonable individuals may hold different reasonable views. Holding *completely arbitrary judgments* indicates that the person in question has not reflected over their reasons for acting in certain ways. Contrarily, if someone holds *inherently arbitrary judgments* reflection would have taken place. Inherently arbitrary judgments can be presented in two categories. In the first version, the person who is about to make a decision is *rational* in that he or she just sets an end for what he or she wants to obtain by performing the distribution and chooses means accordingly when considering particular cases. Another alternative is that he or she is *reasonable* (which does not prevent him or her from acting rationally) by striving to fulfil the goal of distribution in a way that other reasonable people, people who share the same aim for justification of their views, find acceptable. While a rational person will only justify their decisions according to a goal they set for themselves, reasonable people will have to understand this goal for the decision-making in terms they would expect other reasonable people to agree on. The outcome of different rational people's judgments about who should get which goods must be expected to vary if they all were to judge the same case. This would not come as any surprise. But the same will also be true of reasonable people's judgments about a particular case because of what Rawls referred to as 'the burdens of judgment'. So although the considerations lead to what the decision-maker considers to be a reasonable view, it is still arbitrary but in an inherent sense. It is arbitrary in a way that cannot be avoided despite the means as well as the aim being well justified.

Considered hierarchically, we can distinguish from the bottom up between discretionary judgments that are completely arbitrary, those which are simply rational and those which are reasonable. However, this last category of reasonable judgments can be divided into two sub-groups as they might be reasonable in a theoretical sense or in an empirical sense. A street-level bureaucrat might believe he or she holds a reasonable view on what to distribute. But whether other reasonable people would actually consider the reasons provided for the concrete distribution as fair, might be questioned. This is not only because burdens of judgment might entail reasonable disagreement. It might also be that the street-level bureaucrat while believing him or herself to be reasonable, has stopped the process of reflection too soon. The street-level bureaucrat may mistakenly believe that when there is established coherence between the moral judgment about what to do in the concrete case and a principle (narrow reflective equilibrium) even also background theory (wide reflective equilibrium), the grounds for the proposed action are reasonable. The problem is that it would take a certain capacity to ‘draw oneself up by the hair’ to get an overall view of all the competing principles and theories that could potentially have initiated revision of the judgment by the street-level bureaucrat. Considered in this way, an assumption about the reasonableness of one’s own judgment when deliberating alone would either mean 1) one has an unjustified belief that others as a matter of fact will accept the reasons grounding the proposed action, or simply 2) one believes one has well justified reasons for the proposal. Notice that both 1) and 2) are compatible with the moral sense of justice characterising the reasonable.

So in order to test the reasonableness of one’s judgment, that is to find out whether the terms one believes to be fair actually appear so in others’ views as well, the justification process should move towards a wide collective reflective equilibrium, involving the points of view of all concerned by the distribution: that is ultimately the whole society. Thus the reasonable might provide judgments that are reasonable in the sense of appearing fair within a narrow or wide individual deliberation or a wide collective deliberation towards reflective equilibrium. We can now divide the potential justification of street-level bureaucrats’ *reasonable* judgments into three sub-categories of how well the judgment about the particular need is justified.

**Levels of justification**

Below I present the hierarchy of justified judgments with regard to their level of justification. Note that what actually can be demonstrated as fair judgment in the sense of being accepted by all reasonable persons might appear at every level in inverse proportion to being a pure coincidence.

<b>Reasonable Judgments</b>	Collective, wide reflective equilibrium	
	Individual, wide reflective equilibrium	<i>Inherently arbitrary</i>
	Individual, narrow reflective equilibrium	
Rational Judgments		
<i>Completely arbitrary</i>		

By the hierarchy of levels of justification for fair reasons presented here we are left with yet another way to consider the normative meta-regulation of discretionary judgments. In addition to the normative context of judgment this adds new criteria to which discretionary judgment can be evaluated as *best calculated*.

**From formal considerations to substantive compliance**

We can now return to the question above: How can we “balance a condition-treatment pairing which constitutes a need under the requirement of fairness”? When discretionary judgment is called for to determine a need for a certain good, and the goal of the distribution is vaguely articulated, the street-level bureaucrat is left with his or her specific occupational knowledge, experience and habits to decide what it will be fair to offer. Ideally then, we can imagine a process of balancing a condition-treatment pairing that takes place against the background of an individual deliberation towards reflective equilibrium. In this deliberation, beliefs about the need for a certain good (represented as the means to realise the goal) and the goal it self are tested and eventually revised against each other. But the need must also be tested against the general principles of equal treatment, reproducibility and individualisation in order to be justified as fair. Could this treatment be provided to everyone in the same situation? Would the reasons I identify also be reasons my colleagues (with the same education) would stress as the essential reasons? Is this really what this particular person should have? Revising a need might then again result in revision of the presumed goal of distribution. Then, the street-level

bureaucrat should be aware of the various efforts one can make in order to end up with the best justification. Ideally, when deliberating alone one could try to challenge one's own view by testing it against other surrounding judgments, principles and theories. Moreover, if possible, consideration about what would be fair to provide is more likely to come out as reasonable if it is tested against other people's different points of view. So ideally, considerations about fair particular needs should be carried out collectively.

Ideally, this is what "balancing a condition-treatment pairing which constitutes a need under the requirement of fairness" adds up to. This is how fair distribution might be carried out by street-level bureaucrats who imposed acknowledged normative constraints on their own reflection while also being willing to act on their conclusions. This indicates the general structure of a framework for evaluating discretionary judgment.

### ***Summary of the general framework***

So far I have presented a general framework for individual, discretionary judgment, delegated and exercised within a democratic welfare state. I have presumed three general principles derived from the idea of moral, personal and political autonomy. I have deliberately presented these principles broadly enough to cover various theoretical and actual versions of states based on welfare and democracy. Against this background, I posed the question of how calls for individual judgment within the institutionalised structure of a democratic welfare state would be constrained. Considering the distinction between discretion and judgment, I have described how confidence in institutions and trust in individuals enables democracy and targeted welfare distribution and I have considered how accountability is required to maintain these attitudes. Further, I have considered two different approaches to normative meta-regulation of individual discretionary judgments; normative contexts of judgment and levels of justification. These approaches add up to a general framework for evaluating discretionary judgments in terms of fairness.

## **DISTINCT TOPICS AND SPECIFIED FRAMEWORKS**

The specific topics for this study are surrogate decision-making on behalf of patients who have been assessed as not competent to make their own decisions, and just claims on health care put forward by physicians. Against the general account for discretionary judgments, I will now specify these topics separately. First, I account for how a well established practice of surrogate-decision-making based on individual judgment institutionalised in a democratic welfare state raises the question of trustworthy treatment of individuals deprived their moral and political right to make autonomous choices. Secondly, I look closer into the complexity of conditions involved in making just health care claims within a democratic welfare state by discussing the structural frames for trustworthy equitable clinical judgments. This section of particular frameworks leads towards specification of the aims of the articles.

### ***Competence assessment, surrogate decision-making and discretionary judgment***

For decades now, the autonomy of patients has been considered a crucial value to be promoted in health care contexts. The idea of patients' self-governance has been explored and discussed from a varieties of angles; what does the idea involve (Faden and Beauchamp 1986; Beauchamp and Childress 2001), when did respect for patients coincide with respect for autonomy (Lysaught 2004), autonomy and enrolment in research (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research 1979; Emanuel, Wendler et al. 2000; Helsinki-deklarasjonen 2000), the consequences of patient autonomy in physician-patient relationship (Quill and Brody 1996), consequences of patient autonomy on implicit health care rationing (Lauridsen, Norup et al. 2007), how autonomy relates to competence for decision-making (Beauchamp and Childress 2001), and how patient autonomy affects physicians' priority settings (Carlsen and Norheim, 2005).

Patients' autonomy can be described and discussed in quite different ways. It might be considered, in terms as moral autonomy, as personal autonomy and as political autonomy. There is a general moral duty to take care of vulnerable patients in order to treat them as ends in themselves (moral autonomy). This duty also involves respecting their capacity to set ends

for themselves and derive opinions about their own best interest (moral and personal autonomy). And finally, patients are also citizens with political rights and obligations (political autonomy).

The most debated issue concerning patient autonomy is probably informed consent. Interestingly, the practice of requiring consent from a patient might be justified by both moral and personal versions of autonomy and this can perhaps explain the indubitable attractiveness of this practice. The practice sustains moral autonomy in that people are respected by being treated as ends in themselves and not subjected to the physicians' concepts of the patients' best interest. Furthermore, requiring consent is a way to respect personal autonomy by leaving the health care decision to rest on individuals' concepts of their own best interest. And finally, the requirement of patient consent is, when institutionalised, a way to demonstrate patients' political group power versus the political group power of health care workers as it sets boundaries to potential coercion in terms of patient rights.

Considered as ideal theory, it is hard to find arguments against requiring patient's consent for health care treatment. However, challenges arise as soon as ideal theory is to be put into practice in specific settings of individual health care distribution. We can question whether patients who sign a consent formula or affirm by a nod, really are individuals freely considering their own best. Is it even obvious *what* they are actually consenting to? Do they consent to the unpredictable consequences of the health care interventions such as irritating or even dangerous side effects? What does informed consent actually amount to (O'Neill 2002; O'Neill 2003)?

Despite the conspicuous attention paid to ensuring patients' consent to health care treatment, the many obscurities attached to the practice have led to doubts about the true value of consent as it is currently practised (Schneider 1998; O'Neill 2002). O'Neill seems to conclude that the only effect of the consent procedure (although this in itself is an important aspect) is to provide some protection against misuse and exploitation since the procedure allows the patient to refuse suggested treatment (O'Neill 2002). Furthermore, the practice can be seen as in conflict with at least the concept of moral autonomy. Someone might use their right to deny health care and this is a decision to be respected no matter what the resulting condition for the patient. For others, witnessing the patient's preventable suffering, the ideal of promoting personal autonomy by denying treatment could be seen to be at odds with the ideal of moral

autonomy requiring of us to help others by treating them as ends in themselves. This would not be seen as a real conflict if the denial was an expression of the patient's genuine personal autonomy. But given all the obscurity involved in the consent process, there are times when there could rightfully be reason to doubt whether the person in question is actually realising his or her personal autonomy by refusing treatment. In such cases, the two concepts of autonomy are brought into conflict by a practice mainly designed to maintain personal autonomy.

We can see that personal autonomy seems to have the strongest standing of the autonomy concepts potentially involved in patient autonomy, by the way the requirement for consent structures the way *all* patients are treated. All adult patients are treated as if they possess the necessary personal autonomy to make their own qualified decisions about their own health care, until there are reasons to doubt their capacity for doing so (Buchanan and Brock 1990). Logically, it then follows that they need to have their capacity assessed before actions are taken on the basis of their expressed preferences. If they are assessed not competent to make autonomous decisions, whether they consent or not to an intervention no longer matters. At this point, the concept of moral autonomy supports institutionalised practice in the appointment of surrogate decision-makers. Surrogate decision-makers are supposed to ensure that the patient's best interests are maintained. In one view, this represents a way to place the moral responsibility for the incompetent's well-being with someone, thus, protecting the patient's right to be treated as an end in themselves when at their most vulnerable. In another view, by appointing a surrogate decision-maker who knew the patient when they were competent, one might argue that the personal autonomy of the patient is extended. The patients- self-determination can be seen as extended by decisions which rest on assumptions about what the patient would have valued if still competent. This type of substitute judgment has been heavily criticised for being speculative and based purely on hypothetical thinking (Buchanan and Brock 1990). Nevertheless, there is little debate that any standard of best interest should involve considerations about what the formerly competent patient *used to value* (Brock 1996). In this way, the ideal of personal autonomy is carried on into the care of those assessed to be incompetent.



