The University of Chicago
Graduate School of Business
Center for Health Administration Studies (CHAS)
1101 East 58th Street, Walker 111
Chicago, Illinois 60637
(312) 702-7104

WORKSHOP IN HEALTH ADMINISTRATION STUDIES

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CHRISTINE CASSEL, M.D.
Associate Professor
University of Chicago Hospital

"Rationing Health Care Resources by Age"

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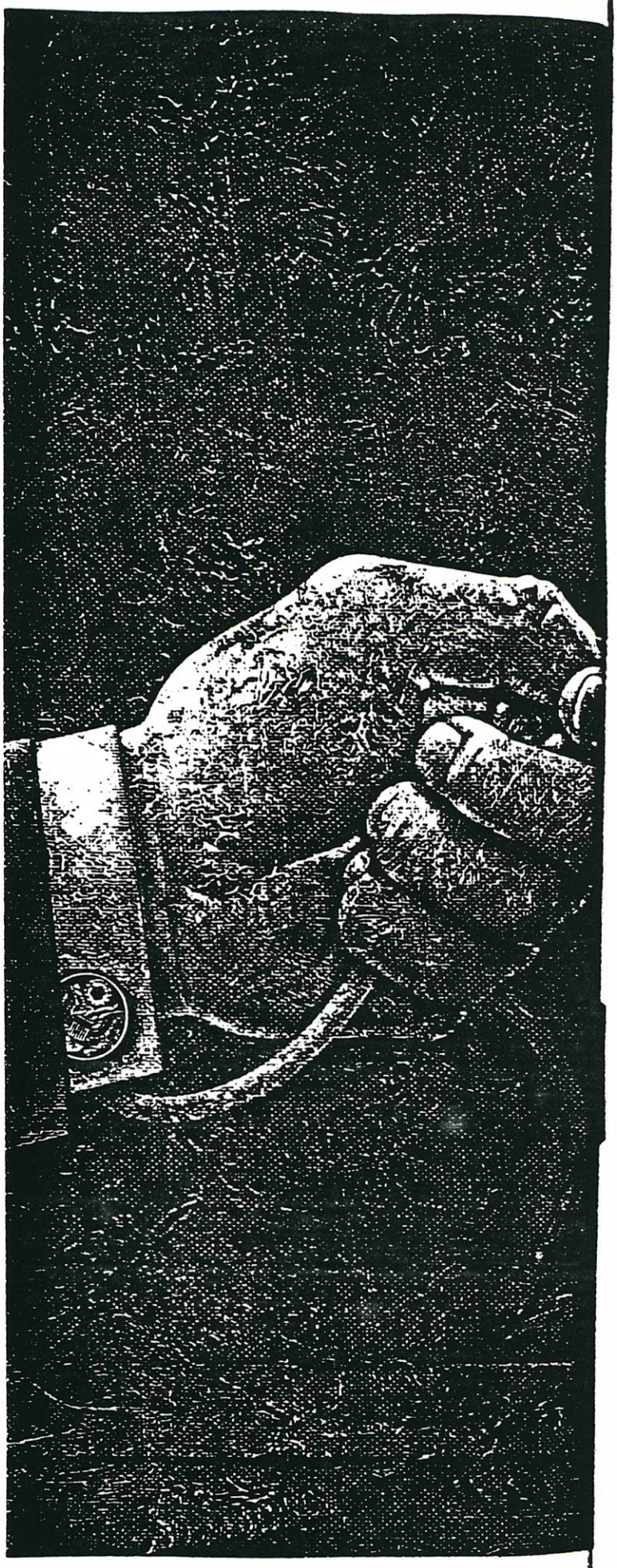
WHEN IT'S TIME TO LEAVE

Can society set an age limit for health care?

By Roy Hoopes



Daniel Callahan, Ph.D., director of the Hastings Center in New York, is a pleasant, gentle 56-year-old man who writes on ethics in medicine. Like Herman Kahn 28 years ago in his book *On Thermonuclear War*, Callahan has chosen to think about the unthinkable—not about the devastating effect of a nuclear holocaust, but about what government will do if it no longer can afford all the high-tech medical equipment people want or need.

Callahan's research and thinking took him down the slippery slope of euthanasia and into the unthinkable possibility of the government setting limits on health care at some point in one's life. He has had supporters, but at the same time he has aroused a stormy controversy some commentators think will drag on until the baby boomers reach their later years. He has also mobilized a range of critics—from Christine K. Cassel, M.D., at the University of Chicago Pritzker School of Medicine (who says Callahan's unthinkable ideas are "neither careful nor thoughtful") to Moses Cammer, a letter-to-*The New York Times* writer (who says they remind him of the medical ethics of Adolf Hitler).

continued

After you've led the Good Life, is it goodbye?

What started the controversy was Callahan's book, *Setting Limits* (Simon and Schuster, 1987). "The time has come," he writes, "in the case of medicine and the care of the aging to develop a more purposive agenda, one that asks just what it is we are after. The short-term successes of medicine continue to divert attention from the now-recognized cumulative social burdens of an aging society they are creating. . . . We can no longer afford to avert our eyes from what that signifies.

"Two basic questions need to be posed," he continues: (1) How should we pursue appropriate goals for medicine "in light of the new possibilities of aging as a stage of life?"; and (2) How should we define the meaning of aging "in light of the new possibilities of medicine?"

Callahan answers: "I want to argue that medicine should be used not for the further extension of the life of the aged, but only for the full achievement of a natural and fitting lifespan and thereafter for the relief of suffering. At the same time, we need to clarify the goals of aging. The primary aspirations of the old should include, among their own reasonable needs, the needs of their fellow elderly and of their families, as well as the welfare of the young in general and of the coming generations."

Callahan cites figures showing that by the year 2000 there will be 9.5 million more elderly, and 600,000 more people in nursing homes, than there were in 1985. He also cites an Urban Institute Study on Medicare that says a moderate projection of the shortfall in Medicare costs after some baby boomers join the elderly will be 0.6 percent of the Gross National Product, or $34 billion.

And that is the moderate projection. "The worst-case projection," says Callahan, "shows the shortfall more than twice as great." But, he says, his argument is not based solely on financial considerations: "Even with relatively ample resources, there will be better ways in the future to spend our money than on indefinitely extending the life of the elderly. That is neither a wise social goal nor one that the aged themselves would want, however compellingly it will attract them."

So Callahan asks: "How might we devise a plan to limit health care for the aged that is fair, humane, and sensitive to the special requirements and dignity of the aged?" What philosopher Callahan (he has a Ph.D. in philosophy from Harvard and is a former editor of the liberal Catholic weekly, *Commonweal*) bases his case on is a new philosophy of aging that he says will help us prepare for the incomprehensible medical health crisis looming ahead. "Our ideal of old age should be achieving a lifespan that enables each of us to accomplish the ordinary scope of possibilities life affords. . . . On the basis of that ideal, the aged would need only those resources that would allow them a solid chance to live that long and, once they had passed that stage, to finish out their years free of pain and avoidable suffering. . . . The needs of the aged, as so defined, would therefore be based on a general and socially established ideal of old age and not exclusively, as at present, on individual desires—even the widespread desire to live a longer life."

Thus a fair basis for limiting health care of the aged would be established recognizing the needs of the elderly within those limits, but "making a clear use of age as a standard."

In other words, after you have led the Good Life, it could be time to say goodbye to your loved ones and friends. But what age and what set of guidelines would be used to help Medicare officials decide when a patient has had what Callahan calls a "natural lifespan" and is ready for a "tolerable death"?

These are difficult questions, but Callahan attempts to answer them: A "tolerable death" comes "at that stage in a lifespan when (a) one's life possibilities have on the whole been accomplished,(b) one's moral obligations to those for whom one has had responsibility have been discharged, and (c) one's death will not seem to others an offense to sensibility, or tempt others to despair and rage at the finitude of human existence."

The question of age is more difficult. Throughout most of the book Callahan avoids being specific about the age when someone might reach the completion of a natural lifespan, which keeps the reader turning pages. For example, in arguing his case for establishing guidelines, he writes: "Though they would face a denial of life-extending medical care beyond a certain age, the old would not necessarily fear their aging any more than they do now, nor would the young—even knowing that life-extending equipment would be cut off at a certain age."

