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RESPECT FOR PERSONS PERMITS PRIORITIZING TREATMENT FOR HIV/AIDS

THADDEUS METZ

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ABSTRACT
I defend a certain claim about rationing in the context of HIV/AIDS, namely, the 'priority thesis' that the state of a developing country with a high rate of HIV should provide highly active anti-retroviral treatment (HAART) to those who would die without it, even if doing so would require not treating most other life-threatening diseases. More specifically, I defend the priority thesis in a negative way, by refuting two influential and important arguments against it inspired by the Kantian principle of respect for persons. The 'equality argument' more or less maintains that prioritizing treatment for HIV/AIDS would objectionably treat those who suffer from it as more important than those who do not. The 'responsibility argument' says, roughly, that to ration life-saving treatment by prioritizing those with HIV would wrongly fail to hold people responsible for their actions, since most people infected with HIV could have avoided the foreseeable harm of infection. While it appears that a Kantian must think that one of these two arguments is sound, I maintain that, in fact, respect for persons grounds neither the equality nor responsibility argument against prioritizing HAART and hence at least permits doing so. If this negative defence of the priority thesis succeeds, then conceptual space is opened up for the possibility that respect for persons requires prioritizing HAART, which argument I sketch in the conclusion as something to articulate and defend in future work.

I. INTRODUCTION

I am interested in answering a question about a particular sort of healthcare rationing in a developing country with a high rate of HIV infection. Supposing that such a country cannot afford to treat all those with life-threatening illnesses, would it be morally right for it to give priority to those suffering from HIV/AIDS? Concretely, ought the state generally provide highly active antiretroviral treatment (HAART) to those who will die without it at the expense of, say, kidney dialysis to the young with kidney failure or chemotherapy and surgery to the aged who have cancer?[1]

[1] Although this question focuses on how to ration only *treatments* for life-threatening illnesses, an answer to it would prima facie ground an analogous answer to a question about how to ration *preventative measures* with respect to them.

Address for correspondence: Thaddeus Metz, Philosophy Department, University of the Witwatersrand, Private Bag 3, Johannesburg, WITS 2050, South Africa. metzt@social.wits.ac.za

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I suspect that an affirmative answer is justified, but I do not seek to provide a complete defence of such a view here. A complete defence would require, among other things, providing an argument in favour of the 'priority thesis' that a developing society ought to treat HIV/AIDS before other potentially fatal conditions, which, in turn, would require addressing some of the most controversial issues in healthcare rationing – for just one example, whether the elderly have a *pro tanto* weak claim to treatment. I do not have the space to undertake such a project, although I note that the intuitive rationale favouring the priority thesis is, very roughly, that acting in accordance with it would do a lot of good. Treating HIV/AIDS in a poor country with a high rate of HIV, even when doing so would require forgoing other life-saving treatments, would be a way to save many long lives worth living, something that is desirable in itself and that would also have the function of preventing orphaned children, violent crime and more poverty. In the conclusion of this article, I sketch the direction that such a positive argument for the priority thesis ought to take, noting that it can have a deontological foundation and need not be grounded on consequentialist considerations. In the body, however, I defend the priority thesis negatively, by refuting objections to it. My main goal is to show that influential arguments against the claim that a developing state ought to favour treatment for HIV/AIDS over other life-threatening illnesses are unsound.

More specifically, I aim to rebut two arguments against the priority thesis that have been thought to follow from the Kantian principle of respect for the dignity of persons. The 'equality argument' more or less maintains prioritizing treatment for HIV/AIDS would objectionably treat those who suffer from it as more important than those who do not. The 'responsibility argument' holds, roughly, that acting in accordance with the priority thesis would wrongly fail to treat people as responsible for their actions, since most people with HIV could have avoided infection. One way to object to these arguments would be to reject a Kantian conception of morality in favour of, say, a utilitarian one. That, however, is not my strategy. I instead suppose that right action is largely, if not entirely, a matter of treating people with respect, and maintain that respect grounds neither the equality nor responsibility arguments. If this negative defence succeeds, such that no reason is left to find the priority thesis disrespectful, then conceptual space is opened up to provide a positive argument that the principle of respect requires it.

Note that it is, on the face of it, difficult for the defender of the priority thesis who accepts the principle of respect to respond effectively to *both* objections. If a Kantian were to object to the responsibility argument, then it would be natural for her to claim that a person's 'responsibility' for having acquired a disease is morally irrelevant since all that matters is that her life is at stake – which claim undercuts the thesis that lives threatened by HIV should be saved before those that are not. And the straightforward Kantian way to object to the equality argument would be to say that the bare fact of lives being at stake does not exhaust the reasons for treating some instead of others, since decisions individuals have made in the past can be relevant to whether they warrant treatment now – which claim is also in tension with the thesis that even those who could have avoided bringing HIV upon themselves should receive treatment at the expense of those not responsible for suffering from other terminal diseases. It seems as though *either* the equality argument or the responsibility argument must be sound, given a Kantian moral outlook, for the intuitive way to object to one of these arguments is to invoke the key premise from the other one. My task is to resolve this dialectical conundrum, showing that, in fact, neither argument against the priority thesis is sound.

I begin by briefly clarifying the priority thesis and the principle of respect (II). Then, I articulate the equality argument against the priority thesis and explain why the standard and forceful objection to it from a respect-based perspective appeals to the relevance of patient responsibility in the past (III). Next, I spell out the responsibility argument against the priority thesis, and I refute it by analyzing the relevance of responsibility in more detail than is usually done in the context of bioethics (IV). I argue that, even supposing that many of those with HIV could have avoided becoming infected, basing decisions about whom to save on responsibility in the appropriate way does not entail the disrespectfulness of the priority thesis. I conclude the paper by

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suggesting ways to develop a positive, respect-based argument for the priority thesis in future work (V).

II. AN ANALYSIS OF PRIORITIZING HAART AND OF RESPECT

The priority thesis is the claim that the state of a developing country with a high rate of HIV infection should provide HAART to those who would die without it, even if doing so would require not treating other life-threatening diseases. This is a rough statement, and one major task in this section is to reduce its vagueness and to provide some nuance. Another is to spell out the respect-based moral theory I shall use to evaluate it.

The priority thesis

First off, the priority thesis is a claim about the obligation of a state; it does not say anything about the obligation of private institutions. In so qualifying the thesis, I do not mean to suggest that the latter are not obligated to prioritize HAART. Instead, since the two arguments against prioritization most naturally apply to a public medical context conceived as required to treat citizens with respect, I focus on it, leaving open the possibility of extending the thesis to include a private clinic or hospital.