## **O'Neill about the triumph of personal autonomy in health care**

O'Neill criticises the triumph of what she calls the Principle of Individual Autonomy (what I call 'personal autonomy') in contemporary bioethics for undermining rather than fostering trustworthy professional performance (O'Neill 2002). O'Neill argues that in practice the Principle of Individual Autonomy amounts to no more than a requirement for informed consent. By requiring the patient's consent to medical interventions, the idea of patients making autonomous choices is considered to be 'attended to' no matter what the Principle of Individual Autonomy actually involves. Hence, in its most modest form, the Principle of Individual Autonomy is equivalent to giving informed consent. O'Neill considers this principle unable to bear the ethics of biomedicine. Instead she introduces Principled Autonomy (moral autonomy), a principle based on a Kantian concept of autonomy. In short, Principled Autonomy is considered to be "a non-derivative, fundamental requirement on thought and action" (O'Neill 2002, p 94), which implies that "we act only on principles that can be principles for all; it provides a basis for an account of the underlying principles for universal obligations and rights that can structure relationships between agents" (O'Neill 2002, p 96). "Autonomy in action is no more - but also no less - than the attempt to act on principles on which all others could act" (O'Neill 2002, p 94). Principles that are of major importance in bioethics such as rejecting and avoiding coercion and deception, exemplify such basic principles of morality. In bioethics, as in everyday life, O'Neill stresses the task of "identifying ways to live up to these principles in actual circumstances" but doubts that any timeless account can be provided of "the more narrowly specified human rights and human obligations that would express and implement these principles, or of specific institutional structures needed to realise these rights and obligations at all times and all places" (O'Neill 2002, p 95). By re-thinking autonomy as Principled Autonomy, she points out how the practice of informed consent must be bolstered by the health care workers acting trustworthily in health care contexts according to the demands of the basic moral principles.

Those who have commented on O'Neill's writings about the need for re-establishing trust (she seems to use 'trust' primarily in the sense of 'confidence') in bioethics, seem to be occupied with details in her interpretation of the Kantian argument for Principled autonomy (Wilson 2007), the practical implications of this way of rethinking autonomy in clinical practice (Stirrat and Gill 2005) and the role of trust in health care (Hall 2005). In my reading, O'Neill has made an important theoretical move back to the institutional level where the ideal

requirement for consent has been transformed into the *policy* of requiring informed consent. By picking up the Kantian version of moral autonomy, she tries to re-establish one of the ideal principles which underlie the initial requirement for institutionalising consent. This principle was lost in the translation of the ideal theory of consent into practice. According to the established practice of requiring consent and assessing competence, the concept of moral autonomy reoccurs in an ad hoc way when there is no more consent to give. It is called for to justify decent treatment of those without the capacity to enact personal autonomy. O'Neill puts the concept of moral autonomy back on a level with the concept of personal autonomy, seeing both as fundamental principles on which all institutionalised health care should be based.

The ethics following from Principled Autonomy are supposed to have an effect on how competent patients are treated, supporting trust in individuals and, according to the distinction made above, confidence in the institutions. By institutionalising the dictums that can be derived from the concept of moral autonomy, we ought to be able to trust that even if the practice of informed consent should fail in realising its intended ideals, there is a security net in place to ensure proper treatment. Is there anything in this groundwork of bioethics that would affect the way individuals who lack the ability to enact their personal autonomy are treated? My hypothesis is that a realisation of O'Neill's suggestion would not leave us with any *new* reasons to trust that we will respectfully be taken care of if we lose our competence to make autonomous choices. This is not because of deficiencies of O'Neill's account. Rather, it is because of the way competence is assessed and the practice of delegating discretion to surrogate decision-making, which can be shown to be in conflict with the idea of respectful treatment derived from the concept of moral autonomy. Consequently, it can be argued that the established way of treating individuals who lack decision-making competence conflicts with both versions of personal and moral autonomy which constitute a democratic welfare state. In Article I, I explore why I think this is so. Moreover, when discussing the results of the line of reasoning in this article below, I will clarify how the policy I suggest to meet this challenge can be considered a substantive realisation of the general framework for delegated discretion accounted for above.

## ***Fair distribution of health care, accountability and discretionary judgments***

We saw above that physicians could be considered as street-level bureaucrats with the delegated authority to meet individual needs within the public distribution of health care. How can these kinds of needs be met fairly by physicians exercising discretionary judgment? Furthermore, if we were to be able to trust that they act fairly; what would be required?

Distribution of health care within an organised society involves various levels of decision-making. First, at a superior level of state constitution, one must agree whether health care is a social good that should be distributed fairly by the state (Daniels 1985; Sen 2002). The concrete organisation of health care within a state is affected by the priority given to health care versus other social goods. In the following, I will assume that health care is considered an important social good to be distributed by a democratic welfare state of the type set out in the introduction. The level underneath, the macro-level, is the level for public health care decisions carried out by government and health authorities. Then there is the meso-level where local decisions concerning regional management, hospitals and community services are taken. And finally, health care decisions are carried out at the micro-level, which is the clinical level where consultations between patient and health care workers take place. With regards to resource allocation, these decisions are framed by the decisions at the upper levels. However, doctors, especially, have traditionally enjoyed a great amount of discretionary freedom (Freidson 1988) This goes in particular for general practitioners who often work outside management without the same constraints as in organised care units such as hospitals. In addition, their field of practice, primary care, is complex. It often involves considering needs based on ambiguous and sometimes composite conditions that have to be untangled in order to provide the relevant care. General health care can be characterised as care provided under a great amount of uncertainty as it is the first step in disclosing the conditions which, together with knowledge about available treatment, determine what health care there actually exists a need for. This process of identifying health care needs (including sick notes and specialist referral) calls for discretion in a crucial way. Strictly systematic regulation of this complex discovery process at a higher level of authority would simply not be aligned with effective care.

In the following, I will unite the kinds of health care decisions aimed at patient groups or populations, whether taken by health authorities or local management, into the category 'macro-level decisions'. These decisions are the results of macro-level decision-making which here is also taken to include the meso-level.

So, within this structure of organised public health care in a democratic welfare state, doctors, and especially general practitioners have traditionally been left with discretionary power to decide on individual needs for distributed health care. According to the general framework above discussing formal constraints imposed on discretionary judgments of needs, how can we specify the needs physicians are to consider for distribution?

### **Needs versus health care needs**

In general terms, doctors are supposed to identify the patient's need and then eliminate this need by available and acceptable health care. More precisely, the physicians are expected to:

- 1) diagnose the patient,
- 2) consider treatment which is relevant to the condition
- 3) supply this treatment and
- 4) finally, evaluate the recovery of the patient

But what is a 'need' in this particular context of health? The first step to demarcate this concept, is to relate 'need' to the specific knowledge and available means physicians have that might eliminate or reduce the need, namely knowledge about what kind of health care corresponds to different, identified conditions. 'Need' in health care, subjected to the clinical judgment of physicians, is most conspicuously understood in terms of 'need for health care' since health care is the remedy the physicians have to meet the 'need' with. So, in a clinical setting, when is judgment, or more specifically clinical judgment, acquired?

### **Clinical judgment**

The concept 'clinical judgment' is used with different meanings. It seems to have been understood as the equivalent to a physician's ability to know instinctively the right thing to do', and as 'the state of art' (Eddy 1996, p 323). In contrast to such a ideal, the concept has also been presented as a certain way of obtaining knowledge as opposed to evidence-based

knowledge (Tanenbaum 1993). Moreover, it also seems to designate the kind of reasoning that processes all available evidence and enables the physician to draw conclusions applicable to individual patients (Eddy 1996, p 3). This latter sense of ‘clinical judgment’ would be on a par with the description above of ‘epistemic discretion’ in that the reasoning process discerns right from wrong interventions (Grimen and Molander 2008). However, it is not clear whether clinical judgment in this sense exclusively denotes judgment exercised in relation to bio-technical factors or whether it also involves normative, non-technical considerations in terms of social reasons.

The *need for health care* can be described in terms of a condition-treatment pairing (Hasman, Hope et al. 2006). The same relation between condition and treatment can also be laid out as a hypothetic imperative for medical actions with curative purpose (Grimen and Molander 2008): if x (condition x), then y (treatment y). For instance, if someone has been diagnosed with appendicitis, then remove it by surgery. However, in a clinical context, this relationship can be affected by uncertainty in different ways:

- 1) It is clear what x is, but y is unclear, (this describes cases where the diagnosis is easy to determine, but there is no obvious standard treatment)
- 2) it is unclear what x is, but y is clear (this is cases where diagnosis is hard to identify, but the treatment is conventional)
- 3) it is unclear what both x and y are (this is typically cases where it is hard to establish what exactly is causing the suffering as well as what can be done to alleviate it)
- 4) the relation between x and y is unclear (the connection between x and y must be empirically justified. Although the connection may be supported by statistics, there is always a possibility that y is not the solution to x in this case)

All these kinds of situations call for clinical judgment. In the way presented here, clinical judgment is closely related to the bio-technical potential of curative medicine where the judgment might be assessed by success or failure in improving the patient’s health. However, there are more aspects of judgment involved in considerations about needs for health care than what is captured by the curative condition-treatment model presented here. First, in case 2) even though y is clear there might be several treatments known to be effective but which might vary with regard to costs and side-effects. Then judgment is called for to decide which to offer. Secondly, in the case of preventive medicine, when the condition is clear but treatment unclear, judgment is called for to consider risk factors. But before suggesting any

kind of intervention, the risk factors must be considered in accordance with expected valuable utility in terms of advantages and drawbacks for the patient. Thirdly, the condition-treatment model does not capture the judgment involved in the process of diagnosing the condition. This aspect of judgment is essential in the work of general practitioners and relates to choices of tests and referrals in order to determine the condition-treatment pairing. Fourthly, we could have added a fifth category to Grimen and Molander's list above, namely the alternative where both  $x$  and  $y$  are clear. According to the condition-treatment model, this is probably left out because the model assumes it is clear what is wrong with the patient and it is clear what would be an effective treatment. An uncomplicated fracture must be plastered. There is no need for judgment to state that. But, by leaving this alternative out of the list we miss the opportunity of seeing that judgment is needed to determine whether or not a clear-cut pairing of condition and treatment really is to be considered a need at all. For instance, in the case of a presumed healthy pregnant woman and easily available technology, should examination with ultrasound be considered a health care *need* in spite of there being no signs of complications? In this fundamental way, the discretionary judgment of physicians might underdetermine what *should* count as a health care need. Fifthly, individual judgment also cuts across any condition-treatment scheme in that it transfers general condition-treatment knowledge to particular cases. In doing so they might, (and I add, should), not only consider the bio-technical functioning in isolation but related to the overall well-being of the patient in question. Anything else would conflict with respecting the autonomy based principles of a welfare state. This opens up for letting knowledge of personal information about individuals affect the considerations about their health care need and adds yet another aspect of value-based judgment to the need determination.

So even on a condition-treatment model, judgment does not only work to solve uncertainty about condition or treatment or both. It also works normatively in the way that value based assessments seem intrinsically connected to the whole process of identifying health care needs. (And then we have not even looked into the ways paternalistic considerations might come on the top of the medical considerations, or how explicit priority setting between several different identified health care needs might affect the situation.) I take the term 'clinical judgment' to include all of these technical and normative aspects of judgment involved in determining a need for health care. This is an important point that must be stressed. A too narrow interpretation of 'clinical judgment' in a technical, objective sense might be misused in apparently providing undisputable answers to debateable question about needs. And in

particular, it might mask the aspect of fairness purported by any judgments about health care needs within democratic welfare states.

