Of course, it is easier for people to argue about greedy managed care organizations, evil insurance companies, and incompetent government bureaucrats than to discuss the need to ration health care. After all, everyone agrees that managed care organizations exist. No one agrees whether rationing exists or has to exist. Instead, to many people concerned about health care cost containment, rationing is an unjustifiable evil. It is wrong that it exists. It is immoral that physicians are allowing it to occur. It is even more evil that physicians are often the ones doing the rationing.

Given the relatively recent push to contain health care costs, it should be no surprise that the “R” word is controversial, or that it is often used to discredit political opponents or industry competitors. “Rationing” has become a code word for immoral, inappropriate, or greedy.

Because it is so unpopular, most debates focus more on whether we should ration health care than on how we should do it. In many cases the debaters do not even agree on what it means.

I want to convince people that rationing is necessary. I expect this view will be unpopular. But I am not running for public office, so the only people I have to be popular with are my wife (who is blindly in love with me) and the members of my tenure review board (who won’t read this book). I can afford to be unpopular.

We cannot have it all. We cannot afford to give every health service to every person who could possibly benefit. Most people’s health would improve if they had dietitians review what they ate for dinner and physical therapists work the kinks out of their lower backs. Most hospitalized patients and most nursing home residents would benefit from a higher nurse-to-patient ratio. If we could really afford to have it all, standard contrast dyes would no longer be standard, and newer, more expensive dyes would be offered to everyone. Instead, we would only concern ourselves with effectiveness analyses—showing us what works best so we could make sure everyone gets it. But there are limits to what we can offer everyone, and we must start figuring out how to set those limits.

In traveling farther down this road of gloom and doom, I am not only going to insist that we have to ration health care, but also that some of this rationing ought to be done by physicians at the bedside, and that our most useful rationing tool (at the bedside and at policy levels) is cost-effectiveness analysis. Although there are ethical problems with physicians rationing from their patients, and with rationing according to cost-effectiveness, bedside rationing, based on cost-effectiveness, ought to play a larger role.

The moral questions raised by cost-effectiveness analysis deserve to be debated by a broad audience.

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**Reading 18**

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**The Pied Piper Returns for the Old Folks**

**Nat Hentoff**

I expect that the sardonic Dean of Dublin’s Saint Patrick’s Cathedral, Jonathan Swift, would appreciate Daniel Callahan’s *Setting Limits*—though not in the way he would be.

supposed to. Swift, you will recall, at a time of terrible poverty and hunger in Ireland, wrote *A Modest Proposal*. Rather than having the children of the poor continue to be such a burden to their parents and their nation, why not persuade the poor to raise their children to be slaughtered at the right, succulent time and sold to the rich as delicacies for dining?

What could be more humane? The children would be spared a life of poverty, their parents would be saved from starvation, and the overall economy of Ireland would be in better shape.

So, I thought, Callahan, wanting to dramatize the parlous and poignant state of America’s elderly, has created his modern version of *A Modest Proposal*.

I was wrong. He’s not jiving. . . .

Callahan sees “a natural life span” as being ready to say goodbye in one’s late seventies or early eighties. He hasn’t fixed on an exact age yet. Don’t lose your birth certificate.

If people persist in living beyond the time that Callahan, if not God, has allotted them, the government will move in. Congress will require that anybody past that age must be denied Medicare payments for such procedures as certain forms of open heart surgery, certain extended stays in an intensive care unit, and who knows what else.

Moreover, as an index of how human the spirit of *Setting Limits* is, if an old person is diagnosed as being in a chronic vegetative state (some physicians screw up this diagnosis), the Callahan plan mandates that the feeding tube be denied or removed. (No one is certain whether someone actually in a persistent vegetative state can feel what’s going on while being starved to death. If there is a sensation, there is no more horrible way to die.)

What about the elderly who don’t have to depend on Medicare? Millions of the poor and middle class have no other choice than to go to the government, but there are some old folks with money. They, of course, do not have to pay any attention to Daniel Callahan at all. Like the well-to-do from time immemorial, they will get any degree of medical care they want.