But what age? Callahan takes several pages to answer this critical question, and even then leaves it up in the air: "No precise chronological age can readily be set for determining when a natural lifespan has been achieved—biographies vary—but it would normally be

expected by the late 70s or early 80s. While a person's history may not be complete . . . most of it will have been by that stage of life. It will be a full biography, even if more details are still to be added. Death beyond that period is not now, nor should it be, typically considered premature or untimely. Any greater precision does not at present seem possible."

Callahan recommends more extensive discussion on this point, discussion that "would also have to consider whether, for policy purposes, it would be necessary to set an exact age or a range only, and that would pose a classic policy dilemma. Too vague a standard of a 'natural lifespan' would open the way for too great a flexibility of application to be fair or workable, while too specific a standard—one indifferent to the unique features of individual biographies—would preclude prudence and appropriate room for discretion."

The unthinkable thought, then, is that at some point in the future, after a person has had a natural lifespan, government policy will have to deny that person life-extending medical treatment. And our first hint of the reason comes when Callahan quotes Roman statesman-orator Cicero: "Old men . . . as they become less capable of physical exertion, should redouble their intellectual activity and their principal occupation should be to assist the young, their friends and above all their country with their wisdom and sagacity."

Callahan says the goal of merely seeking a longer and simultaneously better life for the elderly "is a recipe for monomania and bottomless spending. . . . A goal of aging that stresses the needs of future generations, not only those of the old, and a goal of medicine that stresses the avoidance of premature death and the relief of suffering would together provide an alternative to our present situation. . . . Its purpose should *not* be to spare the young the care of the old. Its purpose must be to see that each age group gets what it truly needs to live a life appropriate to it, and to see that each age group gives to the other that which it alone can give."

This ideal of the older generation's obligation to the young is not exactly a new concept. In 1986, former Colorado Governor Richard D. Lamm (who is now di-

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Are we making old age a decent time of life?

rector of the Center for Public Policy and Contemporary Issues at the University of Denver) probably launched the "generational conflict" when he said that old people should be prepared to depart this vale quietly and cheaply in order that they would leave something of value for the young. The following year he further expanded his thesis in a major address, "The Ten Commandments of an Aging Society," to the Eddy Foundation in New York. The ninth of his commandments was: "Do not let young children suffer because of health care we give the elderly." Lamm's argument maintained that we already ration health care "for the benefit of the aged" more than any other group. "We spend more than a billion dollars a day for health care," said Lamm, "but our bridges are falling down, our teachers underpaid, our industrial plants rusty."

About the time the controversy over Lamm's words simmered down, *Setting Limits* appeared and brought the "generational conflict" idea back into the mainstream once again—which is precisely what Callahan had in mind.

"The proper question," said Callahan, "is not whether we are succeeding in giving a longer life to the aged. It is whether we are making old age a decent and honorable time of life."

While many critics agree with Harry R. Moody, Ph.D., of Hunter College's Brookdale Center on Aging in New York, who wrote that Callahan made "a welcome and courageous contribution to an important debate," others do not: "It's a mischievous book," says Robert Butler, M.D., of New York's Mount Sinai Medical Center. "It provides powerful fodder for anyone who wants to save money on health care—people in Congress, people in this Administration, people in future administrations."

Many disagree with Callahan's cost arguments: A Congressional study—*Life-Sustaining Technologies and the Elderly*—says "an analysis of Medicare expenditures shows that the majority of elderly people who die do not incur high Medicare costs in their final years. And of those elderly patients whose health care costs are very high, while approximately half die, the other half survive."

Two students of health cost—William B. Schwartz, M.D., and Henry J. Aaron, Ph.D., —estimate that Callahan's recommendations "would do almost nothing to slow the rise in costs of medical care . . . the impact on costs would be minimal. . . . Indeed, a simple calculation shows that even if all fruits of future medical progress were denied to the elderly, the nearly 5 percent annual growth rate in medical costs would be slowed by less than half a percentage point."

And Chicago's Cassell asserts that even if the cost of keeping the elderly alive in their last years is considered excessive, "it is not immediately obvious that this is a bad way to spend medical dollars."

There are other objections, some of which Moody sums up: "The U.S. spends 11 percent of the GNP on health care. But who says any specific amount is too high? Maybe we would spend more. . . . Increases in health care costs have not come about chiefly because of medical technology. Population aging, malpractice, overtreatment, poor reimbursement incentives and high salaries for medical practitioners have been the real culprits. We should attack these first."

Although all life-extending treatments are not necessarily expensive, what we hear most about are the more costly life-sustaining techniques—the artificial heart, kidney dialysis, respirators, etc.

Callahan, in fact, uses the artificial heart to illustrate his thesis. It costs around $150,000 and will probably provide only four more good years of life; actually one of those years would not be especially good, which means three good years of life at $50,000 a year. Callahan does not think the government should pay this after one has had a natural lifespan.

Another question was raised in an *Atlanta Constitution* editorial: What if the savings turn out to be less than Callahan anticipates? "Who would be sacrificed then?" asked the paper. "Seventy-year-olds? The disabled?"

This, of course, suggests one reason why Callahan's book has aroused such concern. Many people fear that a policy that attempts to rationalize the expiration of any category of people based on age or place in the lifespan's evolution is just one step away from euthanasia—which Callahan, however, argues against: "To sanction euthanasia as a special benefit for the aged," he writes, "would signal a direct contradiction to an effort to give meaning and significance to old age."

Still, there are those who believe that if once you accept any kind of age criterion for ending a life, when circumstances and attitudes change the age criteria can

change. As the *Constitution* suggests, if the age today is late 70s to early 80s (after you have led the Good Life, of course), might it not be early 70s tomorrow?

"There could be two million people over 90 [in the United States] in the early 21st century," says Chicago's Cassell, "and you cannot just let two million people die. We cannot make a policy based on an outdated notion of what the proper lifespan is.

"We do not need an arbitrary age at which to define someone as socially dispensable," she says. "Instead we need a structure for an age-irrelevant society . . . where medical decisions are made on an individual basis."

Early this year, Callahan presented his thesis to an AARP group that included some Association Board members and AARP health care experts. Reaction was mixed. One Board member said, "I do not want extraordinary means used to keep me alive. I think resources should go to infant mortality." Another—a doctor—said, "We must be sure we are extending life, not death." But most everyone at the meeting agreed with the conclusion of the Congressional study *Life-Sustaining Technologies* that decisions about withholding treatment "must be made on an individual basis and should never be based on chronological age alone."

AARP Executive Director Horace Deets observes: "Receipt of health care, including continuing or withholding life-prolonging treatment, should be a matter of personal choice, not rationed on the basis of age. AARP will continue to educate its members about medical treatment options and legal tools, such as living wills and durable powers of attorney for health, to enable them to make—and carry out—more informed decisions about the personal use of life-prolonging technology. We encourage the public discussion required over the next decade to find new methods of health care cost containment and control of new technology to maintain quality care for current and future generations."

It has also been pointed out that there is no guarantee the money saved on extending the life of the elderly would be spent on the young. In fact, as Nat Hentoff, a columnist who specializes in writing about our rights and liberties, wrote: "There is no telling how Congress might transform such a plan, nor is there any way of ensuring that the bureaucrats running the program would be in the caring likeness of Daniel Callahan."

Norman Daniels, chairman of the Tufts University Department of Philosophy, says of Callahan's concept of how you make life meaningful: "He seems to think the aged do it by serving the young, but Claude Pepper makes life meaningful by serving the old."

Daniels also has written a book on the question of health rationing—or rather allocation. It is titled *Am I My Parents' Keeper?* (Oxford University Press, 1988), and his answer is No. Callahan agrees: The number of the elderly, the fact that they are living much longer than they used to, and the sometimes high cost of sustaining their lives has outdated the once-traditional concept that the young of the family had a special obligation to take care of the old.

Daniels' main contribution to the controversy is an effort to supply a just framework for a policy that looks at individuals not as members of one generation, but as needing and deserving health care from the cradle to the grave. "Treating the young and the old differently, however, may not mean treating people unequally," says Daniels. "Over a lifetime, such different treatment may still result in our treating people equally."

Instead of asking what the young owe the elderly, or vice versa, he proposes that the younger generation look at the older generation as "our future selves." The framework for the policy would be a "prudential lifespan account" administered by "prudent deliberators" operating behind a veil that prevents them from knowing what age in anyone's life is "now."