### **Normative contexts of clinical judgment in a democratic welfare state**

Three normative contexts of judgment were recognised above as general constraints imposed on discretionary judgment of street-level bureaucrats in democratic welfare states. We must consider how the principles of individualisation, reproducibility and equal treatment relate to clinical judgment of health care needs.

On a general level, clinical judgment can be seen as working under the principle of individualisation since health care must be adapted to the particular situation and condition of the individual patient as long as the aim of the care is to make the individual regain his or her health. Clinical judgment is called for to consider the bio-technical and by implication also non-technical issues, that affect the adequate treatment provided. For the bio-technical issues, reproducibility is required with regard to diagnosis. However, as public health care calls for equal treatment of cases that are equal in relevant aspects across the population in order to treat citizens as moral equals, the non-technical reasons are also subject to the principle of reproducibility. Although, as accounted for above, reproducibility of value based judgments might be unobtainable, how could public health care be institutionalised in order to meet these requirements in the best possible way? To approach this question we will first have to consider the overall aim of health care distribution.

### **Social determinants and the aim of health care distribution**

Remember the three general principles I set out as constituents of a democratic welfare state. These were derived from the three versions of autonomy; moral autonomy, personal autonomy and political autonomy. The rationale for providing redistribution of certain goods with regard to specific needs was based on the moral autonomy concept requiring us to treat each other as moral equals in the sense of treating them as ends in themselves. This implies obligations to help those who are worse-off, and enable them to realise their personal autonomy.

On a population level, inequalities in health can be seen as correlating to social factors, or social determinants, such as race, gender and socioeconomic status (Marmot 2004). Inequalities arise not only between, but also within countries (Donkin 2002; Huisman, Kunst et al. 2004; Folkehelseinstituttet 2007). The underlying causes for how socioeconomic positions affect health are embedded in complex social and economic structures of society. Although the exact causes of health disparity among groups of people are hard to find, the correlation between various living and working conditions such as nutrition, stress and unemployment have been documented to affect health status (Wilkinson 2003). Although such correlations have been a concern in public health research for a long time, the ethical issues that arise out of this link between inequality in health, social justice and health equity have not been an issue for exploration until recently (Marchand, Wikler et al. 1998; Daniels, Kennedy et al. 1999; Anand 2004; Ruger 2004; Daniels 2006). Bioethics has primarily been occupied with ethical issues arising in clinical medicine. When bio-ethicists have considered issues of justice or equity, the focus has been on access to health care and the general right to health care. The field of bioethics should broaden its agenda by addressing the impact of social determinants on health and health inequalities (Wikler 1997; Brock 2000).

The acknowledgment of health inequalities should affect what we consider the overall aim of just distribution. If health care is considered essential to promote fair equal opportunity for normal functioning and therefore essential to the idea of justice, inequalities in health caused by social structures and affecting some people's opportunities for normal functioning, are unjust inequalities (Daniels 2007). Not all health inequalities are unjust but those affected by social structures are *health inequities* (Braveman and Gruskin 2003). Health inequities still persist despite equal access to health care, so *access to health care* is only one determinant among several (Marmot 2004). Therefore, *just health* rather than *just health care* should be the overall aim of distribution (Daniels 2007). Acknowledging this aim is to recognise the importance of research into the causal pathways of factors affecting our health as well as the importance of developing effective strategies to reduce the inequitable health inequalities.

It seems widely agreed that major efforts to reduce health inequity must be directed towards 'the causes of the causes' of the observable inequality (St.meld. nr 20 2006-2007; Commission on Social Determinants of Health 2007). Despite the challenge involved in identifying *how* determinants affect the health of individual's, innovative approaches to inequalities in health have been developed in various countries. For example, establishing



policy-steering mechanisms, strategies for protecting the health of employees, affecting health-related behaviour and improving the quality of care as well as territorial approaches to targeting disadvantaged populations (Mackenbach and Bakker 2003). These are all policies which aim to alter the conditions for disadvantaged groups in a population perspective. This population perspective is also central to recent approaches to developing clinical guidelines involving equity concerns (Aldrich, Kemp et al. 2003; Dans, Dans et al. 2007). Such guidelines could be an effective means of reducing health disparities by directly aiming the care provided. Unfortunately, however, physicians in primary care, that is, general practitioners fronting what is usually people's first access to health care services, adhere to guidelines to variable degrees (Carlsen 2007; Rashidian, Eccles et al. 2008). Interestingly, there seems to be a gap in the literature with regard to how *individual discretionary judgment* of physicians *could* or *should* contribute in a coordinate way to reduce health inequities when considering needs for health care. To approach such a suggestion, let us first consider how fair allocation of resources can be carried out at an institutional level.

## **Accountability for Reasonableness**

In order to reduce health disparities, we must expect a variety of strategies to be developed at institutional level to respond the complex causes of social inequalities. These strategies occur as various resource allocations at an institutional level. Broadly defined, 'priority setting' is considered to be "allocation of resources between competing demands", and priority setting is expected to occur "in every health system at the macro-level (national, provincial), meso-level (regional, institutional) and micro-level (clinical programs)" (Kapiriri, Norheim et al. 2007, p 79). This definition is broad enough to involve 'rationing' defined as "the withholding of potentially beneficial health care through financial or organisational features of the health care system in question" (Norheim 1999, p 1426).

Priority setting must address the idea of *fair distribution*. However, because of the burden of judgment, we cannot expect reasonable people to agree on principles for fair distribution. Moreover, priority settings must also be *legitimate*, in that those who make the decision are considered to have the moral authority needed to decide upon the distribution. According to Daniels and Sabin, the question of legitimacy and fairness would most appropriately be posed from the perspective of those who are denied treatment when resources are allocated. From

their perspective, under what conditions would health plans or public authorities legitimately have the moral authority to make limit-setting decisions? And under what conditions would they consider the limit-setting decision sufficiently justified as fair? (Daniels and Sabin 2002) Daniels and Sabin assume legitimacy and fairness connect to each other as follows: “*We may reasonably accept an authority as legitimate only if it abides by a procedure or process or even substantive constraints such as Constitutional protections, that we consider generally fair. If the authority abandons fair procedure, it may lose its legitimacy. Similarly, in contexts where an authority that claims no legitimacy employs a fair procedure, especially, where there may be prior disagreement about what counts as a fair outcome, we may not only accept the outcome as fair.*” (Daniels and Sabin 2002, p 27).

Daniels and Sabin suggest a framework, Accountability for Reasonableness, to ensure that priority settings at the institutional level are fair and legitimate. The conditions set out for this framework are supposed to be acceptable to all reasonable fair-minded persons. According to Daniels, the fair conditions for legitimate outcomes in resource allocations are (Daniels 2007, pp 110-111):

1. **Publicity Condition:** Decisions regarding both direct and indirect limits to meeting health needs and their rationales must be publicly accessible.
  
2. **Relevance Condition:** The rationales for limit-setting decisions should aim to provide a reasonable explanation of how the organization seeks to provide “value for money” in meeting the varied health needs of a defined population under reasonable resource constraints. Specifically, a rationale will be “reasonable” if it appeals to evidence, reasons and principles that are accepted as relevant by (“fair minded”) people who are disposed to finding mutually justifiable terms of cooperation. Where possible, the relevance of reasons should be vetted by stakeholders in these decisions – a constraint easier to implement in public than in private institutions.
  
3. **Revision and Appeals Condition:** There must be mechanisms for challenge and dispute resolution regarding limit-setting decisions, and, more broadly, opportunities for revision and improvement of policies in the light of new evidence or arguments.

4. **Regulative Condition:** There is either voluntary or public regulation of the process to ensure that conditions 1–3 are met.

The crucial idea underlying this framework is that fair-minded people will accept that the basis of allocation decisions are relevant reasons when health care needs are to be met fairly under the constraint of moderate scarcity. The goal for this kind of procedural decision-making would be to have all relevant information considered, and broadening the range of participating fair-minded state-holders would contribute to this aim. However, Daniels and Sabin stress that the framework should not be considered a substitute for democratic processes enacting the will of the people. Rather, the framework should be taken to *facilitate* democracy in that “[t]he four conditions connect decisions at any institutional level to a broader educative and deliberative democratic process” (Daniels 2007, p 111). Let us briefly consider how these four conditions might make such a contribution.

### **Publicity, Relevance, Revision and Regulation**

The *Publicity Condition* is important in different regards. First, when the decision-making authorities are explicit about the reasons and rationales for the priority settings, the transparency allows for the demonstration of a consistent and coherent policy in how these decisions are carried out. To be more precise, it allows for disclosure of the fact that an appropriate justification has taken place and that the relevant reasons for the deliberation are linked to the particularity of the case in question. Importantly, publicity in priority setting is more likely to meet the formal fairness principle of equality telling us that equal cases are to be treated equally and unequal cases differently if there are relevant reasons to justify they differ. Publicity makes it easier to go from case to case by judging the same criteria of relevancy and thereby strengthening the fairness of distribution across particular cases. Second, if citizens are not allowed to see how and why priorities are made, they are prevented from enacting their political autonomy by being engaged in social government.

The *Relevance Condition* echoes Rawls’ account for the reasonable as presented above. The rational for a decision is considered reasonable if the reasons the priority setting is based upon are the kind of reasons fair-minded people, possessing the moral willingness to seek for reasons that would be acceptable, see as relevant. The rational for priority settings must involve reasons that stakeholders, such as patients, find relevant in this regard. Accountability

for reasonableness thereby involves testing of the reasons for the allocation under resource constraints against various views in order to be relevant. To involve stakeholders to vet the reasons for priority setting is a way to give more credibility to the aim of having all relevant reasons considered. Their role should be considered instrumental in scrutinising the relevance of the reasons considered. Insofar as their participation improves the accountability of reasonableness, the legitimacy of the priority setting is equally enhanced.

The framework requires mechanisms to revise and challenge the decisions. *The Revisability and Appeals Condition* will allow people who were not engaged in the original decision-making to advance their views by engaging in deliberation after the decision has been made. Given the publicity and relevance conditions, people's challenges might be directed at the justification the priority setting was based upon. People are thereby empowered to engage in a broader social deliberation about limit-setting in health care.

Finally, the *Regulative Condition* is part of the framework as it works to ensure that the three previous conditions are met. The idea is that those responsible for making allocation decisions concerning health care should, by some kind of public regulation, be required to subject denials of care to an independent review.

### **Fair distribution at the micro-level**

Accountability for Reasonableness is designed to be applied on an institutional level. Assuming legitimacy and fairness of macro-level decision-making, we must pose the question how this can affect micro-level decision-making? As I discussed in the General Framework above, the way the distribution is realised at street-level (micro-level) in terms of discretion versus constraining rules is also an issue concerning *how* to promote fairness. What is most fair; considering the particular situation of the individual with regard to equity and enacting the principle of individualisation based on discretionary judgment, or ensuring equal treatment by constraining the room for discretion by requiring adherence to rules? This question must be answered when it comes to the issue of inequities in health and efforts that can be made in clinical practice to reduce health disparity. Such an approach must involve exploration of the relation between macro- and micro-level decision-making in terms of equity. If clinical guidelines are based on fair procedures according to Accountability for Reasonableness, will the legitimacy attached to such guidelines automatically transfer onto

the clinical decisions at micro-level when physicians adhere to the directive of the guideline? The implications of this relationship with regard to equity in health care must be considered and there is a gap in the literature when it comes to this relationship.

### **Medical professionalism, trust, confidence and accountability**

We are now left with two important questions: How might discretionary judgment be involved in reducing health inequities? How do legitimate guidelines affect the legitimacy of clinical judgments? Let us briefly look into how the medical profession imposes norms of fairness on their members' decisions to sustain trust and confidence in the performance of the profession and clinicians ability to act fairly.