The state of a developing country with a high rate of HIV infection 'ought' to prioritize HAART in both moral and legal senses. Its medical institutions are ethically obligated to favour treatment of HIV/AIDS, which ethical obligation ought to be politically enforced. A court system should force a recalcitrant state's medical institutions to prioritize HAART, although I am not sure whether an HIV positive citizen may rightly sue the state if it does not decide to prioritize HAART over treatment of other life-threatening illnesses.[2]

[2] I am unsure of deeming such a lawsuit to be permissible since the state might have a duty to favour treatment of HIV positive individuals over treatment of those with other life-threatening illnesses, which duty is not correlated with a right to prioritized treatment. For discussion of duties without correlative rights, see O. O'Neill. 1989. The Great Maxims of Justice and Charity. Repr. in O. O'Neill, *Constructions of Reason.* New York, NY: Cambridge University Press: 219–234. Note that denying a right to sue in the case where the state has not adopted the policy of prioritizing HAART is consistent with granting a right to sue in the case where the state has adopted this policy but failed to act in accordance with it.

When I say that 'other life-threatening diseases' should go untreated if necessary to treat HIV/AIDS, I do not mean literally all others, but rather most. I suspect that treatments for some non-HIV-related diseases share the characteristics that would make it respectful to prioritize HAART. In the conclusion, I indicate what these characteristics are, and suggest some other treatments that are likely also worth prioritizing. In short, I am not maintaining that only HAART should be prioritized, but that it is one of a small handful of treatments that should be (I set them aside, however, in the rest of my discussion).

Finally, the priority thesis does not imply that HAART should *invariably* be provided before other life-saving treatments. The priority thesis instead maintains that there is a strong *pro tanto* duty for the state to generally favour the provision of HAART, which duty is often but not always conclusive. For there to be a strong *pro tanto* duty to prioritize HAART means that there is moral reason to *some* significant degree to do so, which reason could nonetheless be outweighed by other reasons in a given situation. Even if there is sometimes all-things-considered justification for favouring the treatment of non-HIV-related diseases, I maintain that there would usually be some significant moral loss in doing so and that there are comparatively few cases in which treatment for such diseases should be favoured.

To illustrate the point, consider an analogy with hiring someone for a job. Job-related qualifications provide strong *pro tanto* reason to hire a given individual, but they are not necessarily decisive. Factors such as affirmative action could mean that, in a particular instance, there is conclusive reason to offer the post to someone who is not the best qualified. This point is consistent with the claim that qualifications should be a 'priority' when hiring, i.e. that something morally important is lost if a less than the most qualified candidate is hired and that typically qualifications should win out.

The principle of respect

Having spelled out the priority thesis in more detail, I now provide a brief analysis of the moral perspective with which I appraise it, the Kantian principle

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of respect for the dignity of persons. Although this moral theory is familiar, it is important to differentiate it from related ideas in order to avoid confusion.[3] The Kantian norm maintains that persons ('agents'), i.e. beings with the capacity for reflection and for action in light of it ('autonomy'), have a superlative intrinsic value ('dignity'). They are good for their own sake just because of their nature as persons, and this goodness is higher than anything else in the world.

Note that moral status is deemed to inhere in personhood, and not human life *qua* biological kind. Respect for human life would likely require sacrificing resources in order to protect an anencephalic neonate, but respect for personhood probably would not. From a Kantian (but not Catholic) perspective, our most fundamental obligation is to treat beings with the capacity for reasoned deliberation and choice as having a qualitatively superior final goodness. Conversely, our basic duty is to refrain from degrading agents, i.e. not to treat beings with the capacity for autonomy as though they lack a dignity.

To *treat* a person a certain way is to perform an action for a certain purpose (to act on a 'maxim'), and hence is not a matter of whether this purpose is in fact realized or of whether this action has certain consequences in the long run. For instance, to kill an innocent for the purpose of obtaining money treats her disrespectfully, whereas killing an aggressor in order to protect one's innocent self does not, and this is so regardless of what the long-term results of such actions might be, viz., even if the former action turns out to benefit many, and even if the latter action in some way goes horribly awry.[4]

More generally, coercion and deception, when done for purposes other than defence of the innocent or punishment of the guilty, are disrespectful in that they treat another person's capacity to make decisions merely as a means to an end. However, the principle of respect must not be reduced to the claim that we must not treat people solely as tools or must not interfere with permissible exercises of their autonomy; there are three other, more positive (but non-utilitarian) obligations that respect grounds, for a large majority of Kantians.[5] First, respect requires us to aid other persons, at least when we can do so at little cost to ourselves. Intuitively,[6] refusing to rescue a drowning child so as to get to a movie on time would be disrespectful, i.e. would treat a person as having less than the highest intrinsic value. It is such a judgment that, from a Kantian perspective, grounds the state's duty to adopt welfare programmes such as public healthcare; they are justified because they sustain and develop people's ability to reflect on, adopt and pursue ends (not because they make people happy). Second, respect for persons requires treating persons as equals, something that can go beyond the mere avoidance of manipulation. To award competitive opportunities such as education and jobs on the basis of race or gender, for example, would be degrading even though it might not involve any interference (and even if it would maximize the general welfare). Third, respect for persons requires treating people as responsible for their behaviour by allocating benefits and burdens based on the kinds of choices they have made. Criminal and civil liability, for example, should be largely based on past facts about guilt (as opposed to what would best promote people's quality of life in the future).

These latter two respect-based requirements are what pose a prima facie problem for the priority thesis. The equality argument maintains that a

[3] Immanuel Kant is the primary philosophical source of the principle of respect for the dignity of persons, but I do not seek to present Kant's own specific views. Instead, I here articulate a theory of morally right action stemming from Kant's writings that many contemporary professional ethicists have found persuasive. For my own articulation and partial defence of a Kantian perspective, see T. Metz. The Reasonable and the Moral. *Soc Theory Pract* 2002; 28: 277–301.

[4] There is of course more to say about the way the consequences of actions should matter to a Kantian. For instance, any plausible Kantianism will maintain that an action must be *likely* to realize its purpose, but will deny the claim that the *actual* realization of the purpose has any bearing on the rightness of the action.

[5] In *The Doctrine of Virtue*, Kant construes respect as merely negative, practical love as positive, and both responses as required by the fundamental duty to treat persons as having a dignity (or as 'ends in themselves'). Contemporary Kantians have changed the terminology so that a duty to respect rational nature is now the broad, fundamental requirement that admits of both negative and positive dimensions.

[6] Ascertaining which actions are (dis)respectful, and hence wrong, requires judgment informed by reflective equilibrium on the nature of (dis)respect. Unlike consequentialism, one cannot draw a conclusion about what is wrong merely by conjoining certain empirical claims (about what the consequences of actions would be) with a fundamental moral principle (prescribing the best consequences). Respect-based reasoning about what is wrong invariably includes an intermediate, normative judgment about what is (dis)respectful, which judgment is, for most contemporary Kantians, justified on coherentist grounds.