Their task would be to allocate health care resources over an individual's lifetime. In this way, the young could not object to anything given the elderly—and vice versa—because they are all beneficiaries of a presumably fair health care system.

It would be as difficult to administer Daniels' Lifespan Account as anything that might grow out of Callahan's proposal, of course, but some critics believe it rests on a stronger philosophical and moral base. At the same time, Callahan wants it made clear that "I am very much in favor of long-term health care and then some form of National Health Insurance. These things must come first, before we start making long-range plans."

Cassell not only agrees but feels the real solution might be found here: "Other programs, such as National Health Insurance, will be more effective at cost-cutting and cutting the fat out of the system."

Meanwhile, it would seem that Callahan has launched a controversy that might easily run into two decades of seminars, debates and talk shows—at which time he will be nearing the end of *his* "natural lifespan" and be thinking about a "tolerable death," possibly weighing the subject with a new perspective.

But today he says: "I don't want to make a choice then. I want to make it now, when I have had a chance to think it through. I don't think society owes me an artificial heart, even though I might want one at the time. I am stuck with that decision." ■

JAGS 36:644-647, 1988

Should We Ration Health Care by Age?

Larry R. Churchill, PhD

Age-rationing of health care is beginning to be widely debated. Two recent proposals are examined. It is argued that age-rationing proposals must be viewed in the light of current rationing practices, and that all such proposals must be placed in the context of a more just overall health care system. J Am Geriatr Soc 36:614-617, 1988

The rationing of health care by age is being openly debated as a possibility. Yet most discussions overlook the fact that we are already rationing health care in the United States — by age and by a variety of other means. A clear-eyed realization of these practices must inform any new proposals to ration by age. Two of the most compelling arguments for age rationing have been put forword by Norman Daniels and Daniel Callahan. The contention of this essay is that both these arguments fall short, but that the way they fail is noteworthy for furthering the debate and discerning how we might proceed in the future.

RATIONING AS A CURRENT PRACTICE

The realization that we ration health care in this country is slow and painful. It runs counter to the mythic belief that America is a land of plenty and prosperity. Americans tend toward optimism and a belief that technical ingenuity will avoid the specter of rationing that haunts other countries. Henry Aaron and William Schwartz are exemplary devotees of this mythic belief. In *The Painful Prescription*, they describe the travails of British rationing, but are seemingly unaware of the problems of American rationing.[1]

In America we do not ration by a central authority, but by price, and in secondary instances by disease (as in federal coverage for renal dialysis and Hansen's disease) or by age (as in Medicare) or by race (as in the Indian Health Service), and so on. John Wax (in "Ethic and Conflict," an unpublished paper) of the Veterans Administration Hospital of Palo Alto has listed 18 ways to ration health care:

1. Ability to pay
2. Age
3. Residence
4. Entitlement
5. Need
6. Anticipated clinical outcome, or effectiveness
7. Political contacts
8. Acceptability as a research subject
9. Lottery
10. First come, first served
11. Social worth
12. Moral or religious worth
13. Dread factor of the illness
14. Public or media pressure
15. Power of relevant specialty groups to command resources
16. Attractiveness to screeners
17. Risk of death or serious illness or injury if treatment is not forthcoming
18. Risk of legal or financial liability if treatment is withheld

We could find examples of each of Wax's 18 ways, but the basic mode in the U.S. is price rationing. Access is mostly contingent on having a way to pay for it, either out of one's own resources or with some form of insurance. The essential point is that allocation by price is a rationing scheme — one which we have easily accepted in health care as an extension of basic economic assumptions, and one which largely absolves any particu-

From the Departments of Social Medicine and Religious Studies, University of North Carolina at Chapel Hill.

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Address correspondence and reprint requests to L.R. Churchill, Social Medicine, University of North Carolina, Chapel Hill, NC 27599.

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lar persons from responsibility for the results.[2] Because no one actually decided to exclude the poor (as it is their lack of money that excludes them, not our actions), no one is responsible, and no one is to blame. Indeed, the genius of laissez faire health care is that it orders the priorities of care by not ordering them, that is, by letting market forces determine allocation. This enables us to say, regarding the outcomes, that we are all innocent of ill will or prejudice against those who cannot compete. In the end, because no one is in charge, no one is responsible for the bad outcomes. In this way of thinking, inequities and maldistribution are unfortunate, but not unfair.

The difficulties we have in rationing health care in the United States are not just quandaries about how best to allocate our resources. They are difficulties that arise from our reluctance to think about rationing health care at all. The idea is alien and somewhat repugnant, largely because our emotional commitment to ideals of abundance and self-sufficiency have deep resonance.

But to phrase the question rightly we must ask not "Will we eventually have to ration?" but rather "Since we must and do ration health care, what sort of rationing process is just?" Setting priorities in a health care system and deciding on a just allocation for the elderly must take place within this larger realization.

To summarize, the argument so far is this. Our market-driven health care system is a de facto rationing scheme. Current scatter-shot health policies are a mishmash of reactive programs designed to patch and plug a price-rationing system. The result is a secondary system that rations, among other ways, by age (Medicare), by disease (end-state renal disease), by media appeal (parents pleading for livers for their children), and by provider philanthropy. Meanwhile, a powerful set of mythic beliefs keeps the acknowledgment of rationing in the background, through the use of utopian assessments of our abilities and myopia about our needs. The hard choices of scarcity, we tell ourselves, can be avoided by efficiency, technological innovation, cutting the defense budget, or out-producing our needs. In fact, no society has been able to avoid rationing its health care services. The only question is how to do it justly.

RATIONING BY AGE

Should we ration health care by age? One response might be, "Why not?" We ration by other means which are as morally repugnant as age discrimination. I have already noted that we ration by age by means of special funding for the elderly. Perhaps we should not so favor the aged. One could argue that we should let the current, largely market-oriented rationing devices have their play, and let the wealthy elderly buy all they wish and let the poor elderly perish, or give them a Medicare safety net proportional to their Social Security payments. This is a response of equity, in the sense that it fails to either favor or discriminate against the elderly. They get neither more nor less than others just because they are old, and equity is served. But notice it is an equity within a market-driven scheme, and this keeps us from asking the crucial question of whether that larger scheme is itself just. But surely this is just the question we want to ask, and I argue is the only coherent way to ask the question of how much and what kind of health care the elderly should have.

When most people talk about age-rationing, they don't mean dispensing with or curtailing Medicare on some market basis. Rather, they typically favor leaving all this in place and simply having an age cut-off for access to some services. For many, this would mean something like the age-rationing of end-stage renal disease treatment in the United Kingdom, or denying heart transplants, for example, to those over the age of 55.

One such argument in favor of age-rationing is utilitarian. The young have a greater claim to health resources because they have more productive years ahead to be salvaged. This is a "future earnings," or "human capital" approach. Age may not be a perfect predictor of utility, but it is a predictor. If we concede that interventions are less likely to be economically beneficial with the elderly, and generally that the likelihood of benefit decreases progressively with age, then treating the elderly equitably with other age-groups seems wasteful. The idea presented here is that the elderly are getting more than their share of the health care pie. The suggested remedy is to transfer some of these resources to younger age-groups, perhaps especially children, whose overall health care has deteriorated over the past decade.

This is a compelling argument, as long as we take for granted that this sort of crude utility is the aim of health care. In any health care system, there is a need for efficiency. But utilitarian standards, at least in this vulgar version, subvert many of the reasons we think health care important. Efficiency is a means, not an end. And utility is a necessary, but secondary criterion, following more primary moral norms. Besides, once we get beyond sheer quantitative measures of utility (such as years of survival, or dollars earned), utility becomes very difficult to judge. Classical utilitarians, such as David Hume or John Stuart Mill, never supposed that utility could be quantified in this way. Moreover, contemporary utilitarians tend to ignore the social sentiments which classical utilitarians believed undergirded their approach, and without these, utility calculations become provincial and self-serving, as Judeo-Christian traditions have always insisted they are.

A more sophisticated age-rationing possibility is presented by Norman Daniels.[3] Daniels claims that most age-rationing schemes presuppose a synchronic, or slice-of-life perspective, which are invariably age-biased against the elderly. But unlike other rationing

schemes, such as those based on unchanging characteristics such as race or gender, age-rationing might make sense if we adopt a diachronic, or across-a-lifetime perspective. In Daniels' scheme, age-rationing could be part of a larger commitment to egalitarianism. When we are young, we would equitably receive resources to assist us, with the understanding that as we age, relatively fewer resources will be expended so that the next generation may receive the same benefits we received in our youth. So what from a slice-of-life perspective looks unfair seems egalitarian from the over-a-lifetime view.