Sociological literature on professions offers interesting perspectives on regulations of individual physician's discretionary judgment. Considered as a profession, characterised with extended powers to control its work autonomously, medicine relies on its members' *professionalism* to sustain the trustworthiness and confidence in the delegated discretion they collectively enjoy (Freidson 1988). What, then, is this medical professionalism? In general, it can be considered as the profession's self-imposed normative regulation of their work defined against the background of a social contract between medicine and society (Crues, Johnston et al. 2004). However, rather than defining professionalism, academic works within the profession itself seem mainly occupied with presenting the ideals represented by the idea of professionalism (Hafferty 2006). Typically, these ideals describe general requirements of care based on scientifically well justified knowledge and standards for ethical behaviour towards patients, colleagues and authorities. Interestingly, it has quite recently been pointed out two different trends in discussions about medical professionalism in this regards (Hafferty 2006). The trends seem to be situated within reflections emerging from within the two different health care systems in the USA and the UK. Proponents of professionalism in the mainly private insurance based health care system in USA emphasise self-reflective activity of physicians as crucial in providing good care (Epstein 1999; Coulehan 2005). The national health care system in the UK, on the other hand, promotes academic works on professionalism that stress the need for public insight and participation in the regulation of medicine (Irvine 2001; Irvine 2007).

The ideal of American medical professionalism was challenged few years ago for being too narrowly defined (Wear and Kuczewski 2004). The authors suggested changes could be made in educating medical students into awareness of the corresponding relations between social determinants and health. By encouraging this broader perspective on relevant reasons for treatment, self-reflection as constituting medical professionalism is radically challenged when it is pointed out that clinical health care concerns not only moral standards of patients' best interests but political standards of fair distribution according to social inequalities as well. Furthermore, this political turn will also call for clarification of the professions limited legitimacy in acting with moral authority in issues concerning social justice. Public deliberation is required. Conjoined with the other approach which vindicates the central requirement of public accountability imposed on the practices of medical profession, a new ideal of medical professionalism might arise. My hypothesis is that such an ideal for professional discretion addressing the inequity in health challenge by fair clinical judgments, must be based upon a framework for accountability for reasonableness specially designed to be applied on the clinical level to ensure legitimacy in clinical judgment. This hypothesis has not been paid much, if any, attention in the literature. My preparation and discussion of this hypothesis run through three articles which all concern the discretion of clinicians and just distribution of health care. My theoretical discussion of this hypothesis will be embedded in a practical framework for reasonable clinical judgments. This framework can be considered the second substantive realisation of the general meta-regulations imposed on delegated discretion within a democratic welfare state.

## ***Aims***

### **Aim of Paper I: Patient autonomy, assessment of competence and surrogate decision-making: a call for reasonableness in deciding for others**

In this paper, I address some of the shortcomings of established clinical ethics centring on personal autonomy and consent and what I label the Doctrine of Respecting Personal Autonomy in Health care. I discuss two implications of this doctrine: 1) the practice for treatment of patients who are considered to have borderline decision-making competence and, 2) the practice of surrogate decision-making in general. The aim is to show that because of 'structural arbitrariness' in the whole process of how we assess decision making competence, this area is open to disrespectful treatment of individuals and that the practice of surrogate decision making may continue this arbitrariness. And I ask what can be done that would give us reasons to trust we would receive respectful treatment even if we are judged not competent to make our own decisions.

### **Aim of Paper II: Klinisk Skjønn og Prioriteringer**

In this paper the aims are to consider: Where should the doctors draw the boundaries for their responsibility? What type of priority settings are involved in exercising clinical judgment?

### **Aim of Paper III: Priority setting in health care: On the relation between reasonable choices on the micro-level and the macro-level**

In this paper, I aim to discuss the following questions: Given the assumption that guidelines purport some kind of legitimacy, how binding is this legitimacy on particular cases potentially subjected to the directives?

What are the conditions that have to be met in order to ensure that individual claims on health care are well aligned with an overall concept of fair health care?

## **Aim of Paper IV: Priority setting in health care: A framework for reasonable clinical judgments**

In this paper the aim is to clarify the following issue: What would be the criteria for reasonable clinical judgments when departing from presumed legitimate guidelines?



## PART III: METHODOLOGICAL CONSIDERATIONS:

### ***A method for theoretical bioethics***

Theoretical discussions about the conditions for bioethics can be called theoretical bioethics or meta-bioethics. In the following I will consider what a methodology for theoretical bioethics might include. Underlying these considerations is the idea that this method must be compatible with moral, personal and political autonomy which form the basis of the political principles of a democratic welfare state (see part I.)

A crucial pre-requisite, from my point of view, is that any method in theoretical bioethics must address what I will call *The immanent ethical requirement for consistency in institutionalised bioethical policies aimed at the same group of people* (The immanence requirement). The argument for this requirement is very simple: The overall aim of bioethics is to do *right*. Theoretical bioethics might have implications for policy-making and all policy-making concerning the same group of people should be based on the recognition that policies aimed at promoting some moral good must not work against each other. To impose policies that imply conflicting directives would not be a respectful way of treating people as ends in themselves. As discussed in section I, this is one of the bearing values of a democratic welfare state. Consequently, theoretical bioethics must search for consistency in all institutionalised bioethical policies that regulate the same group of people and avoid practices that undermine each other. For example, a policy which stresses patients' right to self-determinacy in health care settings could clash with a policy which encourages health care personnel to ensure that patients make 'right' decisions. There is a need to organise theoretical bioethics so as to avoid conflicting policies. So, the demand for consistent policies is itself an ethical concern, immanent in ethical practice, and not just a pragmatic requirement imposed upon policies from outside the theory and practice of bioethics.

This is a quite modest claim. I stress that there is a call for 'consistency' and not 'coherency'. A requirement of coherency would imply that the policies could *justify* each other. 'Consistent policies' simply refers to policies which do not work against each other when affecting a certain group of people, such as a group of patients, a group of professionals, the group of both patient and professionals, or the people within a nation.

To find a method for theoretical bioethics, we must address the following questions:

What is a method?

What are the aims of theoretical bioethics?

What could be the fixed point(s) for a systematic reflection in theoretical bioethics?

## **What is a method?**

‘Method’ can be defined as “a systematic procedure, technique, or mode of inquiry employed by or proper to a particular discipline or art” (Merriam-Webster Online Dictionary 2008). The ‘technique’ involved in works on theoretical bioethics can most accurately be referred to as ‘reflection’. This does not, of course, capture the essence of a ‘technique’ considered as a systematic procedure. What is needed to make reflection over theoretical bioethical issues *a systematic procedure*? To organise something *systematically*, we need fixed points in the proceedings. To establish a *method* for theoretical bioethics, we need to describe some fixed points to render the reflection systematic.

## **The aims of theoretical bioethics**

I take ‘bioethics’ to cover the whole field of ethics that relates to biotechnology, biotechnical research, health and medicine. While ‘medical ethics’ also covers all the health and medicine related issues, ‘bioethics’ reaches even further and includes environmental issues affected by biotechnology. Theoretical approaches and practical approaches to bioethics can be distinguished from each other by the aim of the activity. When we are occupied with practical bioethics, our primary concern is with reaching solutions to the challenges we are facing. When we are working with theoretical bioethics, our primary concern is *justifying the solutions to general or concrete challenges in the field*. In general, I consider the aims of theoretical bioethics to be:

- 1) discussing premises that *might* be involved in arguments about action-guiding norms or particular cases
- 2) drawing adequately justified conclusions about action-guiding regulations
- 3) sometimes making adequately justified conclusions about concrete cases

1) Theoretical bioethics can focus exclusively on the premises that *might* be involved in justifying action-guiding regulations or particular cases. Examples of theoretical issues might be; the moral status of embryos, using animals as organ-donors, or the autonomous status of patients. Reflections over these issues are typically carried out as *conceptual analysis* and as theories about how the empirical world *occurs* and theories about how it *ideally* should be constituted. Thus, these theoretical reflections might be both descriptive and normative.

2) When the aim of reflection is to develop justified action-guiding regulations, reflection might either concern i) the general theoretical conditions for the regulation, ii) the practical challenges of implementing justified and theoretically generalised regulations in a ‘messy’, empirical world, or iii) the unintended effects of an implemented regulation. With regards to the practical challenges of implementation, the theoretical conclusion and formulation of a regulation might specify who is affected by the regulation of actions, what kinds of action the regulation involves and how the success of the policy might be evaluated (for instance, the policy of promoting patient’s autonomy by requiring consent). Typically, in White Papers and law formulations concerning health care, regulations are often vaguely formulated, while local institutionalised practice is based on much more specific interpretation. However, if there is no rule that explicitly points out *who* the regulation concerns or *how it is supposed to be carried out*, it is left to the discretion of ‘those in charge’ to figure out how the regulation should structure particular contexts. This illustrates a central issue for theoretical bioethics in policy-making: We need to consider how the individual judgment of professionals should be fostered in order to meet the normative requirements of the health care service adequately.

3) Particular cases may also be subject to theoretical reflections. These may be difficult cases where a solution seems hard to justify in terms of the norms or concepts according to which similar cases are usually considered. In such cases there might be a call for theoretical reflection *before* a solution is reached. However, such cases will often be subject to reconsideration and theoretical reflection after someone has complained about the original decision. Moreover, reflecting over concrete examples, real or constructed, can be a good way to provide support for ethical theories.

## **Analytical distinctions within theoretical bioethics**

In order to search for fixed points in a method, we need to get a firmer grip on the issues in theoretical bioethics. It may be useful to distinguish between *an ideal level*, *an institutional level*, and *an implementation level*. *The ideal level* is the level where the reflections concern the ideal conditions for bioethics. This is the level where, for example, conceptual analysis of “autonomy” and “need” and theories about “just distributions of health care” are carried out. Reflection at this level offers premises for justifying how to deal with particular or general ethical issues. *The institutional level* is the level where the conditions for moving idealised theory into the real world are discussed, and policies, methods and frameworks are developed, such as the framework for Accountability for Reasonableness (Daniels and Sabin 2002), norms for professional ethics, considerations about how to foster good clinical judgment as well as methods for analysing and dealing with ethical dilemmas. Finally, there is *the implementation level* where the policies, frameworks and methods are implemented. Whether or not these policies actually work according to the intentions, is an empirical matter to be considered at this level.

Second, it seems useful to divide the issues of theoretical bioethics into what I will call *horizontal* and *vertical reflections*. ‘Horizontal reflections’ concern the issues discussed in general terms and spelled out as theories, conceptual analysis and principles at the ideal level. They might concern *general* strategies for implementation at the institutionalised level. The aims of horizontal reflections are to make conclusions about the ideal conditions for promoting ethical behaviour, while ‘vertical reflections’ concern the actual implementation of regulative idea in the empirical world. This vertical move from theoretical reflection to practice involves taking particular features of the world into account together with the theoretical premises. The aim of vertical reflections is both to make conclusions about particular theoretical solutions at the institutional level and practical solutions at the implementation level.

## ***Fixed point(s) for a systematic reflection in theoretical bioethics***

Given the division of the field of theoretical bioethics into different departments as presented above, we must now ask: Is it possible to develop a general method that covers all these different levels of theoretical bioethics? In order to approach this problem, we must first isolate features of reflections that are shared by both horizontal and vertical reflection. Such

features will constitute fixed point(s) for a methodology in theoretical bioethics. I have so far presumed that theoretical horizontal reflections constitute the normative premises involved in vertical reflections. If this assumption is justified, it is in how theoretical horizontal reflection is carried out we should look for fixed point (s) for systematic reflection. Before concluding that this is so, I will consider the possibility that normative premises for policies might actually be constrained by empirical facts about how the world *is* at the implementation level.