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developing state that provides scarce life-saving treatment to HIV positive individuals but not to others would fail to treat people as equals, while the responsibility argument holds that such a state would fail to distribute limited resources on the way people have made choices. In the rest of this article, I aim to show that the priority thesis is in fact compatible with the proper understanding of what is required to treat people as equals and as responsible.

III. EQUALITY AGAINST PRIORITY

The Kantian maintains that persons have an equal worth, so far as morality is concerned. If the personhood of a given two individuals is equally valuable, and if the personhood of each is at stake, then it would appear that the two individuals have an equal claim to aid in maintaining their personhood. And if they have an equal claim to aid, then the priority thesis is false, for it says that someone at risk of dying from HIV/AIDS typically has a stronger claim to aid than others who are dying from something else. That is the equality argument against priority, in a nutshell.

One does not often find this view articulated by mainstream, secular, professional bioethicists. However, something like it is popular among religious bioethicists who believe in the sanctity of life, and I often hear medical practitioners express it. Indeed, as Dan Brock notes, 'the conventional view in medicine' is that need alone matters,[7] so that those who have an equally urgent need, and an equal chance of having the need satisfied, have an equal claim to healthcare resources. If two lives are at stake, and if each but not both can be rescued, then one must use a random procedure to determine whom to save. Not to use a lottery, and instead to save someone because she will die from HIV/AIDS, would be to treat her as more important than the other person, so the objection goes.

The equality argument against priority would be plausible if human life were what had a fundamental moral status warranting honour. However, the Kantian denies that it does, instead maintaining that the capacity for agency is what has basic moral value requiring respect. Assuming that the capacity for agency is what we must avoid degrading, most Kantians hold that whether it is degrading not to save someone in the present depends partially on the way this capacity has been actualized in the past, which is logically distinct from the issue of need.

There are two different ways that, for the Kantian, previous decisions can affect whom one ought to save. First, sometimes a choice that an *agent* has made in the past affects whom that agent ought to rescue now. To start with a non-medical case, suppose that you are a bodyguard and currently on duty with a client with whom you have contracted to protect. Imagine that an assassin comes to kill your client. You see that you can save either your innocent client or an innocent bystander, but not both. Most friends of the principle of respect for persons would say that you have most moral reason to save your client. Although two persons have an equal need and an equal chance of having that need satisfied, the fact that you have promised to satisfy one person's need provides extra reason to save that person.

Now, medical practitioners just are bodyguards of a special sort. They protect the bodies of patients, not from aggressors, but from diseases. So, if a hospital has for some reason promised to provide life-saving treatment to one patient rather than another who equally needs it, the hospital has more reason to save the person to whom it made the promise. Such a case illustrates that, from the perspective of respect, need is not the only criterion to use when choosing between lives to save; past actions also matter and are often decisive.

More relevant in the present context, however, is the second way in which previous decisions can affect the respectfulness of choosing whom to save. Decisions made by a *patient* also matter when ascertaining whether it is respectful to help one patient rather than another, equally needy one. Again consider a non-medical case before turning to a medical one. Suppose that you are a United Nations (UN) soldier and see three men trying to kill a woman merely because of some arbitrary characteristic such as her ethnicity. Imagine that you have only two choices, namely, either to allow the three aggressors to kill the one innocent or to use deadly force

[7] D. Brock. Justice, Health Care, and the Elderly. *Philos Public Aff* 1989; 18: 297–312: 299.

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against the three in order to save the one. Even if neither you nor the UN has promised to protect the innocent, respect for persons requires that you shoot the guilty three people, supposing they do not heed your warning to desist. The reason it is right to kill the three, if necessary to save the one, is roughly that the three are intending to seriously wrong the one. If burdens must be imposed on someone, then, still roughly, they ought to be imposed on those who have created (in certain ways) the burdens in the first place.[8]

This principle about basing burdens on the choices that created them applies with equal force to a medical context. Consider a variant of the UN case. Imagine that a physician happens to see the three aggressors trying to cleanse the community of the innocent one and also witnesses the UN soldier shoot the three men after they had begun to shoot the woman. Suppose that all three of the men and the woman are wounded and that the medic has only two options of whom to save. Either he can save the three men, on the one hand, or he can save the woman, on the other. I submit that treating persons' agency as having a dignity uncontroversially requires the doctor to save the woman. It would be a moral travesty, from the perspective of respect, to flip a coin to decide whom to save or to save the three because there are more of them (actions that a principle of respect for the sanctity of life might well recommend).

What all these cases illustrate is that the central premise of the equality argument is false. It is not true that, just because two persons with life-threatening conditions are equally valuable, it would necessarily be degrading not to use a random procedure to determine which of them to save. When deciding which individuals with the capacity for autonomy to rescue, respect requires consideration of the way they have exercised this capacity. In particular, it demands factoring in whether some of them are in some way responsible for needing to be rescued (at least at the expense of someone else who needs to be rescued and is not responsible for having created that need).

So far, so good for the friend of the priority thesis, supposing the equality argument has been shown to be unsound.[9] However, the straightforward and familiar way that I have objected to it raises a new problem for the priority thesis. The principle of responsibility I have invoked, which says that past choices by patients ought to crucially affect whether they receive treatment, is prima facie incompatible with the priority thesis, which suggests that the past choices those with HIV/AIDS have made are generally irrelevant, or of little importance, when it comes to deciding whether to treat them. Some Kantians might seek to reject the general relevance of responsibility, but to do so would be implausible. And, in any event, the friend of the priority thesis cannot reject it, lest she be forced to accept the equality argument against priority; for the comparatively best, even if absolutely poor, argument against the relevance of responsibility is the claim that need alone matters when lives are stake. In the following, I therefore seek to explain why, even supposing respect requires basing treatment on responsibility, respect permits priority to be given to HIV/AIDS patients, or at least a very large majority of them.

IV. RESPONSIBILITY AGAINST PRIORITY

My task in this section is to show that the best interpretation of the relevance of responsibility with regard to distributing healthcare resources is consistent with the priority thesis. To do this, I proceed dialectically, that is, I start with the boldest, and perhaps most influential, principle of responsibility,

[8] For more on respect and the requirement of burdens and benefits to track choices in the contexts of economic justice and criminal justice, respectively, see T. Metz. Arbitrariness, Justice, and Respect. *Soc Theory Pract* 2000; 26: 25–45, and T. Metz. 2006. Judging Because Understanding: A Defence of Retributive Censure. In *Judging and Understanding*. P. Tabensky, ed. Aldershot: Ashgate Publishing Ltd.: 221–240.

