

# Philosophical, Ethical, and Moral Aspects of Health Care Rationing: A Review of Daniel Callahan's *Setting Limits*

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By

Richard T. Hull, Ph.D.

## **Introduction**

My assigned task in today's colloquium is to review philosophers' perspectives on the broad question of whether health care rationing ought to target the elderly. This is a revolutionary question, particularly in a society that is so sensitive to apparent discrimination, and the question must be approached carefully if it is to be successfully dealt with. Three subordinate questions attend this one and must be addressed in the course of answering it.

The first such question has to do with the issue of justice: how is it fair to target the elderly in achieving reductions in health care costs? Isn't the proposal, or for that matter, isn't targeting any age group, morally objectionable as a species of ageism, just as targeting members of a particular race or sex would be racist or sexist?

The second subordinate question has to do with the issue of fittingness. Given that we can show in some way that targeting the elderly is not inherently unjust, why would limiting health care to them be a fitting thing for medicine to do? How would it fit, for example, with the traditional commitments of medicine, to sustain life, to relieve suffering, to heal and cure and restore function? And in particular, if medicine has the ability to save and relieve and restore the elderly, why should it replace that set of commitments with a different set for this particular population?

The third subordinate question seems political, an arena reserved for one of my speaker colleagues today. There are, I believe, some underlying philosophical dimensions to its answer, and so I will say something about it. The philosophical/political question is, Given that rationing health care to the elderly is not patently unjust, and given that a case can be made out that the ends of medicine are not violated by such limitation, why should the elderly, as a group, assent to such a limitation?

I want to address these subordinate questions, for I believe them to be the chief stumbling blocks for the possibility of an affirmative answer to our

main question of whether health care rationing ought to target the elderly. Permit me to take them up in order.

### **Justice**

One might begin exploring the question of justice in targeting the elderly by commenting on a dissimilarity between it and questions of justice in targeting other groups. While the question speaks of the elderly as though they were a group of individuals identifiable by a set of definite descriptions in a manner similar to “the Jess” or “the Blacks,” we would do well at the outset to remind ourselves, following the cartoon character, Pogo, that “We has met the elderly, and the is (or will be) us.” That is, our question today is one of whether we should agree to limit health care to ourselves when we read a certain age. I note that Dan Callahan predicts it will take another quarter century to achieve the reorientation of our thinking so that rationing can take place. I’m now 51; add 25 years, 76! He’s talking about rationing MY health care!

That we are talking about all of us and not just one group is an important, although initial, response to the charge that any such proposal is “ageist,” on a par with racist or sexist discriminations. It does differ in the one respect that it is a proposal that affects all who reach a certain age, not just a particular subgroup. Thus, the tests of fairness and impartiality – that is, one of the tests of justice – seem to be passed by the proposal. The proposal is (in the form in which it is given) to target the elderly, not the poor elderly or the Black elderly or the elderly of a particular state.

This initial observation will enable us to apply one of the traditional tests of fairness. In fact, the question is not even counterfactual: if you were in such and such a position, would you agree that so and so be done to you? The question is very real for all of us who will not die before we are old: what will we agree to when we reach that age by way of differential treatment from what we expect now?

Nonetheless, most of us contemplating the question today are not yet in the group that is affected by it. Further, the question arises in the context of competing claims from other age groups – in particular, from (or, rather, on behalf of) children – and members of the adult population for whom poverty limits access to health care, only some of whom are elderly. If economic pressures are the chief factors initiating the question, why don’t considerations of justice mandate rationing health care for all groups, instead of targeting only the elderly?

So we must take a deeper look at the question of justice. To that end, it will be useful first to remind ourselves of some features of our notions of justice, features that have been long-standing determiners of debates over questions of justice.

Aristotle is usually credited with formulating what is now called the formal principle of justice: Treat equals equally. Much has been said about this principle, but its conceptual outlines are clear: we are not just if we treat two individuals unequally unless there is a relevant difference between them. Many of the historical battles over human rights have had as a component a struggle to ascertain whether there are relevant differences between, say, the races, or the sexes, such that differential treatment is morally required (or at least permitted).