### **A three step procedure for implementing regulations**

With regard to vertical reflection, systematic reflection (for a general method) would require a fixed structure of priority in how empirical facts and/or normative considerations impose constraints on each other. The call for regulation of actions usually emerges out of dilemmas rooted in the empirical world. However, to let conclusions about how the world actually *is* affect the conceptions of how it *should be* would be to commit a logical fallacy. We would be logically mistaken to make statements about how the world *should be* based on descriptive statements about how it actually *is* (Hume 2000). For instance, although there are many obstacles in the real world against patients making autonomous choices, we cannot conclude that, for this reason, the requirement for patient autonomy in health care should be abandoned. This speaks in favour of dividing the process of policy-making into the following three steps. First, the bioethical issues in question should be reflected upon in terms of general and normative premises on the ideal level leading to a conclusion about how the world ideally should be with regards to this issue. This step implies that theoretical concerns are discussed apart from particular, *arbitrary* concerns of the empirical world. Here there is no room for pragmatic considerations that adjust the normative considerations in accordance with how the world is. The second step is then to discuss how the theoretical conclusions could be implemented on the institutional level constituted by *general* facts about how the world is. The third step concerns the actual obedience to the requirement of the proposed regulation at the implementation level. In this phase of the process, it might be appropriate to call for pragmatic solutions that adjust the normative conclusions into how the empirical world actually is. However, this is an issue that must be carefully considered and judged in accordance with the particularity of individual cases. This three step procedure for implementing policy can be considered a formally fixed procedure pointing out the *direction of justification* within theoretical bioethics aiming towards a practical conclusion.

At this point of the account, however, we can conclude that theoretical vertical reflections should involve horizontal reflections in order to arrive at a practical solution.

## **Epistemological conditions**

If we can conclude horizontal reflections with substantive accounts of how the world ideally should be, we will have to presume there are normative premises we trust as valid. How do we arrive at such premises? How can we assume the validity of certain premises leading towards a conclusion about how the world should be regulated? These questions concern the epistemological conditions of moral knowledge. Let us briefly consider different accounts for how we may arrive at moral knowledge.

Roughly, I will consider three influential ways we can seek justification of practical conclusions about how to act. First, general principles might be considered as starting points for justifying decisions about what to do. This would be a top-down model for justification and the validity of the relevant premises must be assumed as ‘given’, as *prima facie* obvious in a philosophical or religious sense. Alternatively, we can seek justification bottom-up by deriving generalisations from particular instances. This view gives priority to practical decision-making based on “social agreement and practices, insight-producing novel cases, and comparative case analysis as the initial starting points from which to make decisions in particular cases and to generalize to norms” (Beauchamp and Childress 2001, p 392). This account comprises theories like particularism and casuistry (Toulmin 1981; Jonsen 1991; Callahan 2000). There are arguable weaknesses in each of these approaches. Proponents of the first approach will have to come up with an account of how the principles got their status as ‘given’ or ‘*prima facie*’. Different principles might conflict in some circumstances and because of their lack of specificity; it is often unclear how they are to be applied to individual cases. Those vindicating the second approach will meet a major challenge in the critique that this approach lacks any standard to criticise practise-based judgments from outside the tradition. As a third alternative, we may consider a third approach that integrates both the above models in a justifying system which aims towards a reflective equilibrium of coherent justification. Such a view is embraced by Rawls and Daniels (Rawls 1971; Rawls 1993; Daniels 1996; Daniels 2003) and also Beauchamp and Childress (Beauchamp and Childress, 2001). In these terms, the validity of a substantive conclusion hinges upon how well the judgment coheres with intuitions, background theory and principles derived thereof. In short,

this theory stresses how principles and particular reasons may affect each other under the constraining requirement of seeking a reflective equilibrium among theories, principles, judgment and beliefs that cohere with each other. Although this theory avoids the criticism made of the other approaches about moral knowledge, it has for example been challenged for being vague about its precise scope. As pointed out by Beauchamp and Childress “[T]he focus might be on judgments, on policies, on cases, or on finding moral truth.”(Beauchamp and Childress 2001, p 401).

## **Methods for reflection in theoretical bioethics**

A method for theoretical bioethics will have to reflect on and account for the way we obtain moral knowledge and this will constrain the reasoning that constitutes the horizontal reflection. This goes for all general theoretical reflection that might end up as normative conclusions. Each of the three epistemological approaches considered here could form a basis for a method of theoretical reflection on bioethical issues. The principle based account represents a deductive way to arrive at moral knowledge. The reflections based on this epistemological approach should be structured as a deductive argument with some given, normative premises. The bottom-up judgment-based view represents an inductive way to obtain moral knowledge. Horizontal reflections would be explicitly based upon particular judgments about particular cases. This will structure the theoretical reflection quite differently. A conclusion about theories or general principles must, in this case, be supported by judgments about concrete examples. The third view, individual, coherent justification towards reflective equilibrium requires yet another argumentative structure since conclusions about general principles will have to be tested against considered judgments as well as theories before they obtain status as valid premises. If we approach a particular issue in accordance with these three different argumentative schemas, we might arrive at the same substantive conclusion or we might not. This would be an empirical issue to explore.

## **Distinct methods**

Theoretical bioethics rests on arguments that might be structured in accordance with one of the three epistemological theories about moral knowledge presented above. None of these theories can be considered as perfect, non-questionable approaches to obtaining moral knowledge. Nevertheless, *a method* for theoretical bioethics must presuppose the endorsement

of a specific epistemological theory and the requirement of consistency in the structure of argumentation. If the methodological considerations I have outlined so far are justified, we can conclude that it is possible to establish various methods for theoretical bioethics which all impose equally *formal* constraints on the theoretical work. These are: i) a choice of an epistemological account and ii) the requirement that the argument is structured accordingly. Further, from the actual epistemological theory chosen, *different* substantive constraints on reflection can be derived. These constraints can be specified in accordance with each particular approach. So here we have a formal requirement on theoretical reflections representing a fixed point for a method:

- (1) An epistemological theory to form the basis of valid premises (horizontal reflection) and to constrain the overall structure of argumentation towards a practical conclusion (vertical reflection)

But then we have to ask: Will such fixed reasoning actually be aligned with the immanence requirement? I would say not. As long as we cannot argue the ‘truthfulness’ of one epistemological approach over the others, one might choose the theoretical basis one finds the most convincing and argue accordingly. But then, systematic reflections over bioethical issues might be carried out in different ways by different people and there is no superior coordinating instance or idea to systematically regulate these reflections in accordance with each other. Consequently, consistent policies are not to be expected.

This should tell us that our search for systematic regulation of theoretical bioethics must not end here. We need to look further at the conditions for reflection that allow for different argumentative approaches to ethics (as we have just seen there might be), but which also provide us with further formal constraints. We must take a step backwards and search for a method which:

- i) includes the *objective* that reflection involves the whole field of theoretical bioethics involved in regulation of a given group of people, and
- ii) allows us to consider all distinct reflections as part of an collective, aggregated reflection towards consistent normative policies



In this way, we might be able to derive new constraints for individual, theoretical works in bioethics. Such constraints will, together with 1), add up to a framework of general formal requirements for theoretical bioethics, and might therefore be considered a *general method* for theoretical bioethics as these requirements represent fixed points for systematic reflection.

## **Categories of normative premises**

When we, from now on, consider the individual works on theoretical bioethics, we have to stress a distinction between different categories of normative premises involved in bioethics. On the one hand, there are the general principles supported by theory and presented as universal principles or as derived, more specified principles. On the other hand, normative premises might also be constituted by intuitive judgments about a particular state of affairs. We must be aware that acting in the empirical world is also regulated by normative concerns which do not make claims on distinct theoretical justification. At least, this is so in the absence of identified, conflicting concerns. In the real world, *common morality* is represented in the way judgments about different situations are carried out without appeal to any theoretical account to support a logical derived conclusion (Beauchamp and Childress 2001). Morality understood in these terms might be promoted through cultural, institutionalised practices (Beauchamp and Childress 2001). Considered as two different, but not necessarily distinct, schemas for justification, theoretical and common morality based conclusions might not always coincide when making conclusions about the right thing to do in particular contexts. How to deal with this potential gap is a task for theoretical ethics in general and theoretical bioethics in particular. However, it is important not to ignore the significance of common morality as it is exercised at the implementation level. Although, this kind of morality is intuitive in a crucial sense, and not as ‘worked out’ as theoretical horizontal reflections, it represents the real test for an implemented policy among those affected by it. The common morality of people as the basis for judgment is the basis for recognition that first captures inconsistency between policies in everyday life when people experience frustration over conflicting directives. Common morality of people is what first triggers revision of theoretically elaborated policies (when policies just do not seem right).

Here, procedures should be worked out in order to ensure that The immanence requirement is met. Importantly, however this requirement should be met without falling into the trap of

constructing new, normative theories based on empirical facts about *other* conflicting policies. Such theories would be insufficiently justified premises to be involved in vertical reflections.

### ***Considerations about the general method***

Testing and revising vertical reflections with regard to both the horizontal reflections involved as premises and intuitive judgments about inconsistency between policies, might allow for a systematic, but yet dynamic procedure for improving the justification of policies. In fact, the required reflections described here have much in common with the theory described by Rawls as ‘a collective wide reflective equilibrium’ that searches for coherently justified principles by taking more and more related principles, theories and considered judgments of people into a collective, politicised reflection with the aim of converging on shared principles for justice by overlapping consensus. Moreover, the meta-methodological view of bioethics I have arrived at here is similar to a meta-methodology for ethics in general suggested by Norman Daniels (Daniels 2003). The view presented here remains neutral with regard to which epistemological theory it is right to choose for concrete works on theoretical bioethics, rather it opens up for any theory to work as ‘local’ methodologies (including the method of striving towards individual, as opposed to collective, reflective equilibrium). Rather than considering this a default, I will emphasize that this actually opens up for various, innovative perspectives and the possibility of investigating and testing the premises that form the basis of the policies. The wide reflective equilibrium searched by *individual reflection* in order to establish justification and credibility of one’s own moral judgments about particular cases, principles and theories, can be seen lifted up to a *collective aim for everyone working on bioethical issues*. In this collective goal, reflective equilibrium is sought by striving towards *coherency* between the common morality judgments (intuitions) of those the policies concern, the premises for policies (vertical reflections) and theories (horizontal reflection). ‘Coherency’ implies that these theoretical reflections and intuitions mutually justify each other.

Thinking about bioethics from this meta-methodological point of view, allows us to see how bioethics might be underdetermined by democracy. The conditions of The immanent requirement for consistency in policies and the required top-down direction of justification of those by normative theory might seem like a dictatorial way of controlling the deliberation by disputable premises. However, when we recognise that it is the common morality of people

which initiates revisions or allows people to rest happy with policies even though logical inconsistency can be pointed out, the moral authority is in the hand of the people the policies concern. In order to work as intended (and to avoid bioethical expertise's hegemony with regards to 'moral truths') feed-back mechanisms that capture the experience of those affected by the policies must be institutionalised. The 'common morality' information can be put back into the vertical reflections, as empirical reasons affecting the feasibility of a policy, when the policy is reconsidered. Such information should affect revision of unwarranted presumptions made in theories. This would not directly challenge the requirement of top-down justification as vertical conclusions still need justification from a level of higher generality in order to avoid absolute relativism in bioethical practice. Could this premise that the meta-methodology presented here does not allow for absolute relativism be seriously challenged? As far as I can see, a serious objection would have to be presented as a convincing argument telling us why bioethics should not be institutionalised in any way. I take it that this how far an argument will have to go to undermine The immanent requirement of consistency. I believe it would be hard to find such an argument.

