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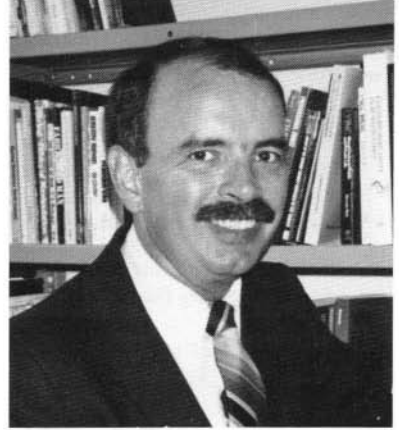
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Allocation and Aging

A review and response to Callahan's *Setting Limits*

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Once we acknowledge and accept our finitude, we can concern ourselves with living well, and care first and most for the well-being of our souls, and not so much for their mere existence
(L. Kass cited by Callahan, p. 75)

As the generation of the baby boom has made its way through its life span, various institutions of our society have felt the strain of its numbers. In our youth, it was the educational system which first felt the impact. Now it is the economy and job market and, as we approach old age, the pinch will be felt elsewhere. This is evidenced in the growing political attention to services and care for the elderly. Combined with significant advances in modern medicine, we are facing what Daniel Callahan calls "a demographic, economic, and medical avalanche."

It is not surprising, therefore, that the perennial question of rationing health care has been discussed with more urgency in recent years. The second half of 1987 saw the arrival of a new book by Callahan, director of the Hastings Center medical ethics research institute, which addresses this concern. His book, *Setting Limits: Medical Goals in an Aging Society*, suggests rationing of medical care, in part, on consideration of age. The purposes of this volume are to "stimulate a public discussion of the future of health care for the aged . . ." and to "propose a different way of understanding that care than is commonly considered: that of using age as a specific criterion for the allocation and limitation of health care" (23).

In taking up this call for public discussion, I wish to review Callahan's proposal, assess its strengths and weaknesses as a contribution to the debate over health care rationing, and suggest directions to push analysis further.

Callahan's analysis ranges over a variety of topics — the meaning of aging, the goals of medicine, moral relations between the generations, and resource allocation. It is useful, therefore, to begin with a summary of the general principles of his position. Callahan states them as follows:

1. Government has a duty, based on our collective social obligation, to help people live out a natural life span, but not actively to help extend life medically beyond that point.
2. Government is obliged to develop, employ, and pay for only that kind and degree of life-extending technology necessary for medicine to achieve and serve the end of a natural life span: the question is not whether a technology is available that can save a life, but whether there is an obligation to use the technology.
3. Beyond the point of a natural life span, government should provide only the means necessary for the relief of suffering, not life-extending technology. (137-38)

Within this framework of principles, then, let us look more closely at specifics of Callahan's proposal. Although the economic concern of escalating medical costs remains constantly in the background of his discussion, Callahan sees the issue of limits to health care to the elderly within a broader philosophical context. He asks us to consider, for example, the question of the meaning of aging. Old age, he suggests, has been robbed of meaning (the internal sense of one's life as purposive and coherent) and significance (the social recognition of the value of old age). He sees this failure as derived in large part from what he calls the "modernization of aging". This he describes as arising from the belief that human ingenuity, using the tools of reason and science, can make all spheres of nature, including the aging process, malleable to human manipulation, directed at the creation of an increasingly better future (26). This, in turn, has resulted in an inability to deal directly and honestly with the possibility of finding significance in suffering and decline. And it has issued in the "medicalization" of old age. The power of the meaning of the inevitability of decline and death has weakened against the increasing vision of old age, or the elements of aging, as medical problems which, like other medical problems, are amenable to intervention, manipulation, and conquest.

A Callahan Suggestion

In contrast, Callahan suggests that old age be seen as one of several life stages in a natural life span, each with its own meaning and significance and set within a social web of cooperation among generations. Old age *as such*, rather than the accidental qualities of some elderly (free time, spendable income, etc.) should be seen as meaningful. Although he does

not spell it out with sufficient detail and clarity, Callahan appears to find that meaning in the concept of service to the future by means of serving the young.