[9] I have shown only that need is not decisive when it comes to principled medical rationing, not that it is utterly irrelevant. As Michael Selgelid has pointed out to me, it could still be the case that need provides *pro tanto* moral reason to randomize when selecting which lives to save in a medical context. However, if it is the case that a factor such as responsibility can outweigh need when rationing life-saving resources, then it is likely that other factors can, too. Any more complete refutation of the equality argument against prioritizing treatment for HIV/AIDS would be possible only upon consideration of the positive arguments for prioritizing, i.e. arguments appealing to the quantity, length and quality of saveable lives, as well as the urgent benefits to third parties of saving certain lives. These factors, I submit, would quite plausibly 'break the tie' among equally vulnerable lives, providing reason to save those threatened by HIV/AIDS rather than randomize.

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present counterexamples to it, refine the principle so that it avoids the counterexamples, offer new counterexamples to the refined principle, reformulate the principle again, and so on. I present counterexamples that I believe friends of respect for persons – and any non-consequentialist – would find compelling upon reflection.[10] The principle that remains the least vulnerable to such counterexamples and that is therefore most justified for making respect-based decisions about rationing turns out to be consistent with the priority thesis, or so I argue.

How responsibility should affect the distribution of scarce resources

Here is the simplest and strongest principle of responsibility, one often invoked when discussing how to allocate not only medical goods, but also any benefit or burden pertaining to justice:

> PR1: Respect for persons requires people to bear the burdens of decisions for which they are responsible, rather than pass those burdens onto others without their consent. If $person_1$ has intended to act in a way that will harm others, has foreseen that her action would do so, or could have foreseen it, then respect-based justice forbids making $person_2$ involuntarily suffer, or otherwise pay the costs of, the harm done by $person_1$.

By performing actions that led to one's HIV infection, one has created a need for scarce life-saving treatment that would have to be paid by the state and could go to someone who has a need for it but did not create that need. One is therefore disqualified from receiving treatment, at least for any morally fundamental reason. Recently, David Benatar has invoked something like this rationale to argue that, while as a practical matter the state should treat all those with HIV/AIDS, the state has no principled reason to treat those who could have avoided becoming infected. In addition to there being some people suffering from HIV infection who are in no way responsible for their condition, Benatar remarks:

> there are other people who share in responsibility for the HIV tragedy. This is true of every HIV-positive person who contracts or transmits the condition through negligence, indifference, arrogance, or weakness . . . [S]tate provision of social services is justified by the needs of those who require them through no fault of their own. Those who are responsible for their predicament are not morally entitled to such services. Nevertheless, because it would be both extremely difficult and dangerous for the state to determine who are and who are not responsible for their condition, the state has reason to provide social services to all who need it.[11]

In light of Benatar's rationale, one might reject the priority thesis. For him, those who could have avoided contracting HIV in themselves provide no moral reason at all for the state to treat them, let alone provide strong moral reason for the state to give their treatment priority over those with other life-threatening diseases. It is probably in light of similar reasoning that one quarter of the UK public believes that drug users who contract HIV through dirty needles should be denied free medical treatment.[12]

Although PR1 is commonly invoked in discussions of how to allocate healthcare and other scarce

[10] Some of the counterexamples are 'fantastic' in the sense of unlikely to occur, and I often supplement them with somewhat more 'realistic' cases. However, for methodological reasons, I do not refrain from presenting fantastic cases, for several reasons. First, fantastic cases are useful to control for certain variables, and are sometimes indispensable (e.g. to show that persons are not necessarily humans one must appeal to the 'fantastic' concept of extraterrestrial aliens). Second, they are standard fare in philosophy, widely taken to ground compelling arguments in other fields. (Consider, for instance, the Twin Earth thought experiments that so quickly vanquished the descriptivist account of reference.) Third, work by many of the deepest and most influential bioethical thinkers, including F.M. Kamm and J.J. Thomson, routinely invokes fantastic cases. Fourth, some of the fantastic cases that I appeal to are already in the literature on self-defence, punishment and wealth, and part of my project here is to bring out their relevance for bioethics; ignoring these cases would threaten the unified account of responsibility I am after.

[11] D. Benatar. HIV and the Hemi-Nanny State. *Lancet Infect Dis* 2002; 2: 394. For other examples of PR1 or something close to it, invoked both inside and outside a medical context, see R. Arneson. Liberalism, Distributive Subjectivism, and Equal Opportunity for Welfare. *Philos Public Aff* 1990; 19: 158–194 (esp. 187); E. Rakowski. 1991. *Equal Justice*. New York, NY: Oxford University Press; P. Montague. 1995. *Punishment as Societal-Defense.* Lanham, MD: Rowman & Littlefield Publishers: esp. ch. 2; and J. Kekes. On the Supposed Obligation to Relieve Famine. *Philosophy* 2002; 77: 512–514.

[12] *BBC News*. 2004. HIV Ignorance Still Common in UK. Online: BBC: 1 December. Available at: http://news.bbc.co.uk/go/pr/fr/-/2/hi/health/4056367.stm [Accessed 7 Dec 2006].

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resources, it is too blunt and should be rejected in favour of a revised responsibility principle. To use a counterexample inspired by the literature on distributive justice,[13] suppose that Joseph refuses to wear protective gear when riding a motorcycle and that he crashes because he was speeding. It is no doubt Joseph's own fault that he is writhing in agony before you, a neighbour who knows of Joseph's 'live free or die' attitude. Still, it would be disrespectful for you to do nothing to help him, instead simply watching in morbid fascination or leaving to go walk your dog. It would be degrading of Joseph for you not at least to call an ambulance from a public hospital, and it would be similarly degrading for the public hospital not to treat Joseph upon discovering that he alone was responsible for the accident and the extent of the injury.

Benatar says that, in practice, medical practitioners should not take account of responsibility, and so he might try to recommend that they rescue Joseph. However, his principles do not support such a recommendation in this case, where we presume that the paramedics know that Joseph could have easily avoided his injury. In correspondence, Benatar suggests that the intuition that the paramedics should rescue Joseph is a function of implicitly assuming that they do not know that Joseph is responsible for his needing help. His concern is that the intuition that Joseph should be aided carries no weight, since it 'is affected by the fact that we ordinarily do not know whether the person is responsible for his condition. If we ordinarily do not know, then we might be inclined, for this reason, to think that we should help.'[14] But that strikes me as implausible. Keeping it clearly in mind that the paramedics know that Joseph is solely responsible for the harm that has befallen him, I submit that most (and not merely friends of respect) would say, upon considered reflection, that they have a duty to rescue him, if they can do so with relative ease.