However, a challenge arises for this methodology, when we try to regulate bioethics across national borders, as for instance, within the European Union, where some practices are derived from within the constitution of a country while others are supranational directives. In this regard, the theory must be developed to cope with arrangements which sustain both national and supranational democratic influences. This is a veritable challenge because supranational norms are then imposed on groups of people, who are already subject to and formed by distinct sets of norms. How should a supranational policy meet the immanence requirement? And what kind of procedure could be established to ensure fairness across the views of different nations if a policy needs revision? I take these questions to be issues for further research.

### **General requirements imposed on theoretical works in bioethics**

First we must recognise that the individual approaches must consistently rest on an accepted epistemological theory in order to reach what can be considered *valid conclusions* ( i.e. (1) above). Second, in order to avoid policies working against each other, there is a demand for consistency between policies regulating the same group of people. This suggests that the quality of vertical arguments cannot exclusively be guaranteed by internal logical consistency

within a chosen argumentative structure but also depends on whether the concepts involved are compatible with the concepts on which overlapping policies are based. Consequently, horizontal reflections are formally constrained by the need to strive for *clarity* about all the presumptions ideal concepts rest on. This will facilitate communication between works on theoretical issues. Furthermore, this requirement also supports a collective process towards refined justification of policies.

This call for analytical quality in theoretical bioethics implies bioethical expertise. This demand appears to conflict with the political call for democratic participation and influence on policy-making. To allow for democratic influence *within* policy-making processes in bioethics, empirical research on people's opinions provides premises which can be used in the vertical reflection to challenge and revise theoretical premises. Thus, to facilitate the democratic influence of those the policy-making concerns, clarity on any normative issues potentially at stake within a given topic, emerges as another requirement on works in theoretical bioethics.

#### **Requirements for systematic reflection in theoretical works in bioethics**

- (1) consistency in argumentation according to an endorsed epistemology
- (2) consistency in the conceptual basis for overlapping policies
  - clarity about all normative presumptions the ideal concepts rest upon
- (3) theoretical support for democratic influence
  - clarity on any relevant normative issues potentially at stake

## **PART IV: RESULTS**

### **Result of Paper I: Patient autonomy, assessment of competence and surrogate decision-making: a call for reasonableness in deciding for others**

In this paper, I have discussed how the process of assessing competence following from the Doctrine of Respecting Personal Autonomy in Health care must be considered to be ‘structurally arbitrary’. I have also considered how designating a single surrogate decision-maker can continue this arbitrariness. I have pointed out that arbitrary treatment cannot be a respectful way to care for vulnerable individuals and I have questioned the adequateness of the doctrine to deal with this problem. I have suggested a theoretical framework for *reasonable* surrogate decision-making which could be organised to avoid ‘structural arbitrariness’ as well. This theoretical framework and its practical implication in terms of reasonable surrogate decision-making can be seen to contribute to a more adequate understanding of patient autonomy than the established doctrine. This new understanding incorporates both personal autonomy and a regulative idea of moral autonomy in terms of reasonableness.

### **Result of Paper II: Klinisk Skjønn og Prioriteringer**

This paper was written with the aim of trying to clarify certain perspectives which could help us understand fair priority settings in clinical practice. I have argued that good clinical judgment must be seen to be related to the fact that the decision-maker has accepted him or herself to be morally responsible for securing the particular patient’s interests but also for guarding broader societal interests. Moreover, I have accounted for how exercising clinical judgment can be considered an experience-based process of accumulated knowledge. Against this background I have suggested two remedial actions for priority setting within clinical practice: i) I have provided some analytical tools to improve the overview of the ways clinical priority settings occur: Reading clinical practice in terms of the distinctions between *visible* and *invisible*, *justified* and *unjustified*, *systematic* and *unique* priority settings and the cross-

connections between these distinctions, may enhance the awareness of the normative character inherent in clinical work, ii) I have suggested that discussion groups of clinicians and others interested in the topic are established for debating *concrete priority setting issues*. This could be a way for physicians to establish well founded opinions by collective deliberation, as well strengthening their confidence in their own clinical judgment, while recognising its inherent normative character.

### **Result of Paper III: Priority setting in health care: On the relation between reasonable choices on the micro-level and the macro-level**

Drawing upon a distinction between individual and aggregated needs, I have discussed the formal conditions for just health care at micro-level assuming that existing guidelines are legitimate. I conclude that the presumed legitimacy of macro-decisions cannot be transferred to clinical decisions by simply following the recommendations uncritically. If we are aiming at just health care, we have to ensure both vertical (unequal treatment justified by relevant reasons) and horizontal equity (equal treatment of equal cases) that follows from the formal principle of equality. Even if all this is well taken care of at macro-level and clinicians are offered legitimate guidelines from a macro-level perspective, clinicians must be left discretionary power to consider the vertical equity of individual needs adequately. Because of the nature of the individual need, the legitimacy of individual claims must be accounted for partly in their own right. In order to provide fair health care, a framework for accountability for reasonableness is needed at the clinical level as well. I have suggested a tentative approach by pointing out how collective deliberation might support the individual justification of reasons not to follow the guidelines. However, such a framework must be thoughtfully developed and institutionalised as a supplement to legitimate macro-level decision making. In this way, fair health care might be reached when legitimacy emerges out of the interplay of reasonable justification from the macro-level above *and* the micro-level below.

### **Result of Paper IV: Priority setting in health care: A framework for reasonable clinical judgments**

Working from an account of claims on health care and conditions for professional performance, I have developed a framework for reasonable clinical priority setting. This

framework should be considered a way to meet the challenges of confidence supporting accountability to the public combined with a possibility for public influence on what should be considered fair reasons in discretionary judgment about health care distribution. The framework is provided as a supplement from “below” to the fair macro-level priority setting that generates guidelines from “above” for implementation at micro-level. This should be considered as a way of securing fair outcomes from the interplay between these two levels of decision making. In what has been described as ‘the historical second phase’ of how to deal with priority setting in health care (the move from principled based to procedural priority setting) I have pointed out an internal conflict. This conflict concerns on the one hand, the lack of a common stable unit of a recognised goal of health care and the lack of agreed principles for distribution as a normative basis for health care distribution which tells clinicians how to weight their different reasons. On the other hand, it concerns the clinician’s need for exactly this kind of basis in order to act in a trustworthy fashion as a competent professional in each particular case. The framework provided here presupposes the existence of organised public debate to support optimally justified individual claims on health care. By using this framework, clinicians can solve this conflict. Considered in this way, the framework for reasonable clinical decision making might be taken as a step towards a new phase of priority setting. This phase should be based on the acknowledged need for securing fair distribution in the interplay between macro- and micro-level considerations by legitimising procedures on each level, by well organised and continuing public debate and by individual clinical judgments based on well justified and principled normative bases.

## PART V: DISCUSSION OF THE RESULTS

### *Methodological concerns*

According to my methodological considerations in Part III, the work presented in the articles can be considered as *vertical reflections*. Vertical reflections are theoretical discussions which aim at policy-making based on normative and empirical premises. Three of the articles presented here consider the idea of reflective equilibrium. This can be seen as a method for establishing well founded beliefs about our recognised principles, theories and judgment in general. The concept of reasonableness that underlies the policy solutions I propose hinges on the idea of justification towards a wide reflective equilibrium. In my view, to institutionalise the procedure of justification in this way might be both a way to bolster against the exploitation potentially incompetent persons and a way to achieve fair distribution of individual health care. I have made no attempts to challenge this epistemological method when I use it as a theoretical premise in my vertical reflection. However, I have adopted this methodology by the different ways I have approached the topics of this thesis in the introduction and the articles, respectively. The whole argumentative work presented here can be read as a search for an *individual wide reflective equilibrium* by trying to establish coherence between intuitions, principles and theory. This is why, in the Preliminary Remarks, I explain the importance of reading this Introduction as an integrated part of the thesis.

When I started working on this thesis, I set out to analyse patient autonomy and physicians' judgments within a theoretical context at the level of implementation. My interest in political theory then grew proportionally with my realisation of the limitations of this initial framework. Gradually I had to expand the theoretical framework to consider where the principles justifying my intuitions ('common morality') come from. I was more or less forced, from my point of departure, to end up linking surrogate decisions and clinical judgments with fundamental principles of a democratic welfare state. Most clearly, this can be seen in the development of my argument from my first written article about clinical judgment and priority setting, Article II, then through Article III and Article IV, and into the Introduction. When I now look back on the articles that were produced during this early phase, I could perhaps say that I have now reached the point of coherence where I should have started my considerations about the particular issues. But then, I might have overlooked some of my



primary concerns which were rooted in the intuition-based judgments and considerations I started with. Obviously, growing up in a so called Scandinavian welfare state, I can make no claim to be able to distance myself from the cultural background my arguments flow from. This background has formed both my judgments and the theoretical ideals I find to support them. However, I have tried to show how a given set of political and moral ideas of autonomy support the initially more narrowly justified intuitions about an inadequate concept of patient autonomy and insufficiently justified health care judgments. This argumentative structure might be useful for the justification of other policies implemented within a democratic welfare state under the claim of promoting justice or respectful treatment of citizens.

The political theory involved here is more or less taken at face value. I make no attempt to criticise it. I see it as a further way to broaden my search for reflective equilibrium by including a more extended version of Rawls' theory as well as other theories about justice and testing these against each other and against judgments about particular cases. Meanwhile, I am left with the articles showing the development of my journey. In the following, I will make some comments on the results of these papers.

### **Requirements for systematic reflection**

I have stated my own choice of the method of reflective equilibrium as the way to reach valid knowledge about normative issues. Through this, I have met the requirement of clarity on the chosen epistemological method in works on theoretical bioethics set out in the Methodological Consideration section (Part III) above. But do my papers also meet the requirements for providing *consistency in the conceptual basis* for overlapping policies and *theoretical support for democratic influence*? In other words; have I been clear about all the normative assumptions on which the ideal concepts rest and have I emphasised any relevant normative issues potentially at stake by the policies I suggest?

Firstly, by linking my papers to the values of different versions of autonomy underlying a democratic welfare state, I have tried to *clarify the normative presumptions* that this whole project rests on. Although, this link was not entirely clear to me when I wrote the articles, I now see them as essential in justifying my intuitions, but also in demarcating the framework for the validity of the results of the theoretical discussions and the practical solutions.

Secondly, a result of clarifying these presumptions is to facilitate more targeted criticism.

Criticism that hits clearly identified soft spots in theoretical arguments could affect collective deliberation on theoretical bioethical issues towards a collectively wide reflective equilibrium. Thirdly, inviting targeted critique enhances the likelihood of recognising which normative issues one *really* disagrees about. By unpacking the fundamental values the argument rests on I have tried to emphasise what is really at stake with regard to the development of policies in a democratic welfare state. Disclosure of underlying political values should be considered important to develop and sustain a democracy. In this regard I take it that I have met the requirements for systematic reflection in the theoretical bioethical works listed above.

As it is, I do actually suggest *two different policies* here that are aimed at the same group of people, namely inhabitants in a democratic welfare state. This provides me with an opportunity to consider one central idea in the general method in more detail. Do the suggested policies in this thesis meet the *The immanent ethical requirement for consistency in institutionalised bioethical policies aimed at the same group of people?* Are the policies consistent with one another, or does one work against the intentions of the other? By trying to map the normative terrain of a certain kind of state, I have provided a background of values to test any bioethical policy against to search for consistency among vertical reflections. Remember that ‘consistency’, understood in a weak sense, implies that policies are not to work against each other, rather than that they are supposed to justify each other internally.

In my paper on patient autonomy, I criticise the established doctrine of patient autonomy indirectly on the basis that it does not harmonise well with *all* the versions of autonomy which constitute a democratic welfare state. The policy I suggest instead aims to restore the moral background for patient autonomy which has been distorted as a result of undue weight put on personal autonomy.