Daniels' proposal is an intriguing one, and it has merit. But as he himself acknowledges, it will make sense only within a larger social system which is itself cohesive and just. Unfortunately, our current social and political norms encourage just the opposite of this. The body politic is no organic, unified body at all, but a collection of separate, and largely self-interested, interest groups, each lobbying fiercely for its cause and answerable only to its own constituency. In such a system, each individual or interest group is trapped inside its own slice-of-life, without the benefits of an over-a-lifetime perspective, much less an intergenerational view. And if you think I am exaggerating, or that this sort of myopia is confined to health care, think of our farsighted management of issues like nuclear waste, the national debt, or the depletion of the ozone layer.

The most cogent argument for age-rationing is presented by Daniel Callahan, in his new book, *Setting Limits*.[4] Callahan couches his argument in a sense of prudence about the goals of medicine — to help people achieve a natural life span (late seventies, early eighties), and beyond that, to relieve suffering. Deliberately life-extending health care after the natural life span is to be avoided, and such things as mechanical ventilation and artificial resuscitation are not to be initiated.

The key ingredient to Callahan's argument is his contention that this will be better for the elderly. Callahan claims, not that the elderly do prefer this, but that they ought to prefer it, because ". . . the meaning and significance of life for the elderly themselves is best founded on a sense of limits to health care. Even if we had unlimited resources, we would still be wise to establish boundaries."[4] Callahan avoids the utilitarian, efficiency and cost-effectiveness arguments for age-rationing. He argues rather from different norms. He rightly claims we have been held captive to a technologically driven assessment of needs that has resulted in neglect of the true social needs of the elderly. The true needs (what the elderly ought to want, and what we ought to provide) are 1) as much independence as possible, 2) freedom from fear of impoverishment and other burdens of ill health, and 3) assistance to be "physically and emotionally positioned to seek whatever meaning and significance can be found in old age."[4]

This is, I think, an enlightened vision. This vision has been a fundament of Western wisdom since Odysseus spurned the physical pleasures of immortal life with Calypso to return to the aging but faithful Penelope.

The problem with all this, however, as Callahan himself acknowledges, is that limiting the life-extending health care of the elderly in the absence of meeting their larger social needs and in the absence of a social network that supports prudence in all sectors of health policy, is pernicious. Or, to put it differently, why should we insist that the needs of the elderly be redefined if we (the nonelderly) are unwilling (or unable) to redefine our own? Outside of more generally-accepted prudential policies, the elderly will not benefit at all, they would only lose one set of services without gaining the other (more fitting) ones.

In the absence of larger social changes, the elderly would be foolish to go along. In all fairness, I think Callahan wants to signal the need for more wholesale changes in health priorities, but he does not address this.

Should we ration health care by age? What moral justification could there be for age-rationing? I have argued that there are none, or that currently they exist only at the margins. Any morally justifiable age-rationing scheme will have to be lodged in a more just overall health care system. Rationing aimed specifically and exclusively at the aged will make them scapegoats and will wrongly exonerate the rest of us. But denying any moral basis for age discrimination does not mean that I would approve of any and all expenditures for the aged. Indeed, I disapprove of many of them, especially those now offered in extremis and at the edges of life. (I also disagree with much of what is done to the very young and the middle-aged in the name of health care, and am dismayed by what is not done for many others in society.) So my arguments against age discrimination are not an argument for more of the same regardless of age, but a piece of an argument for a more sane and humane health care system generally.

Former Governor Richard Lamm, who has been (unfairly) vilified for his remarks about our health expenditures on the elderly, likes to tell a story about a candidate for a heart transplant. This patient needs a new heart, is insured, has no other complicating illnesses, is well-informed about the procedure, and is not in direct competition with any other potential recipient. Don't you think he should get the heart? Oh . . . I forgot to tell you, he's one hundred three!

Lamm uses this story to draw out our sense of disproportion about offering heart transplants to the very elderly. To me this story elicits a sense that we should not be doing heart transplants on anyone, regardless of age, until some of the more basic health care resources are available to everyone.

When we are old, we should probably refuse certain very expensive life-extending resources that may be offered and encourage our physicians and families not to

insist on them, and in some cases not to offer them. Moreover, I believe we should encourage a prudent system that does not create an expectation of automatic use, and that curtails the availability of very expensive, marginally effective, life-extending technologies for the elderly, and for the rest of us.

A medical commons depleted of resources because of physicians who are zealous for all treatments possible, or lawyers zealous for litigation, or a public clamoring for longevity constitutes a grave hazard to our collective well-being in the long run.

There are groups in society who would not have their life extended at the margins at great expense. Christian doctrines of stewardship prohibit the extension of one's own life at a great cost to the neighbor. This is not fatalism but a simple matter of proportion. Most patients would not bankrupt their family and deny their children a fair start in life by striving for a last, expensive extension of their own lives. Neither should we extend our lives at the margins if by so doing we deprive nameless and faceless others a decent provision of care. And such a gesture should not appear to us as a sacrifice, but as the ordinary virtue entailed by a just, social conscience.

Underlying attitudes of stewardship and proportion is the conviction that life is not an unblemished good, nor death an unmitigated evil. Older traditions (as of Jews, Christians, Stoics, Moslems) have always believed it was important to die at the right time and for the right reasons. This is not to romanticize death, but merely to say that we cannot pursue longevity with such a passion as we now manifest and at the same time remain faithful to the spirit and meaning of our lives in community.

CONCLUSION

We have the irony of a health care system which denies care to roughly 20% of the population, while offering graded levels of excellence to the remaining 80%. We have a system which rations primary care, the most effective and efficient interface of doctor and patient, while putting virtually no limits on marginally effective, very expensive, high technology interventions. We have a system which is committed to unlimited efforts to salvage life in the hospital setting, but very little for home care, rehabilitation or chronic illness.

Among the chief reasons for this are, of course, our deep commitments to capitalistic modes of financing, the commercialization of medical need, moral and cultural individualism, an infatuation with technology, a belief in prosperity and progress, worship of youth and fear of death, and neglect of the rhythms of the generational cycles.

We cannot fix all this at once, but we can start. A beginning is a realization that vulnerability to disease, disability and death are things which unite us. A realization that we are in the same circle biologically and geographically, should clarify our need for policy that puts us all in the same circle in health care as well.

The current proposals to ration health care by age are untenable. Like schemes to ration by price, race, social worth or merit, they emphasize what divides and separates us. Limitation of health care resources to the elderly can be morally licit only in the context of an overall policy that recognizes prudence in all sectors of the population and that emphasizes our affinity with the elderly.

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Sexual Dysfunction in the Elderly Male

To the Editor: — Morley et al's excellent article[1] on the management of sexual dysfunction in the elderly male fails to mention vacuum constriction devices (VCDs). I believe these should be tried along with the other measures outlined prior to recommending a prosthesis. Undoubtedly, penile implantation has undergone considerable improvement over the past decade; however, complications, especially postoperative infections (which may occur in up to 40%)[2,3] and adverse psychologial sequelae,[4] and the fact that it is irreversible still make it a relatively hazardous procedure. VCDs, which logically may be used either before or following intracavernosal (IC) drugs[1] according to the patient's preference, have the advantage of being less invasive, safer, and generally less painful. Also, there is no limit on their frequency of application. However, it is likely that both physician and patient will view them as more unorthodox (ie, less medical) and will be more skeptical.

One system tested consists of a transparent acrylic cylinder to one end of which a vacuum pump is attached.[5-8] Two substantial rubber bands are doubled over the cylinder at the opposite end, which is open. The cylinder is placed over the penis and pressed against the body with enough force to form an air-tight seal. A vacuum up to 250 mm of mercury may be developed and the penis gradually fills with blood, becoming rigid. This may take several minutes. The rubber bands are then pushed off the end of the cylinder, constricting the base of the penis, and the cylinder is removed. The bands may be left in place for up to thirty minutes, during which an erection is maintained. This is likely to be somewhat larger than normal, because in addition to the erectile tissue, the superficial penile veins become distended. Also, the skin color is more dusky and the penile temperature may drop by up to 1°C. The bands prevent emission at the end of orgasm, the semen flows away when these are removed. However, the nature of the climax is not otherwise significantly altered. If a decision is made to use the device, subjects are required to practice with it in the physician's office. Once the technique has been mastered, he is provided with VCD and encouraged to use it at home whenever he and his partner wishes.