Furthermore, an explanation of why this duty obtains is readily available: the need to respect Joseph's dignity as a finite rational being. There is principled and not merely pragmatic reason for the paramedics to help Joseph, i.e. Joseph himself provides reason to help him. Refusing to help Joseph in this situation would fail to treat him as though he is an autonomous being with a superlative intrinsic value. True, Joseph has exercised his capacity for autonomy in a foolish way, and giving him medical assistance is going to cost taxpayers money that we may suppose he cannot repay. Even so, when a person is responsible for facing a life-threatening injury and when it could be treated at minor cost to others, others have a duty to try to alleviate that harm (supposing the person desires such help from them). Otherwise, they are acting as though small financial resources are more important than persons. Hence, PR1 is false.

In response to this counterexample, the critic of the priority thesis may seek to revise her principle of responsibility to accommodate it. She may point out, for example, that the problem with prioritizing treatment for HIV/AIDS over other life-threatening illnesses is that those suffering from the latter would not bear a merely minor cost on the order of somewhat higher taxes. Instead, if priority were given to those with HIV/AIDS in a developing country that cannot treat all life-threatening illnesses, then those facing non-HIV related life-threatening illnesses would lose their lives. Let us therefore consider this version of the principle of responsibility:

> PR2: Respect for persons requires people to bear the *substantial* burdens of decisions for which they are responsible, rather than pass those burdens onto others without their consent. If $person_1$ has intended to act in a way that will *gravely* harm others, has foreseen that her action would do so, or could have foreseen it, then respect-based justice forbids making $person_2$ involuntarily suffer, or otherwise pay the *significant* costs of, the *serious* harm done by $person_1$.

PR2 does not entail that others have no obligation to help Joseph, since the costs of helping him are insubstantial (or so I suppose in the case). PR2 therefore avoids the counterexample to PR1. PR2 is a problem for the friend of the priority thesis, which maintains that others should pay significant costs – sometimes their lives – because of the choices of those who could have avoided acquiring HIV. The priority thesis is the claim that a public hospital has

[13] E. Anderson. What is the Point of Equality? *Ethics* 1999; 109: 295–296.
[14] Correspondence with the author, 23 February 2006.

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strong moral reason to provide HAART to those who would die without it, even if they could and should have avoided their infection and even if providing HAART to them would mean that others with non-HIV-related terminal diseases would not have access to the life-saving treatment they need. In a condition of scarcity where we must choose between one of two lives, it seems that it would always be disrespectful to save the one who has created a need to have his life saved, supposing the other did not create his need. If heavy burdens must be imposed on someone, then surely the respectful course is to impose them on those who could have avoided the need to distribute heavy burdens in the first place. Or so it seems.

There are counterexamples to PR2 to be found, not in bioethics journals or books so far as I am aware, but rather in analytical literature on self-defence, which literature has happened to use medical examples. A common theme is a medical professional whose negligence will result in the death of another person unless the medical professional is killed. Suppose, for instance, that a near-sighted doctor has carelessly swallowed a patient's pacemaker (thinking it is a pill) and that the only way to replace the pacemaker in time is to immediately slice open the doctor's belly.[15] Or imagine that a lab assistant forgets something and as a result infects her supervisor with a deadly disease that can be cured only by a blood transfusion that would kill the assistant.[16] Less fantastically and more commonly, consider a surgeon who, failing to take due care, does irreparable harm to a patient's liver. Even if the patient were to go on a waiting list and receive a liver from someone other than the surgeon himself, someone else on the list will not get that liver, and so the surgeon's mistake would still cost someone her life unless he gives up his own liver and hence his life. PR2 entails that the negligent parties in these three cases *must* bear the cost of death,[17] for they are responsible for the fact that someone must bear such a cost and, if the negligent parties do not die, then other parties, ones who are not responsible for the fact that someone must die, will involuntarily die. However, few would say that respect for persons *requires* (let alone permits) killing the negligent parties in these cases.

To avoid such counterexamples, let us reformulate the principle of responsibility again. Even if negligent decisions are insufficient to ground an obligation to bear heavy burdens resulting from them (supposing that someone must bear these burdens), reckless or purposeful decisions might plausibly be deemed sufficient to do so. Consider, then, the following:

> PR3: Respect for persons requires people to bear the substantial burdens of decisions for which they are *knowingly* responsible, rather than pass those burdens onto others without their consent. If $person_1$ has acted in a way that she *foresaw* would gravely harm others, then respect-based justice forbids making $person_2$ involuntarily suffer, or otherwise pay the significant costs of, the serious harm done by $person_1$.

PR3 avoids the three medical practitioner counterexamples facing PR2 since it does not say that one's negligent action is sufficient to make one liable for all the substantial harm that it does. Instead, PR3 says that being aware that one's choice is likely to do grave harm – by definition absent in negligence – is necessary for having a duty to suffer or pay for it. Since a number of people who are HIV positive were aware that their behaviour could result in HIV infection and hence the need for life-saving treatment in a condition of scarce resources, PR3 entails that prioritizing treatment for them would be disrespectful and hence unjustified.

However, PR3 seems vulnerable to counterexample. Consider a case in which Kumi, a woman who has lived all her life in a patriarchal society, visits a society that is egalitarian, or at least much less male-dominated. Imagine that Kumi has been in this new country for a few days, when one of her hosts, Mark, decides to take her for a long drive to see the sights. After Mark has driven for an hour or two, he asks Kumi whether she would like to drive. Despite the fact that Kumi has never driven in her life, knows the harm that can result from a car accident, and is worried that she might crash the car, she says that she would like to drive. Kumi then turns out to

[15] D. Wasserman. Justifying Self-Defense. *Philos Public Aff* 1987; 16: 366–67; cf. Montague, *op. cit.* note 11, pp. 48–49.

[16] C. Ryan. Self-Defense, Pacifism, and the Possibility of Killing. *Ethics* 1983; 93: 518–519.

[17] Supposing, of course, that the other party does not volunteer to die.

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collide with another vehicle, causing severe injury to herself and the other driver. Suppose, now, that the paramedics have the time and resources to save only one person. Whom should they rescue?

PR3 entails that, upon learning of the cause of the accident, the paramedics *obviously* should decide to rescue the other driver.[18] However, it is far from clear that there is conclusive, let alone strong, reason not to save Kumi, keeping in mind Kumi's background. First off, Kumi was not used to men asking whether she would like to do something; what have the form of 'requests' from men in her society are usually in content commands. Second, Kumi lacked the self-esteem to be assertive, at least when it came to saying 'no' to a man. Third, Kumi was scared of what the man's reaction to her non-compliance would be; in particular, she feared his anger and the chance of being abandoned in a place where she cannot support herself. Fourth and finally, Kumi had never spoken about driving before with her family or friends, partly since women are not supposed to drive in her culture and since her parents would have found it awkward to discuss.