In our present context, we may rephrase the question: Is there anything morally relevant about the elderly that bears on our treatment of them? Specifically, is there anything true of the elderly as a group that is not true of any other age group, anything that would be relevant to targeting them for some significant limitations in their access to health care?

One of the most thoughtful and thorough attempts to answer this question is that of Daniel Callahan in his 1987 book, *Setting Limits: Medical Goals in an Aging Society*. Much of what I have to say in my remaining time aims at encouraging the audience to obtain and ponder this book. For Callahan takes as his twin tasks the identification of the special features of the elderly from which arise both their value *and* the rationale for limiting health care for them.

The distinctive quality, which Callahan sees as relevant to our thinking about the elderly, is the quality of *having lived a full life*. Callahan believes that the elderly generally possesses this quality by their late 70s to early 80s. Having lived a full life encompasses having accomplished, or had the opportunity to accomplish, most of life's major possibilities. "These include work, love, the procreating and raising of a family, life with others, the pursuit of moral and other ideals, the experience of beauty, travel, and knowledge, among others."

This characteristic of having lived a full life has several important consequences. One is that the notion of "a natural life span" is defined biographically, not biologically. Even if the biological limit to human life is, say, 120 years, biographically one has lived a full life by the time one achieves two-thirds of that theoretical limit. A second consequence of this biographical characterization is that for one who has lived a natural life span, death is not a tragedy. One has experienced life's possibilities in large measure; one's chief moral obligations to those for whom one has had responsibility have been discharged, and one's death will not seem "an offense to sense or sensibility, or tempt others to despair and rage at the finitude of human existence. Death at such an age is not "premature," not because it occurs at the theoretical limit of biological life for the species but because it does not occur before the major elements of one's life narrative are achieved.

This characteristic of having lived a full life Callahan sees as defining the unique value of the elderly to society. The elderly are conservators of the past, the medium through which the accumulated wisdom of the culture is transmitted to succeeding generations. The elderly are able to provide perspective to those who are younger and still striving to achieve the various possibilities life offers. The elderly have potential as guides, as sources of reassurance, as ones who have lived through all of life's stages and braved its passages. The elderly are uniquely valuable in this role. Better day care made available socially is an alternative to grandparents as sitters for children of working parents, but there are no alternatives to the elderly as repositories of wisdom and perspectives about experiences yet to come to their future counterparts.

Perhaps the most contribution of the elderly is their perspective on the declines associated with aging, and death's role and place in a life. Biologically, death permits the species to make way for itself; after reproducing and rearing to independence, the dying off of one generation frees resources for succeeding ones. And decline – the gradual failure of biological systems — permits death to occur.

Reproduction in humans is more complex than in other species lacking culture, for reproduction must not involve only the production of a new generation biologically, but its education and enculturation. As keepers of the culture, the elderly serve a vital reproductive role well into the years beyond their physical reproductive limits. And, as ones who have traversed the fullness of life, they play a unique and special role, for which it is appropriate to value them.

These observations prompt anew the question of justice. For, if the elderly are so valuable as transmitters of culture, doesn't it follow that, rather than limit health care resource allocation to them, we should be talking about how to extend their lives so as to retain their value? If as agents of cultural transmission the elderly are so essential, why wouldn't it make more sense to favor the needs of the elderly over other age groups that have less cultural utility? What is it about having lived a full life that constitutes a relevant characteristic in terms of which it makes sense to target the elderly for health care rationing? Let us pause for a moment and review another common ethos, for the purpose of answering this question by means of a contrast.