So, *Setting Limits* is class-biased in the most fundamental way. People without resources in need of certain kinds of care will die sooner than old folks who do not have to depend on the government and Daniel Callahan. . . .

Callahan reveals that once we start going down the slippery slope of utilitarianism, we slide by—faster and faster—a lot of old-timey ethical norms. Like the declaration of the Catholic bishops of America that medical care is “indispensable to the protection of human dignity.” The bishops didn’t say that dignity is only for people who can afford it. They know that if you’re 84, and only Medicare can pay your bills but says it won’t pay for treatment that will extend your life, then your “human dignity” is shot to hell. . . .

It must be pointed out that Daniel Callahan does not expect or intend his design for natural dying to be implemented soon. First of all, the public will have to be brought around. But that shouldn’t be too difficult in the long run. I am aware of few organized protests against the court decisions in a number of states that feeding tubes can be removed from patients—many of them elderly—who are not terminally ill and are not in intractable pain. And some of these people may not be in a persistently vegetative state. (For instance, Nancy Ellen Jobes in New Jersey.)

So, the way the Zeitgeist is going, I think public opinion could eventually be won over to Callahan’s modest proposal. But he has another reason to want to wait. He doesn’t want his vision of “setting limits” to go into effect until society has assured the elderly access to decent long-term home care or nursing home care as well as better coverage for drugs, eyeglasses, and the like.

Even if all that were to happen, there still would be profound ethical and constitutional problems. What kind of society will we have become if we tuck in the elderly in nursing homes and then refuse them medical treatment that would prolong their lives?
And what of the physicians who will find it abhorrent to limit the care they give solely on the basis of age? As a presumably penitent former Nazi doctor said, “Either one is a doctor or one is not.”

On the other hand, if the Callahan plan is not to begin with a formula, new kinds of doctors can be trained who will take a utilitarian rather than a Hippocratic oath. (“I will never forget that my dedication is to the society as a whole rather to any individual patient.”) Already, I have been told by a physician who heads a large teaching institution that a growing number of doctors are spending less time and attention on the elderly. There are similar reports from other such places.

Meanwhile, nobody I’ve read or heard on the Callahan proposal has mentioned the Fourteenth Amendment and its insistence that all of us must have “equal protection of the laws.” What Callahan aims to do is take an entire class of people—on the basis only of their age—and deny them medical care that might prolong their lives. This is not quite Dred Scott, but even though the elderly are not yet at the level of close constitutional scrutiny given by the Supreme Court to Blacks, other minorities, and women, the old can’t be pushed into the grave just like that, can they?

Or can they? Some of the more influential luminaries in the nation—Joe Califano, George Will, and a fleet of bioethicists, among them—have heralded Setting Limits as the way to go.

Will you be ready?

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**Reading 19**

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**Letting Individuals Decide**

**Terrie Wetele and Richard W. Besdine**

*Setting Limits* is disturbing in several ways. First, there is the premise that we are justified in setting public policy that determines a “natural life span” for an entire cohort of the population. Referring to the Nazi concept of the *Untermensch*, Callahan notes the evils that result from the political determination that a life is dispensable, but he sets aside the concern far too easily that the elderly—or any other age group, for that matter—would interpret his “natural life span” policy as devaluation of life in old age.

A second concern is whether the program could be applied consistently and fairly. Noting that a policy to limit public payment for life-sustaining care on the basis of age would lead to a two-tiered system in which wealthy older people could still buy such care, Callahan still does not believe that “a society would be made morally intolerable by that kind of imbalance.” It was just such an imbalance between those who could pay for care and those who could not that led to the enactment of Medicare and Medicaid 25 years ago.

Many distinctions on which the proposed program would depend are not made clearly or reliably. For example, the distinction between interventions that prolong life and those that relieve suffering is perhaps easy to make conceptually and in situations, but not at the