Now, Kumi has been reckless and not merely negligent; she was aware that driving could well result in injury and she chose to drive anyway. In light of the above four factors, however, it is not clear that respect for the capacity to make autonomous decisions requires her to be the one to die. The reason is that liability for substantial harm is a function not merely of having knowledge that it is likely to result from one's action, but also of having sufficient control over one's action. Kumi has made a voluntary decision to drive, and her decision is neither justified nor fully excused by the four factors. They do, nevertheless, mean that Kumi had much less than full control over her choice to drive, which mitigates the extent of her responsibility for the choice, and does so arguably enough to make it respectful to save her instead of the other injured driver. I therefore propose a fourth version of the principle of responsibility, one that will be attractive to those doubtful that respect requires Kumi to bear the burden of death.

> PR4: Respect for persons requires people to bear the substantial burdens of decisions for which they are knowingly *and freely* responsible, rather than pass those burdens onto others without their consent. If $person_1$ has acted in a way that she foresaw would gravely harm others, *and if she had substantial control over the decision to perform the action*, then respect-based justice forbids making $person_2$ involuntarily suffer, or otherwise pay the significant costs of, the serious harm done by $person_1$.

PR4 does not entail that Kumi must die, and hence avoids the problem facing PR3. That does not mean, however, that PR4 would clearly be the object of consensus among friends of respect for persons. If Jones is in a crowd and throws a grenade at an innocent, isolated Smith, Smith may not lob the grenade back at Jones; this is true if many more innocents would be killed along with Jones and even if there were nowhere else for Smith to lob the grenade.[19] For another case, consider a sergeant who, annoyed by a private, sends him on an unnecessarily dangerous mission. Even if the only way to rescue the private from enemy fire were to draw it upon himself, the sergeant need not bear that cost, if the only way to get his other, green troops to safety were to stay alive and guide them. What these two cases suggest is that parties responsible for the prospect of serious harm should not bear it if doing so would risk even more serious harm to innocents. So, consider the following:

> PR5: Respect for persons requires people to bear the substantial burdens of decisions for which they are knowingly and freely responsible, rather than pass those burdens onto others without their consent, *but not if innocent third parties would be substantially burdened as a result*. If $person_1$ has acted in a way that she foresaw would gravely harm others, and if she had substantial control over the decision to perform the action, then respect-based justice forbids making $person_2$ involuntarily suffer, or otherwise pay the significant costs of, the serious harm done by $person_1$, *assuming innocent third parties would not be*

[18] Again, supposing the other driver has not volunteered to die.

[19] Some may complain that this case is unrealistic, but it illustrates in simple terms what, after all, the US government claimed the recent war in Iraq was about. Even if Saddam Hussein had had weapons that he would have used to try to kill tens of thousands of US citizens, it would have been unjust for the US to launch a war that was likely to kill hundreds of thousands of Iraqi citizens.

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gravely harmed were person$_1$ to bear the harm or the costs of it.

As one might expect, there are counterexamples to PR5. However, since they do not affect debate about the priority thesis, I do not revise the principle in light of them.[20] If any principle of responsibility should be invoked to evaluate the priority thesis, PR5 (or something very close) is it. I shall grant that it should in principle play a major role when allocating resources, and should do so in practice when and only when reliable information about people's degree of responsibility is readily available.

Recall that I have been searching for the most justified principle of responsibility in order to provide a firm ground for a respect-based objection to the priority thesis. The basic objection is that since many with HIV/AIDS are responsible for their plight, they do not warrant priority treatment. Executing such a general argumentative strategy in the particular context of PR5 would give us this argument against the priority thesis:

1. Respect for persons requires people to bear the substantial burdens of decisions for which they are knowingly and freely responsible, rather than pass those burdens onto others without their consent, though not if innocent third parties would be substantially burdened as a result.
2. The priority thesis entails that a state ought to pass the substantial burdens of decisions for which many of those suffering from HIV/AIDS are knowingly and freely responsible onto others suffering from other life-threatening illnesses for which they are not so responsible and to do so without the latter's consent, even though innocent third parties would not be substantially burdened by making those suffering from HIV/AIDS bear these burdens.
3. Therefore, respect forbids acting in accordance with the priority thesis.

Premise one is just PR5, which I grant for the sake of argument. So, the key question is whether premise two is true, something I answer in the remainder of this discussion.

Replies to the responsibility objection to the priority thesis

There are two plausible ways to rebut the second premise, two reasons for denying that considerations of responsibility undermine the claim that those with HIV/AIDS should generally receive treatment before those suffering from other life-threatening diseases. One is that very few of those infected with HIV in the developing world count as 'knowingly and freely responsible' for being infected. A large majority of those who are HIV positive in poor societies are not responsible of the sort required by PR5 to be liable for bearing the burden of death, even supposing they could have avoided creating a situation in which someone must die. I now defend this key claim, noting that most of those infected with HIV in developing countries fall into one of two categories: those who were not aware of what would lead to HIV/AIDS and hence were not 'knowingly responsible,' on the one hand, and those who were aware of what would lead to HIV/AIDS but lacked the substantial ability to avoid risking infection and hence lacked 'free responsibility,' on the other.

First, then, consider the dismal statistics regarding how many people in developing countries are aware of how HIV is contracted and prevented. A recent study shows that 50% of South Africans who have tested positive for HIV did not think they were at risk of infection and that 66% of the South African general population does not think it is at risk.[21] In sub-Saharan Africa, only 8% of young people outside of school have access to education on

[20] Two cases come to mind. First, if a good Samaritan reasonably believes that a certain course of action would help someone but it ends up harming her, the Samaritan is not liable to give up his life if necessary to save the victim's. So, if a SWAT member shoots a hostage, fairly thinking that wounding her would be the most effective way to rescue her and save her life, then the SWAT member is not liable to give up his organs if necessary to save the hostage's life. Second, some might hold the view that, even if killing first-degree murderers could somehow bring back their victims, or even if torturing torturers could somehow heal the wounds of their victims, it would be disrespectful and hence wrong to do these things. If one is sympathetic to both cases, then we need a PR6 that makes exceptions for rescue attempts and uncivilized actions. These exceptions are not relevant to the question of whether to prioritize HIV/AIDS, since virtually no one acquires HIV so as to save others and since the issue is which people to let die, not whom to kill.

[21] Daily News Central: Health News. 2005. *Ignorance about HIV Risk Rampant in South Africa*. Online: Daily News Central: 30 November. Available at: http://health.dailynewscentral.com/content/view/0001972/43/ [Accessed 7 Dec 2006].