### **Fittingness**

Much may be said about the value of American individualism: the notion that "individuals have the right to seek that which in their private judgment will bring them happiness," with the only limit on that right being that "they may not do harm to others in seeking their personal self-

fulfillment . . . . The search for the good of human life, for its purposes and ends and meaning (if any), is left to the individual.” (p. 58) The relevance to aging and health care is this: “Individual people will look upon aging in different ways, express different tolerances for the burdens of old age, seek different goals and lifestyles in old age, and differ about how long they want to live and about the medical conditions under which they are willing to die. It is perfectly fitting in a pluralistic society, “dedicated to individual liberty and opposed to a coerced notion of a good life,” “that such differences should exist and be allowed to flourish. Medicine should serve that diversity, which does not in any case admit of a single right answer about what people ought to want.” Unless there is evidence that satisfying the desires of the elderly for a longer and healthy life would harm others, medicine should give people what they want.”

In laying out this liberal, individualistic vision, Callahan notes that it contains no basis but the harm their increasing needs pose to the satisfaction of the needs of others for targeting the elderly for limitations in health care resources any more than any other group. If the demands of the elderly for health care resources harm the health needs of other age groups, or harm social needs other than health, then we have a prescription for intergenerational conflict in which those of different generations will perceive the needs of others as threatening. Moreover, if there is no perspective on the unique value of the elderly, they will be perceived as offering no special value to offset those costs. For their part, the elderly will find that their increasingly greater medical needs will evoke increasing resentment and the stage becomes set for conflict.

But the greatest failing of individualism that Callahan sees is the failure to offer any sense of meaning to the declines and deaths awaiting us all. Death, whenever it occurs, will be outrageous, defensible at best as release from a life in which one is increasingly unable to seek that which in one’s judgment would bring happiness, the final theft of the possibilities of happiness of which one has been systematically deprived by a cruel or indifferent universe. In his view, individualism sets the elderly up for abandonment: abandonment by a society grown weary of their burdensome needs, abandonment by a body of failing systems, and ultimately, abandonment by life itself.

The alternative view, that age and decline and death have positive values at the level of cultural transmission and enablement of new generations, creates the rationale for limiting medical resources for the aging. Having lived a full life means that the ends of medical care should be different for the elderly. Death is not the enemy, discomfort is. Thus, the ends of medicine ought to be to increase the quality of life, to enhance one’s ability to enjoy it, but not to extend life for the sake of more and yet more of whatever it might bring. In particular, Callahan calls for limitation of new

and exotic technologies that make no positive contribution to life's quality but only extend its length, often at the expense of its quality. And, even if such technologies might make for an increased opportunity to live a full life when applied to younger persons, their existence is no automatic warrant for their application in the elderly, simply because the appropriate medical goals for the elderly are different than for other age groups.

### **Medicine's Goals**

We have gone a long way towards answering the second of our subordinate questions, about the fittingness, from medicine's point of view, of limiting health resources for the elderly. If physicians come to see their goals as not the extension of life irrespective of the age of the patient, but as in service of the fundamental human drive to experience life's major possibilities and then to offer relief of suffering, "The needs of the aged, as so defined, would therefore be based on a general . . . ideal of old age and not exclusively, as at present, on individual desires — even the widespread desire to live a longer life." (135) We would therefore have an age-based criterion — the living of a full life — which was also need-based — the need, having lived a full life, to be relieved of suffering — for medicine's limiting access of the elderly to the full range of medical technology in terms of its own, rethought goals.

### **Selling the Idea of Limitation of Access to Life-prolonging Technology to the Elderly**

Our third subordinate question had to do with what possible motive the elderly might have for accepting limitation of access to health resources, given that we come to see that limitation as not unjust and as consonant with medical values. For, the elderly are a large, growing, politically powerful group. Individualism, for all its faults, is still a dominant philosophy and may be expected to become even more so as the generations that have so lived their lives under its influence enter the aged population. What inducement, political or moral, is there for an elderly person to accept a deliberate limitation on the range of medical technology to which he or she may resort?

Let me limit my comments to moral reasons, reserving the more political questions for later speakers. It seems to me that the moral reasons open to the elderly for such acceptance are of two sorts: ones grounded in self-interest, and ones grounded in what might be called a philosophy of life.