Experience is more limited with the VCD than with IC drugs, but a majority (over 90%) of chronically impotent males (with both organic and psychogenic etiologies) have been able to induce an erection firm enough for intercourse whenever they have wanted.[5-8] Actually, as with drugs, it is probable that the VCD would work regardless of the type of impotence, unless the extent of any underlying pathology seriously disorganized the hemodynamics of erection. However, older subjects (especially if they have been impotent for many years) are unlikely to respond as fully as younger persons. Strong erections induced with a VCD (or IC drugs) have not always been synonymous with potency. Of patients clearly able to, up to 20% have not engaged in coitus, presumably for a number of reasons, including a low level of libido (neither IC drugs or VCDs increase sex drive), a poor relationship and/or limited motivation. A further 25% of initially satisfied users are likely to lose interest and abandon either or both the approaches within 1 to 2 years.

Possibly the greatest appeal of VCDs (and IC drugs) is their inexpensiveness and the fact that they can be administered and monitored by any interested practitioner without special training. They are not panaceas and will probably have limited overall application. Nevertheless, they may be effective and useful in older patients with either organic or psychosocial impotence (especially those contemplating a penile prosthesis) who fail to benefit from traditional sex therapy and who are motivated for treatment. Further experience with a VCD may generate important information as to how a subject may cope psychologically, both with the restoration of potency, and an artificial aid. Because the VCD is noninvasive and without serious side effects, an individual who had difficulties with this would probably have significantly greater trouble with a surgical implant.

A. J. Cooper, MD, FRCPsych, DPM, DipPharmMed
Director of Research
St Thomas Psychiatric Hospital
St Thomas, Ontario, Canada
Professor
University of Western Ontario
London, Ontario, Canada

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In Reply to Cooper

To the Editor: — We agree with Dr Cooper that the use of vacuum constriction devices represents an important advance in the management of some elderly males. At the time we wrote our UCLA Geriatric Grand Rounds, we had had minimal experience with these devices in the elderly. Subsequently, we have begun to use them and have found a high acceptance rate among older males and their partners. Our experience suggests that the device is associated with few complications. In view of the high prevalence of impotence[1] among older males with medical problems, this simple device may prove a cost-effective approach to the management of impotence in the older male.

John E. Morley, MB, BCh
Professor and Director
Geriatric Research, Education and Clinical Center
Sepulveda VA Medical Center
Sepulveda, CA 91343

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Surgical Treatment of Recurrent Sigmoid Volvulus Under Local Anesthesia

To the Editor: — Drs Rosenthal and Marshall describe four conservatively treated cases of recurrent sigmoid volvulus in the elderly Parkinsonian patient.[1] We believe that tube sigmoidostomy under local anesthesia is effective in preventing recurrence.

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Age as a Basis for Allocating Lifesaving Medical Resources: An Ethical Analysis

John F. Kilner, Asbury Theological Seminary

Abstract. In light of the growing prominence of an age criterion in patient selection, it is essential to scrutinize the ethical legitimacy of arguments being offered both for and against using age as a criterion. Accordingly, the present study first explores the primary justifications for an age criterion, then examines the criterion's weaknesses. Weaknesses are grouped into two areas: deficiencies in the justifications of the criterion, and overarching critiques. Finally, a way forward in the midst of the present controversy is suggested. The study's conclusion is that an age criterion per se is unjustified, though age may play a carefully defined role in medical assessments relevant to patient selection.

Resource constraints have prompted a search for ways to restrict access to expensive (or otherwise limited) lifesaving medical resources. Increasingly, an age criterion by which older patients would be denied access to certain resources is being championed (Kilner 1988; Pacific Presbyterian 1987: 1–2; Battelle 1986: chapter 2; Evans et al. 1984: 6, 12; Challah et al. 1984: 1120; Evans 1983: 2209). In light of the growing prominence of an age criterion in patient selection, it is essential to scrutinize the ethical legitimacy of arguments being offered both for and against using age as a criterion. Accordingly, the present study will first explore the primary justifications for an age criterion, then examine the criterion's weaknesses.

For the sake of convenience, justifications and weaknesses will be characterized as productivity-oriented or person-oriented where applicable. A productivity-oriented argument is one that is concerned with promoting the achievement of some good, such as efficiency or happiness. In contrast, a person-oriented argument is one that is concerned with respecting people for their own sake, irrespective of the goods they produce. Admittedly, there is a resemblance here to the classical teleological versus deontological and utilitarian versus egalitarian/libertarian arguments. The problem with using such categories, however, is that many egalitarians and libertarians approve of pursuing utility to some degree and many utilitarians approve of basic values like equality and liberty to some degree. Not only are productivity-oriented and person-oriented categories more readily

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applicable to particular arguments, they are also better suited to the cross-cultural comparisons that will be introduced later in this article. Even so, any categories are helpful only in a general way and will not be strained beyond their proper limits.

Justifications

Many arguments can be made for using an age criterion. Some of them essentially equate an age criterion with some form of medical criterion (Smeeding 1987: 143; Knaus et al. 1983: 574; Winslow 1982: 67; Basson 1979: 324–25; Moody 1978: 199–200). According to this approach, elderly patients should be excluded when they will not benefit medically from treatment. (Medical benefit typically involves a significant likelihood that a patient's life will be significantly lengthened or qualitatively improved as a direct result of treatment for a disease or illness). While this approach is widely accepted, it really supports a medical criterion rather than an age criterion per se. The relation of age to medical considerations will be discussed further at the end of this article.

Age criteria can also be justified in their own right. To many, age criteria seem to be an obvious choice for productivity reasons (Rescher 1969: 178–79; Young 1975: 447; Lachs 1976: 8; David 1972: 584). There are several types of explicit productivity-oriented justifications. One type involves the contention that an age criterion will help to insure the best possible return on the investment of resources (Stiller 1985: 135; Rescher 1969: 182; Young 1975: 448). The young are more likely to contribute more to society for a longer time than the elderly. Another type of justification focuses on the convenience of an age criterion. Unlike uncertain and somewhat subjective medical judgments, a patient's age is a comparatively objective and precise basis for selection (Taube et al. 1983: 2020; Jonsen et al. 1982: 31; Freund 1969: xiii). Moreover, it can be applied with little resistance from the elderly, who as individuals (even if not collectively) can be relatively unassertive. Finally, the financial savings that could be achieved if the elderly were excluded are also noteworthy. For example, if only those over 55 years of age were excluded from treatment for renal disease in the U.S., 45 percent of the costs of the renal disease program would be saved (Waldholz 1981: 32). In other areas (such as intensive care), the elderly use such a disproportionate amount of resources that there is a great financial gain when they are excluded. After all—though it is tragically stark to acknowledge—death is the ultimate economy in health care expenditures (Richards 1984: 81).

An age criterion may also have great appeal from a more person-oriented perspective. Interestingly, part of its appeal stems from what it is not. In the face of some lifesaving medical care today which is prone to dehumanize people by trying desperately to forestall death at all costs, an age criterion recognizes that it is appropriate to accept death when old age arrives (Callahan 1987: 65ff.; Becker 1979: 550). The criterion also avoids much of the criticism directed

against racism and sexism, for everyone (if death does not intervene first) is subject to old age. Racism and sexism are considered evil primarily because only certain people are penalized by deprivations attached to race or sex (Daniels 1985: 96–97; Lyon 1986: 59).

Rather than promoting inequality, an age criterion may actually be seen as promoting equality. One form of this argument contends that the most important equality at issue here is the equal opportunity to live to the same age as others (Veatch 1977: 232, 1979: 218; Hastings Center 1979: 54–56, 82; Gunby 1983: 1982). Some notion of a prima facie right to a minimum number of life-years may be involved (Menzel 1983: 191). An alternative version holds that there is a natural life span (perhaps 70 or 80 years)—a span which is normative rather than merely a statistical average at the present moment in history. Once people have reached this age, medicine should generally no longer be concerned with saving or extending their lives (Callahan 1987: 137ff.). This argument also takes a less person-oriented form, in which each year of life, rather than each person per se, is equally valued. From this perspective the concern is to maximize the number of life-years saved by employing an age criterion (Glover 1977: 20; Menzel 1983: 191).