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prevention (with only slightly more in school having it),[22] and according to a recent UNICEF study, 'only 20 per cent of women aged 15 to 24 were able to identify the two prevention methods and the common misconceptions about HIV.'[23] More generally with respect to developing countries, the same UNICEF study shows that 'more than 80 per cent of the young women did not have 'sufficient' knowledge about HIV/AIDS. Many had no idea how HIV/AIDS is transmitted and little or no information on protection methods.'[24] Given that women are more likely to be infected than men, these figures say a lot about the scope of ignorance about HIV. Part of the explanation for the lack of knowledge are cultures that discourage discussion of sex; another part is the lack of contact with prevention services; and another part of it is self-deception, refusal to acknowledge painful realities.

One might argue that many of those ignorant of facts about HIV transmission could and should have known more about it, but such a claim is simply not relevant at this stage of the debate. Even supposing that many could and should have learned more about the disease, their failure to have done so would constitute a lack of due care, i.e. negligence, but, as was argued above against PR2, harming severely and negligently is not sufficient for respect to require one to bear that harm. Instead, a necessary condition for respect to require one to bear a grave harm that one has done is having *foreseen* it, if not intended it. Since the harm having been *foreseeable* is insufficient, all those unaware for whatever reason of how they could have avoided HIV infection are not responsible in the sense relevant to questioning the priority thesis.

Now consider the second major category of people infected with HIV in developing countries, those who were aware of how to avoid contracting HIV but who were insufficiently able to avoid doing so.[25] Part of this group consists of women who have been outright coerced into sex. To illustrate, according to one study, half of young women in the Caribbean who have had intercourse say that their first sexual encounter was forced,[26] while 25% of South African women report the same.[27] Another part of this group are women who have trusted their husbands to keep their promise to remain faithful but whose husbands have slept around, acquired HIV and passed it onto their wives. Still another part are poor women who are exploited for sex by men with money. Sometimes this takes the form of prostitution, while other times it is a matter of women submitting to the sexual demands of their male partners because of economic dependence. And yet another part are women feeling pressured to conform to gender roles, lacking self-esteem and hence finding it difficult to negotiate sexual relationships with men, e.g. being unable to demand that a condom be used. Women who suffer one or, more often, a combination of these influences lack sufficient control to be deemed 'freely responsible' for having contracted HIV. They face at least as much external pressure and internal inability as Kumi in the counterexample to PR3 above.

In addition, men often engage in risky sexual behaviour because of peer pressure and their own judgment of what it is to be masculine. Both the expectations of others and their own sense of what a man ought to do tend to encourage men to have many sexual partners, to father many children, to refuse to wear condoms and to engage in sex even when consent has not been given. Of course, these influences do not utterly excuse behaviour that will foreseeably do grave harm to themselves, their sexual partners and others who might have to bear the cost of their HIV status. Yet they do reduce the degree of fault involved, for it takes more to have to

[22] Joint United Nations Programme on AIDS (UNAIDS). 2004. *2004 Report on the Global AIDS Epidemic (Executive Summary)*. Geveva: UNAIDS. Available at: http://www.unaids.org/bangkok2004/report.html [Accessed 7 Dec 2006].

[23] Joint United Nations Programme on AIDS (UNAIDS), United Nations Population Fund (UNFPA), and United Nations Development Fund for Women (UNIFEM). 2004. Women and HIV/AIDS: Confronting the Crisis. Online: UNAIDS/UNFPA/UNIFEM. Available at: http://www.unfpa.org/hiv/women/report/ [Accessed 7 Dec 2006].

[24] Ibid.

[25] For overviews of why people in developing countries often engage in risky behaviour despite awareness of the risks, see C. Campbell and Y. Mzaidume. How Can HIV be Prevented in South Africa? A Social Perspective. *Br Med J* 2002; 324: 229–232; and UNAIDS et al., *op. cit*. note 23.

[26] L. Halcón et al. 2000. *A Portrait of Adolescent Health in the Caribbean*. Minneapolis, MN: University of Minnesota and Pan African World Health Organization: 14.

[27] *New York Times*. 2006. The 'She Asked for It' Defense Wins. *New York Times* 10 May: Editorial. Available at: http://www.nytimes.com/2006/05/10/opinion/10wed2.html [Accessed 11 Dec 2006].

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overcome the fear of exclusion, ridicule, shame and even depression than not to.

I conclude that a very large majority living with HIV in developing countries, although infected as a result of actions that were not downright involuntary, are not responsible for their infection in the sense relevant to PR5. Most either were not aware that they would be likely to contract HIV or were not easily able to avoid contracting it, which means that PR5 does not deem them liable to suffer the burden of death, supposing that, because of scarcity, preventing their death would mean that others with non-HIV related terminal conditions would die. Hence, PR5 poses no threat to the priority thesis.

The critic of the priority thesis at this point will naturally pose the following question: what about those who *have* had the requisite responsibility for having become infected with HIV? Surely there are *some* people who have been reckless and who did not face external pressure and internal obstacles.

I do think it would be naïve to think that literally all those in developing countries who are HIV positive either could not have easily refrained from risky practices (e.g. multiple sexual partners, unsafe sexual practices, dirty needles) or did not know that such behaviours would be likely to result in HIV infection. However, I point out that the numbers of such people are relatively small. There is *pro tanto* disrespect and injustice in these people receiving priority treatment at the expense of others who are not at all responsible for their life-threatening illnesses. In light of this, I can at this point conclude that considerations of responsibility do not undermine the thesis that, in principle, a *very large majority* of those suffering from HIV/AIDS in developing countries should receive treatment before others facing other life-threatening illnesses. While that is a weaker claim than 'all,' it is significantly more robust than a critic of priority would be content to grant.