Our obligations to respond to health inequities in the first place, and by means of discretion (in combination with priority setting between different goods on an institutional level, as Daniels vindicates) can also be justified against the background of social responsibility flowing from the concept of moral autonomy. More precisely, social responsibility, or solidarity, enacted through discretion, flows from the part of the moral concept that requires us to treat people as ends in themselves. By requiring *accountability* of professional discretion, we maintain the other part of the concept of moral autonomy that calls for treating people equally in order to respect them as moral equals (when equal in relevant respects). The

idea of professionalism works by collectively imposing norms on the individual judgment of all the members of the profession. The framework for reasonable clinical judgments I propose meets both these requirements. In addition, it promotes personal autonomy by aiming at supporting the worst-off with better health and opportunities. And finally, it facilitates democracy by empowering citizens with political autonomy to engage in coordinated and organised public deliberation about health care issues.

The two distinct bioethical policies I discuss in this thesis share the same basis of values. Therefore, the policies I suggest would not be expected to work against each other but rather to co-exist on an institutional level in a democratic welfare state. (Although, we cannot predict that their intentions will not get twisted somehow in the implantation process causing a conflict on the implementation level.) I therefore conclude that when the Introduction and the articles are considered together, this work meets the requirements of a general methodology in theoretical bioethics.

### ***Patient autonomy and the values of a democratic welfare state***

With regard to competence assessment and surrogate decision-making, I have tried to make it clear why moral, personal and political autonomy have not been fully realised in established practice. A practice of promoting patient autonomy primarily based on the idea of personal autonomy requires a yes or no to the question concerning people's decision-making competence in order to proceed in an ethical manner by either leaving the decisions with the patient or calling for a surrogate decision-maker. The procedure according such practice goes as follows: first, adults' competence for making autonomous choices is presumed until others find reasons to doubt it: then the competence is judged on a basis of value-laden premises about performance and correlating levels of competence, and finally if someone is not considered competent, someone else is given the right to make decisions on behalf of the incompetent person. In the cases where individuals are judged incompetent, the result of this process is not just that the people in question are deprived of their rights to make their own decisions. In addition, their corrections of other people's opinions of their best interests cannot consistently be ascribed credibility. By virtue of a competence assessment, these individuals are made even more vulnerable to exploitation, coercion and mistreatment

compared to people who at least have the moral and political right to be taken seriously when they object to some kind of intervention flagged to be in their best interest.

Patient autonomy, in the current context of informed consent, is based on personal autonomy with ad hoc calls on obligations derived from the concept of moral autonomy *after* someone is assessed not competent. This policy sustains an idea of patient autonomy that lacks theoretical justifications to safeguard vulnerable people from not being treated as ends in themselves when their competence is doubted. Moreover, delegating the responsibility for deciding an incompetent person's best interests to one or a few others, formally or informally appointed, is not a way to *guarantee* moral responsibility by ensuring that the vulnerable person is not being treated as an end in him- or herself.

Furthermore, when the state takes away someone's right to enact their personal autonomy by appointing someone else to judge in their best interest, it delegates discretionary power to the surrogate. This means the surrogate decision-makers have to enact political autonomy since bearing such a responsibility on behalf of the state is not to be considered a private matter, but the plight of a citizen. When proxies are appointed, this aspect of the role might be blurred by the fact that the responsibility of care-taking also emerges out of the private relation between the incompetent person and the surrogate(s). However, this means that the judgment is subject to the normative contexts of judgment derived from the principles of a democratic welfare state. When deciding upon the best treatment for a person lacking competence, the situation calls for individualisation of this particular person's need. The substantive content of someone's best interest would often be constrained by what the state might offer anyone in the same situation. For instance in public health care settings, the choices surrogates have will usually be limited and the 'best interest' assessment thereby partly predefined. Thus, there are external limitations to the decisions the principle of individualisation might result in as the options are subjected to the principles of fairness. However, in carrying the delegated responsibility of making decisions about another person's best interest, and thereby realising the state's political obligations of caring for the vulnerable, surrogates should also be seen as carrying the responsibility for making well justified decisions. On an institutional level, as a safeguarding mechanism, the state should be expected to make surrogates accountable for their decisions. A democratic welfare state will have to establish procedures or standards to account for these decisions in order to maintain confidence in the state's organisation of decision-making for incompetent persons.

The practical solution I provide that makes the surrogate accountable in terms of reasonableness for the decision can be seen as a substantive realisation of the meta-regulations argued in Part I to be inherent in delegated discretion.

O'Neill has clearly pointed out that the policy of requiring consent is based upon too thin a concept of patient autonomy, (namely personal autonomy), to bear the field of bioethics. I totally agree and support her call for a concept of moral autonomy (or in O'Neill's terminology Principled Autonomy) to fill out the conceptual moral basis for bioethics. While O'Neill turns to Kant, I content myself with considering the concept a *regulative idea* with which adequacy is brought to bear on our intuitions. Many, including Beauchamp, Childress, Buchanan and Brock have discussed the unstable ground on which assessment of competence is carried out. I have tried to clarify this important point by analysing not only the assessment, but also the preceding and succeeding events of the assessment process, to show the inherent arbitrariness of this whole procedure. As a result I have gone even further than O'Neill in criticising the established doctrine. I question the whole structured chain of events, derived from the priority put on personal autonomy that creates a suboptimal situation for those with unclear competence. My suggestion of a procedure of reasonable justification to protect the vulnerable also represents an attempt to reorganise the logically structured practice allowed for when the implications of moral autonomy are initially ignored.

### ***Just health care and the values of a democratic welfare state***

Distribution of health care according to needs identified by physicians and put forward as claims on behalf of the patients, also challenge the basic values of a democratic welfare state. A crucial issue related to fair distribution concerns the organisation of the distribution in terms of *binding guidelines versus delegated discretion*. By relating to the values derived from different versions of autonomy, we can sum up the challenges meeting the process of institutionalisation and the clinical judgment of the individual physician.

On the institutional level, allowing for discretion versus requiring adherence to rules can be seen as the means to meet unfair inequalities (by discretion) and fair equal treatment of equal cases (by rules). This is how a trade-off between the political principles flowing from the idea of moral autonomy could be institutionalised. On the one hand, treating people as moral

equals by considering them as ends in themselves calls for individualisation and reduction in unfair constraints on the possibilities for individuals to enact their personal autonomy. On the other hand, the equal moral standing of individuals requires equal treatment of equal cases since any discrimination would undermine the idea of equal moral worth. If we focus on justice, this is how the dilemma of organised health care in terms of discretion or rules looks.

In a parallel 'quality of care' perspective, however, discretion versus rules or guidelines is about the quality of the care delivered. Leaving room for discretion allows for individual adjustments of treatment according to the complexity of individual cases, while requiring strict adherence to guidelines would be to promote the most effective, scientifically based care across the whole patient population. There does not seem to be much disagreement about the need for individual adjustment of care if we focus on 'quality of care' since a rule cannot allow for composite particular needs. Therefore, discretion is needed to decide particular health care needs and clinical guidelines exist as guidelines and not as rules precisely in order to allow for the potential complexity of individual cases.

In this thesis, I have tried to argue in favour of discretion also from the perspective of justice in order to diminish unfair inequalities in health. In the Introduction, I approached the issue from *above*, stressing the correlation between social determinants and health status of populations. My assumption is that these concerns must be met with discretion pretty much by the same reasons that run the idea of rule-based 'quality of care' into a paradox. Reasons must be spotted from case to case since they depend on the contextual settings of composite bio-technical and social conditions. In my articles, I have explored this issue from below, that is, from a micro-level point of view, by testing intuitions about relevant reasons for different treatment of bio-technically equal, but socially unequal cases. The argument in favour of discretion emerging from these considerations rested on intuitive judgment that there are unfair inequalities in people's living conditions and that these add up to relevant reasons for justifying different treatment. By seeing the superior aim of health care as *just health* rather than *just health care*, I have now also accounted for the political and moral *relevance* of these reasons.

By calling for discretion against this background, I am by no means suggesting that we give up the idea of striving for equality in treatment by adherence to guidelines, at least not if these guidelines are developed according to fair procedures and can be considered legitimate.

Rather, I stress that we need both discretion and legitimate guidelines. In order to depart from guidelines, any discretionary judgment should, to be considered legitimate, be accountable according to the framework I suggest for reasonable clinical judgments sustained by public deliberation. In this way, physicians might meet both the important requirements which stem from the idea of treating others as moral equals. If we look at fairness, clinical guidelines ensure that equal cases are treated equally with regard to 'the quality of care' and cost-effective rationing, while discretion within the suggested framework ensures that social inequalities affecting the way individuals might benefit from health care treatment might be compensated for by extra efforts to level up their health, enabling them to pursue their own ends and enact their personal autonomy. The public deliberation I see as an intrinsic part of the framework, might affect the justification process carried out by the individual physician departing from the guidelines and help it move in a direction that also sustains reasonable judgments. In this way, physicians can be seen to possess legitimate moral authority to determine health care needs against a background of social injustice. The idea of political autonomy of physicians working as street-level bureaucrats might be realised. Democracy could be facilitated in terms of reasonableness and brought all the way down to the street-level throughout the organised distribution system of a democratic welfare state. Moreover, the idea of organising systematic public deliberation about priority setting in health care could also affect the political autonomy of patients, that is, the citizens. Not only will it open up for more understanding of the priority-setting processes and political influences of people in general on health care decisions. A continuously ongoing, organised public deliberation process could also support patients', or citizens', understanding and acceptance of fairness constraints on health care decisions concerning themselves.

The framework for clinical judgment presented in this thesis encompasses the different approaches to individual micro-level judgments discussed in the Introduction. Firstly, the meta-regulations derived from the works of Goodin, Grimen, Molander, Rawls and Scanlon and imposed on Lipsky's street-level bureaucrats, can be considered a detailed account of the formal conditions involved in fairness standards imposed on discretionary judgement as hinted at by Dworkin. I have explored these regulations against the background of a democratic welfare state. Although Dworkin has declared himself a 'resource egalitarian' as opposed to a 'welfare egalitarian', he might still agree to the formal conditions represented by the principles of equal treatment, reproducibility and individualisation, as well as the regulatory levels of justification. He might, however, disagree in how the different principles

should be weighted relative to each other when fairness is considered in relation to a certain, substantive topic. Secondly, the framework is a response to the theoretical issues of fair clinical judgments left open under Daniels and Sabin's influential work on fair priority setting at the macro-level. The general formal constraints of fairness imposed on street-level bureaucrats can be seen to be specified into the substantive framework I suggest for the particular discretionary judgment exercised by physicians in micro-level distribution.

## **Clinical judgment**

My arguments for the suggested framework rest heavily on a challenge to the ambiguity of the concept 'clinical judgment'. In the Introduction I have drawn on a model presented by Grimen and Molander describing how judgment can be seen to close for uncertainty in reasoning processes. Although they discuss clinical judgment according to this model to some extent, this is not the particular topic for their more general claims about how judgment is supposed to work. This point also goes for Lipsky, Dworkin, Goodin, Rawls and Scanlon as none of these, to my knowledge, discuss clinical judgement in particular. I cannot, therefore, conclude that any of these theorists would agree with me that clinical judgment of physicians should be subject to the general fairness requirements as I have tried to demonstrate.