If the young are to flourish, then the old should step aside in an active way, working until the very end to do what they can to leave behind them a world hopeful for the young and worthy of bequest. The acceptance of their aging and death will be the principal stimulus to doing this. It is this seemingly paradoxical combination of withdrawal to prepare for death and an active, helpful leavetaking oriented toward the young, which provides the possibility for meaning and significance . . . (43)

Co-relative to Callahan's analysis of the meaning of aging as service to the young is his discussion of the responsibility of the young toward the old. This is part of his stress on intergenerational obligations, of *social* ethics. As in an earlier article (1985), Callahan struggles to establish the philosophical grounding for moral responsibility of the young toward the old. He examines, and in turn finds weakness in, several traditional arguments for the filial obligation of children toward elderly parents: reciprocity for earlier support by parents, ties of emotion, implied "contractual" obligations, friendship, and gratitude (88-91). Failing to find an unequivocal principle for obligation among these, Callahan posits the uniqueness of the origin and nature of the parent-child bond as a product of a *sui generis* period of nurturance, intimacy, and sharing. This combines with what he calls the "power of need and dependence" to be a potent basis for a claim of obligation (91-94).

Callahan's struggle at this point results, I believe, from his failure, when borrowing the analysis of family obligation from his earlier article, to transpose it to the *social* ethical framework proposed in his current book. It is not a question of the relation of individual children to individual parents which should be central here, but rather the intergenerational obligation of upcoming generations to those who precede them. In that light, the answer to Callahan's search for a basis of obligation lies in the nature of the organism — i.e., society — which is the focus of his analysis. If we are, in fact, to see ourselves as a *social* organism — with those in each life stage playing an interacting role — then the very reciprocity of roles may be a foundation for obligation. As the old prepare the way for and make way for the young, the young provide the care context for that role to be played. This also furnishes a clearer framework for Callahan's attempt to balance familial and societal (governmental) sharing of responsibility for the elderly. Both have obligations to the old. Physical help and affection are seen by Callahan as central to the role of children toward needy parents. On the other hand, basic economic and medical support — increasingly burdensome in the context of greater life expectancy and chronic illness among the elderly — can be shared by all "children" of one generation for the "parent" generation preceding them through government (and other social agencies) as an expression of intergenerational moral ties.

Medicine in Relation to Elderly

If acceptance of decline and death is part of the meaning of aging and it is the obligation of succeeding generations in society to help the elderly accomplish this in a meaningful way, how are we to understand the goal of medicine in relation to the old? Callahan proposes 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 life span and thereafter for the relief of suffering" (53). Recognizing that the quantity of life is not indefinitely extensible, he opts for the role of medicine as enhancing the quality of a reasonable life cycle. Of what would such a life cycle consist? Callahan describes it as one in which 1) one's "life possibilities" — e.g., work, love, family, social life, pursuit of ideals, and the experience of beauty, travel, knowledge, etc. — have had the opportunity to be accomplished; 2) one's moral obligations to others, especially family, have been met; and 3) one's death, because it comes after a full life, will not be felt by others as an offense to moral and social sensibility (66-72). He defines a "natural life span", then, as "one in which life possibilities have on the whole been achieved after which death may be understood as a sad, but nonetheless relatively acceptable event" (66). Callahan specifies further that to be "tolerable" after a person has achieved this life span, death must also be characterized as "not . . . marked by unbearable and degrading pain" (72).

This leads him to a statement of policy that medicine should have as its goals, both for current technology and research, the prevention of "premature death", i.e., death before the living out of the natural life span he has described and thereafter, the minimization of pain and suffering (148-49). Callahan's preference for quality over quantity of life is not unique in medical ethics. But the addition of its link to a concept of a natural life span does give it a somewhat different focus. The reason for his designation of this life span as extending approximately to the late 70s or early 80s, however, seems arbitrary and is probably based on present medically achievable life expectancies. Why the terminus would not be defined differently in past or future medical contexts is not clear. Nor is it evident that the greater life enrichment opportunities which are becoming available to older, healthy elderly persons can be dismissed as secondary to the fulfillment of "life possibilities" in his proposed definition of a natural life span. Though he seems hesitant to do so, Callahan may have to accept greater flexibility in defining the chronological terminus in his concept of life span.