Surveys of the elderly seem to indicate that death is perceived with far less apprehension than dying. My own anecdotal experiences, in speaking

to elderly persons in retirement villages, public forums discussing the health proxy law, and persons in nursing homes, support the view that the elderly fear abandonment, suffering, the burdensomeness of medicine's fight to extend life, much more than they do death. One of the more remarkable phenomena of medical psychology is the widespread perception that an old person who resists a possible treatment that might extend life is surely depressed. Medicine needs to take a harder look at what it does when, in either a blind pursuit of a sanctity-of-life principle or a fear of lawsuits from guilt-ridden relatives, it presses the elderly to accept life-extending technology. The chances are that, even the individualism-influenced elderly may not perceive such measures as in their interests.

A second sort of self-interests that may be appealed to is the interest of the elderly in the young. Children and grandchildren often form one of the major areas of satisfaction in the life experience of the elderly, who have assumed substantial moral duties in generating offspring. Pursuit of the satisfaction of those duties has formed a major defining portion of a typical elderly person's life experience. Society's fostering and honoring this commitment to the young may provide the elderly with a connection between their own life's purposes and restraint in their consumption of medical technology.

Finally, it may be that the elderly will find moral reasons for accepting limitation if they more actively develop a philosophy of life that sees death as having its proper locus in life, a locus specified biographically rather than biologically, and seen as a part of the unique value of the elderly as enabling the transmission of life and culture. But it is clear to Callahan, at any rate, that much needs to be done in order to create a climate in which elderly persons and their families can come to see acceptance of the finitudes of life as honorable and valuable instead of a kind of cowardice in the face of the enemy.

## **Conclusion**

One rather interesting consequence of Callahan's views is that health care rationing for the elderly ought to be done even if we had the economic resources to provide that group with a full measure of medical technology. Callahan argues from two points: death is appropriate and acceptable beyond the point at which one has experienced a measure of most of life's possibilities; and, the goals of medicine for the elderly population ought to shift from life-prolongation to relief of suffering. Neither of these points is conditional upon scarcity of resources; neither is conditional upon the elderly constituting a harm, through disproportionate consumption of limited resources, to other age groups.

It seems clear that for the case to be made that it is morally permissible to shift resources away from the elderly, the considerations urged by the principle of justice will have to be taken seriously. If Callahan's characteristic of the elderly, having lived a life, is not successfully urged as a basis for just discrimination, I do not see how the question of our colloquium can be answered affirmatively without providing some alternative to that proposed characteristic. For, the suspicions of discrimination are active and need to be anticipated and dealt with fully in order from such proposals to have a chance of success without great conflict.

In conclusion, let me stress the enormously important role which medicine can and must play in creating a climate in which targeting the elderly for health care rationing will be seen as positive and a part of a renewed valuation of older people. The society still looks to physicians for moral leadership, however much it may force up malpractice premiums. Medicine is seen as a principal social trustee of life and its values. Old styles of medical partnership with families and their values have given way to much more impersonal relations. It may be that physicians will have to spend more time in social communication with the general public, and especially with the elderly population, for health care limitation to be perceived and as neither abandonment nor discriminatory. It may also be that physicians will have to become more active politically, to insure rational redistribution. What is clear is that, without a clear vision of the philosophical, moral and ethical dimensions of what it proposes, medicine will not succeed in this important social revolution.

A final, critical note: There may well be in Callahan's proposals the germ of principles for limiting access to the more exotic resources for other populations. I have in mind those individuals who, because of disease, injury, or congenital defect, are incapable of a "full life." One might construct a morally relevant difference on the grounds that their poor prospects are a tragedy, whereas the important thing about the prospects of the elderly is not a life bereft of fullness, but one replete with it to a full measure. Nonetheless, it may well be that we need to rethink the appropriate goals of medicine for other special populations in light of their special histories and prospects.