Nevertheless, I find the thought I have tried to articulate with their help important. When we recognise that clinical judgment is normative in an essential way and is already subject to the requirements of fairness when exercised within a public health care system, the view that justice is some kind of consideration that *eventually* applies to the clinical setting (for instance in terms of cost-effectiveness considerations) is challenged. The view presented here also undermines the distinction used to describe the physicians' role as patient advocates versus gate-keepers since they always work under principled constraints of both individualisation and equal treatment. Moreover, I argue that clinical judgment should explicitly address issues of fairness in order to level up the health of those worse-off because of social injustice. It might be that this is actually practised in an implicit manner, but that the reasons for doing so are veiled under the heading of acting in the 'patient's best interest'. However, physicians should not seriously be expected to perform such a task unless this requirement also is appropriated reflected in the education of medicines. The curriculum for medical education will have to involve courses in social and distributional justice as part of the framework supporting physicians with legitimate moral authority to make this kind of decisions.



## Motivation to act upon fair reasons

Professionalism understood along the lines of the suggested framework does not, however, grant the crucial motivation for members of a professions to act according to the merits vindicated. At the end of the day, the performance of the physicians hinges on their individual motivation. That motivation must somehow accord with their conception of the good (which they may well have been socialised to hold).

If this suggestion about institutionalising discretionary power in order to meet just health claims is supposed to work, we must also be justified in believing individual street-level bureaucrats would be motivated to act according to their awareness of what is needed. Theoretically, we must come up with a theory that supports a belief that street-level physicians (general practitioners) might be motivated to distribute health care fairly to promote just health by allowing for discrimination with regard to relevant non-technical reasons.

According to Rawls' account, a reasonable person would be engaged in institutional decision-making with the aim of reaching conclusions based on reasons that other people sharing the same aim could be expected to find acceptable. In Scanlon's view, reasonable thinking would be constrained by justifying reasons that others affected by the decision, if appropriately motivated, could not reasonably reject. Those empowered with discretion within a welfare state are responsible for acting to support confidence in the distributive institution they represent as well as to support trust based upon the interpersonal relation between street-level bureaucrats and their clients. The motivation Scanlon presumes to be included in the idea of *what we owe each other* calls for justification involving consideration of the views of the person in front of us. Justification in terms of reasonableness towards *particular others* involving their specific history and situation might imply a different reasonable conclusion than the conclusion which flows out of reasonable considerations based on a more abstract ideas of fairness which is appropriate for *institutions* and *policies* for aggregated populations. This seems to be an inherent tension in the whole idea of reasonableness.

At the same time Scanlon's theory might clarify physicians' desire to 'act as their patients' advocates' in cases of moderate scarcity. It might also be part of an explanation of the fact

that general practitioners follow guidelines to a very varied extent. According to the suggested framework, however, we should note the following: If Scanlon is right about his theory, and if physicians are properly educated with regard to the empirical knowledge of social determinants as well as theories about social and distributional justice, we have reason to be optimistic about physicians' motivation to distribute health care fairly by discretion when facing health inequity.

## **Legitimacy**

The framework for reasonable clinical judgments is not derived from Daniels and Sabin's framework Accountability for Reasonableness, but it share the same premises about burden of reasons, Rawls idea of the reasonable and justice in terms of fairness. Moreover, the framework Accountability for Reasonableness has played a crucial role in this argument as a guarantee for the potentiality for legitimate clinical guidelines. My account for fair clinical judgments is equally, or even more, vulnerable to critics as the Accountability for Reasonableness framework by the claim on *legitimacy*. What is involved in the 'legitimacy' these frameworks purport when they can at most claim to facilitate, not realise, democracy? This question has not been fully answered and it points to an important discussion that ought to be carried out if we were to implement the frameworks in democratic welfare states.

However, based on Scanlon's theory, we could argue in favour of the clinician's moral authority to make legitimate decisions. In so far the clinician responds to the call of morality wrapped up in the concept of 'what we owe to each other', he or she possess the certain perspective on the situation that might correct for the lack of attentiveness to ethical, justifiable nuances that come with the dictates of principles when presented in guidelines.

## ***Reasonableness as an institutionalised justification process***

My suggestion for how an institutionalised justification process could be carried out both with regard to surrogate decision-making on behalf of incompetent individuals and physicians' just health care claims, involves the idea of *reasonableness*. These topics call for reasonableness for different reasons. Nevertheless, the reasonableness called for can in both cases be related to the formal frames of normative contexts of judgment and the levels of justifications presented above. First, with regard to the process of surrogate decision-making preceded by

formal or informal assessment of competence, reasonable discretionary decision-making is seen to emerge out of a process of collective deliberation about the particular case in question. Pressing the level of justification of all reasons for a certain decision into collective deliberation within a composite group of people can be seen primarily as a means of safeguarding against exploitation, misuse or simply indifferent treatment of potentially incompetent or obviously incompetent persons. In this regard, the collective search for reasonable reasons in deciding for others is a response to the regulative idea derived from moral autonomy requiring that we treat others as ends in themselves.

With regard to physicians' claims to health care on behalf of their patients, reasonable discretionary decision-making when departing from the guidelines is supposed to emerge out of physicians' reflection and justification of reasons in combination with a parallel, ongoing public debate about reasons that justify discrimination in treatment and the goal of health care. The search for reasonable reasons is both about ensuring equal treatment based on the same relevant reasons when allowing for discretion in interpretations of need, but it is also about public influence on the reasons which underlie the actual distribution of a common good, health care. In this manner it can be considered to have the effect of tightening what was called the 'black hole of democracy'.

For both topics the solution involves forcing reasonableness in decision-making by institutionalising a process of justification. This is not primarily because of suspicions that people do not care about how their decisions are justified. Rather, the benefits gained by appropriate justification in these cases are too valuable in a democratic welfare state to be left as a matter of contingency depending on whether those delegated with decision-making authority are motivated accordingly or not.

## ***Further research***

My theoretical solutions to the topics explored in this thesis point out several potential directions for further theoretical and empirical research. I will sum up the most important ones in the following.

The discussions in the articles are what I have referred to as *vertical reflections*. As they primarily concern issues about institutionalisation, they are not attempts to provide accounts for concrete implementation. Consequently, there is much more to discuss about the feasibility of the suggestions but that goes beyond the aim of my discussions. Given the normative character of this study, it is my intention to reflect over and point out reasons for structural organisation. According to the methodological considerations I have presented, the next step would be to consider the practical challenges of implementing the suggestions provided here. This goes for both the topics.

Firstly, regarding *surrogate decision-making*, specifying the particular conditions needed to ensure the reasonable outcome of the process of collective deliberation is still to be worked out in further detail. I have mainly pointed out the general direction of the work needed. Moreover, discussion is needed on how the deliberating process described here would be aligned with the work carried out by clinical committees already established within hospitals in many countries.

Secondly, it is important to make empirical investigations of how street-level bureaucrats are actually motivated when they make claims on resources on behalf of their clients or patients. It seems to me that analysing how street-level bureaucrats are subjected to expectations of reasonableness would be a fruitful path to learn more about the ideal characteristics of the individuals who distribute the goods of the society. Theoretically, there is tension between the direction of justification of reasonable claims when enacting political autonomy from an aggregated point of view and reasonable claims when enacting moral autonomy from within a context of a particular individual. This appears to me to be a promising starting point for understanding the motivational forces at play when just distribution is to be ensured in the

face of particular individuals with their particular needs. However, a more detailed analysis of the views of Rawls and Scanlon than the one presented here would be required.

Thirdly, there is a need for empirical investigation of the effects of *social determinants* on physicians' judgment about particular health care needs, or more precisely; the effects of equity reasons on health care decisions. Do physicians actually incorporate such reasons when considering health care needs? Moreover, a hypothesis that these kinds of reasons actually work against the implementation of clinical guidelines should be tested to provide useful information for those developing guidelines.

Fourthly, partly connected to the point made above, the approach to reasonable claims on health care provided in this thesis could also provide a theoretical basis for innovative empirical research design. A theoretical concept of a decision oriented street-level bureaucrat could be modelled according to the normative context of judgment settled by the institution a street-level bureaucrat is supposed to realise on the one hand and the various levels of justification according to which he or she might justify his or her judgments as *best calculated* on the other. Empirical surveys could be designed to see what kinds of reasons street-level bureaucrats actually respond to in given hypothetical contexts (while recognising that this will not necessarily be the same they would decide in a real context). In the case of health care workers, the contexts could be presented with minor changes representing bio-technical, social and cost-effectiveness conditions so as to make it possible pick up on the reasons that make a difference in the street-level bureaucrat's idea of a need for health care. The results of such a survey could bring valuable information about the way of justified reasonableness constitutes motivation in health care workers. This might be useful knowledge which might partly explain the variation in adherence to clinical guidelines. And equally important, this would also be a way to pick up on and clarify the kind of reasons street-level bureaucrats are moved by and subject these to public scrutiny in order to test their level of justified reasonableness (and legitimacy) empirically. This would be a way to open up for democratic influence upon the individual, discretionary judgment of street-level bureaucrats, as described in article IV. A fully developed democracy must be expected to allow for criticism and challenge of established practice from those whom the practices concern.

From the point of view of justice, the appropriateness of my suggestions to institutionalised surrogate-decision-making and just distribution of individual health care depends heavily on

the justification of the method of reflective equilibrium. This is not mainly a question about whether humans actually reason in the way the method suggests. Rather, it is a question of whether the method is sufficiently justified to play the role it is assigned to. Do we reach adequately justified beliefs about the appropriate institutions by arguing according to this method? This is an issue for further theoretical research.

There are, of course, several theoretical issues waiting to be explored. When I have discussed the relation between micro- and macro level decision-making, I have presupposed the legitimacy of clinical guidelines. This assumption must be challenged. Because of the different contexts of justification at work at the different levels of decision-making within a state, concepts of *legitimacy* could be elaborated at each distinct level in order to avoid fallacies when applying the results of fair procedures at one level directly on to decisions at another level.

The interpretation of *clinical judgment* involved in this thesis as it is exercised within a public health care system challenges the view that an adequate understanding of clinical judgment represents value neutral knowledge about bio-technical concerns when determining particular health care needs. A profound analysis of how clinical judgment works through the whole procedure of 1) diagnosing the patient, 2) considering treatment relevant to the condition, 3) supplying the treatment and 4) evaluating the recovery of the patient, is based upon various kinds of value assessment and should be systematically worked out in order to obtain theoretical and political transparency of the highly important distributive work of physicians.

Finally, I have tried to demonstrate the political implications of theoretical bioethics as input in the development of policies. I take it that there is a need to elaborate more on the constraints and implications of the methodological consideration of theoretical bioethics discussed here.

## ***Concluding remarks***

This thesis has centred on two topics; surrogate decision-making for individuals assessed non-competent to make their own decisions and fair distribution of health care at the clinical level of decision-making. The papers included in this dissertation lead towards two separate frameworks that suggest substantial changes to current practice in order to avoid exploitation of vulnerable individuals and to ensure fairness in the micro-level distribution of health care. Independently of the arguments offered in the articles, I have approached the same topics by considering the normative meta-regulations inherent in delegated discretion. Against a background of values central to a democratic welfare state, these meta-regulations add up to a general framework for good discretionary judgment applicable to anyone acting as surrogate decision-makers or as street-level bureaucrats aiming at fair distribution of social goods. The two substantive frameworks I suggest concerning respectful decision-making on behalf of individuals lacking or with reduced competence on the one hand and reasonable clinical judgments on the other, were exposed as realisations of the general conditions inherent in delegated discretion. I do acknowledge that the distinct intuition and principle based approaches have been affected by the fact that I grew up in a ‘democratic welfare’ state and that this has formed my common morality and affected my normative reasoning. Nevertheless, I take the mutual confirmation of the two distinct argumentative approaches, bottom-up and top-down, to speak in favour of two normatively robust frameworks. The frameworks might provide a basis for policies to improve and develop democratic welfare states.

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