Another egalitarian proposal is that people should be treated equally—not so much in the present moment as over a lifetime. Health care should be provided in the way that enables all people to live as long as possible (Daniels 1983, 1986: 16–18, 1988: chapter 5; Veatch 1985a: 17–18, 1985b: 77). To achieve this end, the resources available must be distributed throughout each person's lifetime in a way that will protect against early death. Thus expensive lifesaving resources might be made available only to the young, while personal care services might be enhanced for the elderly (and preventive as well as other basic care perhaps provided to all) (Battelle 1984: chapter 38; Daniels 1988: 8–9; cf. Callahan 1987: 148ff.). Alternatively, all resources might be channeled to the young to increase their prospects, while the elderly might be encouraged to commit assisted suicide (Battin 1987: 324ff.). Unlike a more utilitarian concern to maximize the total number of life-years saved—which often helps some at the expense of others—this outlook adopts the perspective of the typical individual and seeks the most prudent distribution of limited resources throughout that person's lifetime (Daniels 1985: 96–97, 1986: 19–20).

Responses to justifications

The foregoing justifications of an age criterion are far from universally accepted (Battelle 1984: chapter 44; Childress 1970: 343). In fact, in circumstances where this criterion is most commonly employed—such as the provision of dialysis in Great Britain—physicians appear reluctant to admit its use. When confronted with a patient who is over the unofficial maximum age, British physicians will often tell the patient that nothing of medical benefit can be done, even when

something can be done (Caplan 1987b: 13–14; Childress 1984: 29; Schwartz and Aaron 1984: 54; Aaron and Schwartz 1984: 101). Some justify this practice with the half-truth that everyone over 55 is "a bit crumbly," but others admit to practicing some deception (Aaron and Schwartz 1984: 35; Ferriman 1980: 4). If physicians do not deter older patients and these patients apply to a clinic for dialysis, they will often be treated (Swales 1982: 117–18; Schwartz and Aaron 1984: 54). So, given limited resources, some means of curtailing the number seeking treatment is needed. Sensing the unacceptability of excluding patients on nonmedical grounds, physicians disguise their use of an age criterion. British physicians are hardly unique in this respect—they are merely the most publicized case. The problem is more general to contemporary medicine (Caplan 1987b: 6–7).

For many physicians, British and otherwise, there are very specific reasons why an age criterion is morally unacceptable. For instance, the justifications of the criterion just elaborated may be unconvincing, largely for person-oriented reasons. Consider first the productivity-oriented justifications. Excluding the elderly will indeed insure a better return on the investment of health care resources. But it may in the process unacceptably demean people—as if the only concern is to get the most productivity out of a group of machines (Calabresi and Bobbitt 1978: 185). An age criterion is admittedly convenient as well. It is objective, but so are many characteristics of persons. The objectivity of a selection criterion does not necessarily say anything about its appropriateness. An age criterion is also convenient in that the elderly may well be the weakest and easiest to exclude from treatment, but some find this a reason for special care, not less care (Siegler 1984: 27). The argument that disproportionate cost savings may result from using an age criterion also may be acknowledged. However, disproportionate spending on an age group is not necessarily a reason for cutbacks if legitimate needs vary by age group. The appropriateness of spending educational dollars disproportionately on children is a possible parallel (Stacey 1983: 7).

The more person-oriented justifications may also be disputed. For instance, the need to accept death when it cannot be avoided can be seen as a good reason to adopt a medical-benefit criterion. But it is not necessarily relevant just because a person is elderly, for an elderly person may have decades left to live if treated. On the other hand, the difference between an age criterion and selection by race or sex may be simply acknowledged without saying anything one way or another about the justification of an age criterion. However, the evils of racism and sexism do seem related to more than the fact that only certain groups in society are subject to them—they also involve placing people at a disadvantage for illegitimate reasons. In this respect, "ageism" may need to be guarded against as fastidiously as racism and sexism, particularly when the victims are already in the vulnerable condition of sickness (OTA 1987: 159; Hastings Center 1987: 135).

The three remaining justifications focus on equal opportunity, life span, and prudence and require somewhat more detailed attention.

Equal opportunity. This justification involves giving people an equal opportunity to live a long time, thereby maximizing the life-years saved. The most controversial issue here is the way life-years rather than lives (persons) are valued. In the eyes of many, persons are more than sums of life-years which are accumulated like property (Bell 1978: 69). They are entities of equal value that must be treated as such (Thielicke 1970: 172; OTA 1987: 158–59). Murderers, some note, are not generally punished less for killing 65-year-olds than for killing 25-year-olds (Bell 1978: 71). While it is indeed better to preserve someone's life for a longer rather than a shorter time, this is arguably a different matter from preserving one person's life for a long time at the price of denying another any chance of living (Columbia Law Review 1969).

An age criterion seeking a maximum savings in life-years would also have the curious effect of saving fewer lives in certain cases. (The assumption here is that an expected minimum length of benefit—e.g., a set number of months—would be required in order to be treated.) Where long-term and reusable resources like dialysis and intensive care are in view, an age criterion would save fewer people for a longer time rather than more people of various ages. The latter would, on average, reach old age and death sooner than the former, thereby freeing up the resources sooner to save more lives. In other words, the benefits of scarce resources would be confined to a few young rather than distributed to many of various ages.

Two problems unrelated to maximizing life-years are also involved in attempting to equalize the opportunity people have to live a long life by means of an age criterion. Compare two women, one of whom is a year older but has recently spent more than a year in a coma. Should the younger woman really be saved instead of the older comatose woman on the grounds that the younger has had less opportunity to experience life? It would appear, rather, that the younger is the one who has experienced more. But if this is admitted, then a problematically large number of imprecise qualitative considerations need to be included in any assessment of who has had the least opportunity to experience life. One supporter of this approach admits that such assessments would be "an overwhelmingly complicated task," calling it "procedurally and administratively a nightmare" (Veatch 1985b: 43, 1986: 146). It may be that other factors, such as one's socioeconomic or spiritual condition, have much more to do with one's lifetime experience of well-being than age does. Age provides too rough an approximation of lifetime well-being (or present physical health, for that matter) to be used where something as important as life is at stake (Francis 1986: 121).

The other problem related to equalizing opportunity to live long concerns the past access of patients to resources. Perhaps a younger person has already received a great deal of medical care, while an older person has received very little. It may not be accurate to say that the younger person should be saved because she or he has not been given as great an opportunity to live as the older person.

It would appear that the opposite is the case (Daniels 1986: 17; Francis 1986: 127).

Life span. No more attractive is the variation of an equal-opportunity justification that limits lifesaving care to those who have not yet reached the end of their natural life span. The very notion of a normative life span is questionable. The human life span has grown through the years as life-extending care for the elderly has improved. An age criterion of the sort envisioned here would significantly hinder medicine from extending even good-quality years at the end of life.

Such an age criterion would also demean those living beyond the natural life span. One supporter candidly admits this problem, given the world as it presently exists (Callahan 1987: 197–98). But this problem is also intrinsic to the justification. The justification's supporters assume that extending life beyond the natural life span is not warranted because everything of significance has been "accomplished and achieved" by that time (ibid.: 66, 172). An implicit productivity orientation is revealed here. What matters is what one succeeds in doing. But the significance of life is arguably as much a matter of "being" as of "doing"—it consists as much of relating to others as of completing tasks. Also, life goals are repeatedly altered to reflect different values at different ages (Daniels 1988: 59ff.). To suggest that people at a later stage of life usually have no goals left is to assume wrongly that the (often productivity-oriented) life goals of earlier years are the last word.

While this productivity bias is not generally perceived by supporters, the quality-of-life orientation of this justification is readily acknowledged. In fact, this justification may in the end really support a quality-of-life criterion rather than an age criterion. One supporter admits that an age criterion to exclude elderly patients would not be warranted unless their quality of life was low (Callahan 1987: 184–85). Whether a quality-of-life criterion or an age criterion is in view, applying the criterion in practice is quite problematic. It is no easier to assess another person's quality of life accurately than it is to determine if people have essentially completed their life goals—that is, without relying on patients' own statements. There is little reason to assume that all elderly will value their continued life less than younger persons will value their own (Francis 1986: 121). Moreover, neither group is likely to be particularly forthright about the degree to which they no longer value their lives when their very lives are at stake. The alternative, of course, is to withhold resources only from those who voluntarily forego treatment—which would be to impose neither an age nor a quality-of-life criterion.