Furthermore, there is a way to defend the more robust claim that treatment for *all* those suffering from HIV/AIDS should be given priority, even given PR5 and even supposing there are many who are 'freely and knowingly responsible' for being HIV positive. Even if the latter do not *themselves* warrant treatment (if treating them would require not treating others who are not so responsible for their terminal disease), PR5 implies that it can be right to give them treatment anyway in the case where *innocent third-parties* would otherwise suffer. The responsibility argument against priority must say that making those freely and knowingly responsible for their HIV infection bear the burden of death would not severely harm many others who are innocent, but this is not true, particularly in places such as Swaziland, South Africa and Botswana, where 10–35% of the population is infected. Not prioritizing treatment for HIV/AIDS in these developing societies would indirectly harm many innocents, including literally millions of children who would become orphans and who, lacking socialization, would tend to support themselves and to resolve conflicts with force. It would also harm millions of people who would die prematurely or be debilitated as a result of poverty. Since it is by and large the sexually active who produce socialized children and economic wealth, great social harm can be avoided only if treatment for HIV/AIDS is prioritized, and great social harm must be avoided, even if those with the disease foresaw infection and had sufficient power to avoid it.[28]

In this section I have worked to show that the most defensible respect-based principle of responsibility relevant to the just allocation of benefits and burdens does not undermine the priority thesis. Supposing that most people in developing countries could have avoided contracting HIV, in a very large majority of cases their actions have lacked the sort of responsibility required to be liable to suffer the severe hardships of AIDS. The kind of responsible choices that would make it disrespectful for a person to receive life-saving treatment at the expense of another's life are, by PR5, those in which the person intended or at least foresaw the death that her action would cause (not merely could have foreseen it) *and* had a substantial degree of control over the action (not merely performed a voluntary action). But very few who have acquired HIV in the developing world satisfy these two conditions. And if I am incorrect

[28] There is no implicit appeal to utilitarianism here. Instead, respect-based reflection on the way responsibility ought to influence the distribution of scarce resources has grounded it. The basic idea is a need to balance respect for autonomy in one way, by tracking its exercise in the allocation of healthcare, with another way, by preventing death. A similar kind of balance is appropriate when it comes to allocating economic shares, on which see Metz, 2000, *op. cit*. note 8.

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about this and there are many who do satisfy these conditions, considerations of responsibility à la PR5 do not forbid prioritizing treatment for them, since lots of innocent third parties would be seriously harmed otherwise.

V. CONCLUSION

I have sought to resolve a dilemma facing the friend of both respect for persons and the priority thesis, the claim that a developing country that cannot provide life-saving treatment to everyone who needs it may rightly give it first to those with HIV/AIDS. It initially seemed as though either the equality argument or the responsibility argument against the priority thesis had to be true, supposing the principle of respect for persons were true. The equality argument maintains, roughly, that only the patient's need to maintain her capacity for agency matters when allocating life-saving resources in a respectful way, in which case the person dying from HIV/AIDS has no greater claim to treatment than someone dying from another disease. The natural objection to make to the equality argument is that not only need matters from the perspective of respect; responsible choices made by patients in the past also matter when rationing in life and death situations. But, if that is true, then respect apparently entails that most of those suffering from HIV/AIDS have no claim to treatment, let alone prioritized treatment, since they have brought about foreseeable and avoidable harm to themselves and since others with terminal diseases have not.

I have worked to show that the principle of respect does not require holding one of these two arguments against prioritizing HAART. My central strategy has been to maintain that, while past responsible choices that patients have made are indeed relevant to allocating healthcare resources, the sort of responsibility that is relevant does not undermine the priority thesis. Specifically, I have argued that the kind of responsible choices that would make it disrespectful for someone to receive life-saving treatment at the expense of someone else's life are, roughly, those in which the agent has foreseen the death that her action will cause and had a substantial degree of control over whether to perform the action. Since a very large majority of those with HIV in developing societies lack either an awareness that HIV/AIDS will result from their actions or a substantial degree of control over the actions that will lead to HIV/AIDS, they are not responsible for having contracted HIV in a way that would make it disrespectful to give them treatment at the expense of others' lives.

I reiterate that in this article I have argued merely negatively, i.e. provided reason to reject arguments against the priority thesis and hence shown that we have no reason to doubt that respect permits priority. I have not argued positively by offering reason to accept the priority thesis itself. I conclude by sketching considerations for thinking that respect requires prioritizing treatment for HIV/AIDS in a developing country that cannot treat all life-threatening conditions, which I believe are worth exploring thoroughly in future work.

There are four factors that I suspect at least jointly would make it disrespectful for states of developing countries with high rates of HIV not to prioritize HAART, even if doing so would mean that people suffering from many other life-threatening illnesses would die. First, most of those stricken by HIV/AIDS would live *lives that are worth living* if they received HAART, which contrasts with, say, preventing a permanently comatose individual from dying or saving someone who would live in constant agony. This need not be construed as a utilitarian idea, for respect requires helping others in ways that are likely to promote their ability to pursue ends.

Second, helping HIV positive individuals would promote *long* lives, unlike, e.g. treatment of cancer for someone in her 80s. Such a concern for the length of life also does not have to be understood in utilitarian terms, for there are probably reasons of fairness for denying life-saving treatment to those who have already had the opportunity to lead a normal life.[29]

Third, HAART is cheap, costing about one US dollar a day, which contrasts with, e.g. the high cost of dialysis. Once again it might appear utilitarian and so disrespectful to base decisions of whom to save on money, but considerations of money in

[29] See R. Dworkin. 2000. *Sovereign Virtue: The Theory and Practice of Equality.* Cambridge: Harvard University Press: ch. 8.

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effect track *high numbers of lives*, which is in fact sometimes relevant to respect. If you are in a rowboat and have the option of saving either one person stranded on a rock or four people stranded on another rock (and cannot save all five), respect for persons probably requires saving the four.[30]

Fourth, many more *innocent third parties would be seriously harmed* as a result of not treating those with HIV/AIDS relative to not treating other life-threatening illnesses. Since so many people with HIV/AIDS in developing societies have children, millions will become orphaned if HAART is not prioritized. In addition, students, medical patients and citizens generally will be harmed as school teachers, medical professionals and police officers die from HIV/AIDS. And, more generally, those who would have the most to gain from a developing economy, the poorest, will be harmed as a result of the most productive segment of the population dying off from HIV/AIDS. The harm to third parties from not treating those with HIV/AIDS differs dramatically from the harm that would result from, say, not treating those who suffer from brain tumours. Here, once more, this consideration need not be understood to be utilitarian, for the Kantian principle of respect requires public institutions to help citizens, where helping means doing what is at least likely to enable them achieve their goals.[31]

All four of these rationales are deeply controversial, making it appropriate to discuss them in detail elsewhere. I close by noting that, if these four considerations are indeed a sound basis for prioritizing HAART, then they might also entail that states of developing countries should prioritize treatments for certain other diseases as well. It is worth considering, for example, whether treatment for tuberculosis, which kills two million people a year, might also warrant prioritization, along with treatment for diarrhoea and malaria, which together kill three million children each year.

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[30] See, e.g. the discussion in T.M. Scanlon. 1998. *What We Owe to Each Other*. Cambridge: Harvard University Press: 230–234.

[31] See section II above. For discussion of a respect-based duty to aid the general population in the context of HIV testing, see T. Metz. The Ethics of Routine HIV Testing: A Respect-Based Analysis. *S Afr J Hum Rights* 2005; 21: 370–405.

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