Prudence. This last justification of an age criterion also raises a debatable issue. Is it truly prudent to distribute health care resources throughout life so that only certain resources are available at each stage of life? If the concern is to make

more personal care services available to the elderly, an age criterion for acute care is not necessary. All that is needed is to place greater priority on personal care services when macro allocation decisions are being made. If an age criterion does have any warrant on prudential grounds, comparing individuals in order to favor the younger is not thereby sanctioned. Only excluding entire age groups from consideration for a scarce resource is justified. But even this idea is open to question because of its idealism and harmfulness.

Ideally the proposal looks good, but even its proponents admit that it would be wrong to introduce it in one health care setting and not in another (Daniels 1985: 111, 1988: 96; Battin 1987: 340). They also admit that it may be politically unacceptable in any setting (Daniels 1988: 97; cf. Wikler 1987: 98). The potential strength of the proposal lies in envisioning the resource problem as one of distributing resources throughout an individual's lifetime. But politically the issue is perceived in terms of which groups will gain the greatest access to the most resources. Moreover, were the proposal applied throughout an entire nation such as the U.S., injustices in the system could cause the application of an age criterion to make things worse (Daniels 1983: 289–91, 1985: 113, 1988: 96; Battin 1987: 340). These concerns are so compelling that one theoretical supporter of age rationing frankly concludes, "This is in no way a recommendation for the introduction of such practices in our present world" (Battin 1987: 340).

Apart from such concerns, though, an age criterion of the sort envisioned could be harmful in its own right. While it might not be as thoroughly discriminatory as racism or sexism, it is subtly discriminatory. It assumes that all persons move through all age categories. But many people are born with congenital, genetic, or environmental conditions which ensure that they will not live as long as most (Francis 1986: 124). The age criterion in view here would also probably seem quite discriminatory on its face. It would put elderly persons who had never required health care but were now being denied needed lifesaving treatment at odds with younger persons who may or may not have used other medical resources in addition to the scarce lifesaving treatment now also available to them. The proposal would also impose constraints on liberty and welfare during the elderly stage of life that would probably be experienced as unbearably harsh even if they were in fact objectively prudent.[1]

At the same time, a serious injustice would seem to be done in the first generation of the proposal's adoption. The elderly would be denied lifesaving resources without having previously received the special benefits accorded younger generations in order to justify denial of these resources in old age. Moreover, in their youth they would have paid for lifesaving resources for the elderly, only to find that when they became old the youth would not provide such resources

1. Daniels (1985: 99) admits the possibility of this problem. Cf. OTA (1987: 159) and Veatch (1985b: 21, 48).

for them (Veatch 1985b: 56). It would hardly be prudent for them to support such a system. Some members of this generation of elderly would be forced to give up their lives for the good of all generations—a classic utilitarian form of injustice. To compensate them fairly during a transitional period would seem to require shifting resources that belonged elsewhere, thereby creating new injustices. This is not merely a theoretical problem. When Social Security legislation was first passed, the idea of giving the then-current generation of elderly less income support than future generations was soundly rejected—even though the contemporary elderly had not paid into the system from which they would be receiving (Daniels 1988: 129). A similar problem would occur every time a new lifesaving technology was introduced (Childress 1984: 29; see also Daniels 1988: 129–30).

The approach may be still less attractive if it entails active (even if voluntary) euthanasia for the elderly. The specter of doctors, not to mention society in general, encouraging people to die so that health care resources can be saved is a potentially ominous one (Callahan 1987: 194). Proponents admit that for euthanasia decisions to be truly voluntary, some of the savings generated when many older persons chose to be killed would have to be made available to provide decent health care for the elderly who chose not to be killed (Battin 1987: 337). But in that case the approach would become self-defeating, since fewer and fewer patients would opt to die if they still had decent health care available. In fact, it is far from obvious that most people would opt for death over illness, even if supportive services were limited (Wikler 1987: 96–97).

Overarching critiques

Implicit in the foregoing responses to possible justifications for an age criterion—and going beyond them—are two basic critiques, one regarding values and the other regarding rights.

Values. An age criterion in most of its forms reflects first of all certain nonmedical values (Working Group 1985: 26; Swales 1982: 117–18; Clark 1985: 121; Katz and Capron 1975: 192).[2] Among these, the value of youth is prominent. The U.S. is an example of a country in which such a high value is placed upon youth that it affects the practice of medicine generally (Lasagna 1970: 83; Clark 1985: 122; cf. Aday and Andersen 1981: 9). Research indicates that the older patients are, the less likely they are to be treated—or even resuscitated—under the same medical circumstances (Scitovsky and Capron 1986: 72–73; Spector and Mor 1984: 332–34; Lubitz and Prihoda 1984; Hilfiker 1983: 717; Crane 1977: 58–61, 1982: 392; cf. Wetle 1985: 263). So it is not surprising to learn that some

2. In the early Seattle hemodialysis days, age was considered at the second stage by the social committee rather than at the first stage by the medical committee; see Alexander (1962: 106).

people originally supported funding dialysis for all because it looked as if young adults would be the primary beneficiaries (Robb 1981: 29; Kolata 1980: 473). No more surprising is the enthusiasm over allocating health care resources generally on the basis of maximizing the quality-adjusted life-years to be saved—an approach necessarily biased toward funding treatments that are mainly beneficial to the young (Avorn 1984; Daniels 1986: 19–20; Canale et al. 1986: 49–50).

The limited value placed on the elderly and their corresponding limited access to certain lifesaving medical resources are largely the product of various cultural and religious values (Greifer 1984: 111). This point becomes clearer when the view of the elderly common in a country like the U.S. is contrasted with that traditionally characteristic of, say, the Akamba people of Kenya. (Western influences are now altering the Akamba view somewhat.) According to the Akamba, persons are much more than economic beings. A poor person in old age deserves as much respect as a rich or otherwise socially important person. In fact, old age calls forth a unique veneration (Ndeti 1972: 104).

The high level of respect accorded to older people in Akamba society is intimately bound up with that culture's view of the relationship of the individual and the community. Whereas the utilitarian view common in the U.S. conceives of the social good atomistically in terms of individual (mainly job-related) contributions summed over the breadth of society, the Akamba view presupposes a social network of interpersonal relations within which one becomes more and more an essential part the older one becomes. The more personally interwoven a person becomes with others through time, the greater the damage done to the social fabric when that person is torn away by death. This extended-kinship social system commands a sort of spiritual loyalty and is ceremonially celebrated in various practices and rituals (Morgan 1967: 65; Edgerton 1965: 4–5; Muthiani 1973: 74; Ndeti 1969: 1186; Middleton and Kershaw 1965: 72).

A different set of cultural values surrounding old age leads many Akamba to age-related resource allocation decisions that are very different from those supported by many in the U.S. In my own study of Akamba medical personnel, I asked them whether an older or a younger man should be saved when there are resources enough to save only one (Kilner 1984). Faced with such a dilemma, many Akamba argue that even a very old man should be preferred because he "has more responsibilities" and "is a father to many people."[3] European countries such as Sweden could also be cited as examples of places where greater respect for the elderly leads to age criteria (when they even exist) which are much less restrictive than in the U.S. (Brody 1981: 225; Hallan and Harris 1970: 212; Katz 1973: 418; Velez et al. 1981: 356). Opponents of an age criterion employ these facts to argue that alternative attitudes toward the elderly are possible.

3. The expressions here are taken from interviews with Kiua Mulela (Muvuti Location) and Esther Nthenya (Mbiuni Location).

In fact, such opponents go farther and argue that any society should resist the temptation to discard its elderly for a variety of reasons. The first reason is that if economic productivity is important, then the elderly are more deserving of reward than anyone for their lifetime of contribution (Perkoff et al. 1976: 918). Second, major lifetime achievements may still be before them (Horn 1987: 62–67; Berlyne 1982: 189). Third, the elderly are important to society for reasons other than their economic productivity. They often have wisdom to share, patient love to bestow, and various (though perhaps unspectacular) services to provide (OTA 1987: 157; Maitland 1987: chapter 3; Harris 1987; Veatch 1985b: 40; Cassel 1985: 8; Porter 1985: 406; May 1986: 51–61; Califano 1986: 175; Fox and Swazey 1978: 238). Even claims about their diminished mental abilities have been challenged by recent studies (Gillund 1987; Horn 1987). Should they be penalized simply because their society overlooks, perhaps inadvertently, the true value of their contribution? But the very attempt to justify the continued existence of the elderly in terms of their social contributions may itself be misplaced. People have different worths in a social sense, but many consider their worth as persons to be intrinsic to their personhood (Ramsey 1970: 258–59, 1978: xii–xiii; Beauchamp and Childress 1979: 196; OTA 1987: 154–55; Callahan 1987: 116). The proposal to engineer such intrinsic valuing out of society (by systematically cultivating in people a sense of obligation to die when they are first thought to be terminally ill—see Battin 1987: 335) is quite distressing from this perspective.

Rights. The notion of intrinsic worth is foundational to the final critique of an age criterion mentioned earlier: An age criterion may be weak not only because of the mistaken values that undergird it but also because it is a direct violation of basic human rights. A person's life arguably should be preserved simply because it is a human life. In this perspective, the age attached to that life would be irrelevant (Leenen 1982: 34; Somerville 1981: 1110; Robin 1964: 624). Otherwise, one's right to life would diminish with every day that one lives. But basic human rights are not so variable. They are attached to personhood per se. A year of life at any stage of life can be equally precious (Berlyne 1982: 189; Roxe 1983: 832). It has been suggested that the elderly have a right to humane termination procedures rather than a right to continue living (Battin 1987: 336), but such a perspective appears to be more concerned about conserving society's resources than about how persons per se are treated.

The terminology of rights, however, may be misleading where the resources necessary to honor those rights fully do not exist or have not been made available. Under such circumstances, the related language of equal respect (especially in the context of equal needs) may be more precise. In these terms, an age criterion may be disrespectful of the elderly as persons. Not only are they excluded from treatment as a class, but individual differences that would make some much better candidates for treatment than others are not recognized (Massachusetts Task Force 1984: 78; Annas 1985: 188; Horn 1987: 63–66; Caplan 1987a: 16; Veatch

1985b: 50–51; Childress 1984: 28; Levinsky 1984: 1574; Binstock 1983; Austin and Loeb 1982: 264–65; Bell 1981: 155). In the process of showing such disrespect to an entire group of people, society itself can become brutalized. Even under schemes where the concern is not age per se but some other goal such as distributing limited resources prudently throughout people's lifetimes, an important symbol may be at stake. Where the elderly are left to die with no access to lifesaving treatments that are available to others, people actually practice abandoning the elderly and in that sense exclude them from communal care. Although philosophical justifications might be offered, the damage to society's sense of responsibility for all of its members would be done (Calabresi and Bobbitt 1978: 39; Childress 1984: 29, 1986: 318; Task Force 1986: 90).[4]

These criticisms may lose some of their force where the resources in view are not at least potentially lifesaving. But where life is at stake, the same fundamental human need and thus a rightful claim on available resources arguably comes into play (de Wardener 1966: 108). In fact, should the elderly have some particular difficulty making use of needed resources, then need itself can be seen to dictate that special efforts be made to overcome these difficulties (Katz 1973: 415). In the opinion of many, special need—if it can be compensated for—is hardly the basis for less care. So, for instance, where the elderly have found it difficult to withstand the immunosuppressive regimen employed with kidney transplants, a frequent response has been to try different immunosuppressive regimens on them until workable treatments have been found rather than simply excluding them from consideration (Sutherland et al. 1982: 24–25).

An overall appraisal

Many arguments can be marshalled both for and against the use of an age criterion in selecting recipients of vital but limited health care resources. Where medical condition rather than age per se is being considered, there is not much controversy (I will comment on that case later). Where age per se is at issue, though, the weaknesses of the criterion are particularly compelling. Not only are its justifications deficient, but there are also broad considerations that undermine its validity.

The propensity of Westerners toward youth and productivity needs to be critiqued by those from other cultures such as the Akamba who have a much greater appreciation for persons per se and the elderly in particular. I suspect that by seeing the elderly with new eyes, we will find that they are as important to the human race as the young. We may also find a corrective for our propensity to value everything (and everyone) in terms of its achievement, and come to value more highly the persons responsible for that achievement apart from their con-

4. Cf. Maitland (1987) on the importance of symbols in shaping the way the elderly are treated in society.

tributions. I submit that it is possible for Westerners to move significantly in these directions without swinging completely over to an indifference toward productivity, which may be destructive to persons in its extreme form.

Presently, though, a utilitarian devaluing of the elderly persists (Siegler 1984: 25; Brandt 1983: 37; Purtilo 1982: 48). Social strategies are needed that take this reality into account and seek to promote the best possible policies in light of it. Good intentions and commitment to laudable concerns such as equal opportunity, a natural life span, or prudence are not enough. Proposals advocating age criteria that would be immoral if implemented "in our present world" may be misleading and even dangerous if they depend on the world being much different than it actually is.

There are strong reasons, then, to reject an age criterion which is essentially nonmedical in nature.[5] However, many of those who favor an age criterion do so for medical reasons. They are concerned in particular that critical resources should not be wasted if the elderly cannot benefit from them. Opponents of an age criterion share this concern.

The challenge is to find a way to pursue this concern that is so widely acknowledged. Perhaps the best way is to be careful about how language is used and to identify as "medical" all matters and criteria that are in fact medical. As noted earlier, age per se is not a medically relevant factor, in that medical problems that make one elderly person a bad candidate may not affect another. Even a short life expectancy for any given elderly person cannot be taken for granted (Perkoff et al. 1976: 917; Annas 1977: 72–73). For this reason it is probably best not to refer to age as a medical criterion (Leenen 1979: 169, 1982: 34; Battelle 1984: chapter 9; Childress 1981: 92). The medical liabilities commonly associated with old age are themselves the potential reasons for exclusion—not age itself. Many elderly, for example, are so physically weakened that they make poor candidates for organ transplantation or intensive care, but others bear up fairly well in these circumstances (Evans and Yagi 1987: 29; Battelle 1984: chapter 36; Callahan 1987: 126; Mulley 1983: 304; Thibault et al. 1980: 301A). In fact, studies show that many elderly fare well even with dialysis, from which they are so often excluded (European Dialysis 1981; Chester et al. 1979; Hutchison et al. 1982; Weller et al. 1982; Taube 1983; cf. Swales 1982: 117–18; Knapp 1982: 847; Caplan 1984: 158; Deitch 1984: 53; Waldholz 1981: 23).

Accordingly, age is best not identified as a separate patient selection criterion at all. Rather, its most widely acceptable role is probably as one of many "symptoms" to be looked for by the physician making the medical assessment required by a medical-benefit criterion. Just as any observed symptom can be an indicator of a possible medical problem, so can age. It may serve as a tool the physician

5. Even supporters of a nonmedical age criterion such as Callahan (1987: 139) admit that a consensus seems to be emerging against it.

uses in applying a medical criterion, not as a criterion in its own right. From this perspective, it is inappropriate to single out age during a discussion of selection criteria in a way that implies it is more than just one among many symptoms considered in the medical assessment. It is more a rule of thumb for this assessment than for patient selection in general (cf. Task Force 1986: 90; Childress 1985: 22).

Even in such a restricted role, age considerations must be carefully handled to insure that they are not accorded more influence than is warranted medically. It is easy enough to underestimate the ability of some elderly to endure treatment when life is at stake, and technological developments repeatedly make treatments all the more endurable (Bergsten et al. 1977: 8; Parsons 1978: 873; Hayes and Gunnells 1969). In the end, the only way to know with confidence how the elderly will bear up under a given treatment may well be to treat them in large numbers, as was done during the early days of dialysis in Italy (Calabresi and Bobbitt 1978: 230). Where possible, a therapeutic trial can be employed to facilitate more individualized assessments.

The demands on available resources today are great, and an age criterion to exclude the (most) elderly would indeed ease some of the pressure. Yet there are other, better ways to respond when tragic selections among patients must be made, as I have discussed at length elsewhere (Kilner 1981). Excluding the elderly will save resources, but ultimately at too great a cost.

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