Where Callahan's proposal has special merit is its application to medical research. Noting that physical mobility, mental alertness, and emotional stability are often undercut by chronic illness, pain, and suffering, Callahan suggests that the focus of geriatric medical research should not be on life extension, but rather on those conditions which diminish the quality of living for many elderly, e.g., dementia (characteristic of Alzheimer's disease), hearing impairment, osteoporosis, osteoarthritis, etc.

Increasing Limitations and Costs

Although his analysis of the meaning of aging, intergenerational moral relations, and the goals of medicine stand logically on their own, it is the rapidly increasing limitation of resources and escalating medical costs which had the most to do with provoking his desire to bring conscious and systematic consideration to the issue of allocation of society's medical and fiscal resources. Callahan sees the dilemma as real and not to be resolved by greater efficiency in medicine or reallocation from other areas of social expenditure (123-28). Besides, he argues, approached from the modern medicalized view of aging, any savings gained in one area would be swallowed up by the — in principle — limitless vision of conquering the aging process. And, in any case, this search for "external" solutions fails to confront the more fundamental philosophical issues referred to above — issues which should be faced regardless of the problem of limited resources.

According to Callahan, public funding of medical care for the elderly should be based on a commitment by the young, both personally and through the institutions of society, to assist in the achievement of a "natural life span" and to allay "economic and social anxieties" associated with aging (118). Such a policy is not a withdrawal of support for the elderly, but only a chronological limit to life-extending medical care. In other respects, this policy calls for expanded support in other elements of Medicare, Medicaid, Social Security, etc. In fact, in order to achieve his goals of a natural life span and a tolerable death, Callahan's policy may not be the allocation limitation program he seems to intend it to be. Achieving his goals may be just as increasingly costly as the life-extending medical care he wants to limit. Although there is limitation in the sense that both life extension and life enhancement are not pursued equally, it may be better to interpret his proposals more in terms of reallocation of resources within medicine.

This policy leads to a termination of treatment (in particular, termination of publicly funded treatment) for the aged, based on three general criteria which, although they might be applied at any age, he sees as having added relevance for the aged. These are 1) the inability to relieve pain and suffering; 2) disproportionate burden imposed by treatment; and 3) inability to restore or maintain minimum quality of life. The latter he defines as the capacity to reason, to feel emotion, and to enter relationships with others (177-80).

Based on these criteria, Callahan outlines standards for morally appropriate (and, therefore, eligible for public funding) medical care for the elderly. These are based on considerations of the patient's physical and mental status and quality of life on the one hand, and levels of possible medical and nursing care on the other. Patients who are brain dead should be declared dead and no further treatment given. Those in a persistent vegetative state should be provided palliative nursing care, but death should not be resisted. Patients characterized by severe dementia, mild to

moderate impairment of competence, and those who, though mentally alert, are severely ill are appropriate recipients not only of palliative care but also general medical care, e.g., antibiotics, surgery, nutrition and hydration, though primarily for relief of suffering rather than life extension. Both nursing palliation and general medical care should be available to those mentally alert persons who, though physically frail, are not severely ill. In addition, intensive care and advanced life support can be provided, though not for an extended time unless necessary to relieve suffering. Finally, a physically vigorous, mentally alert elderly person is eligible, even at public expense, for all levels of care previously described and, in addition, emergency life-saving intervention until such a time as the person deteriorates into one of the other categories (180-85).

Particulars are Debatable

Callahan's attempt to give specificity to the definition and implementation of his policy is a worthwhile step. Disagreement over particulars is to be expected (Callahan himself sees his book as an initiation of a long, but necessary public debate). Callahan notes, but does not thoroughly discuss, several issues which are difficult both philosophically and practically, e.g., avoiding the creation of a coercive atmosphere in which an "obligation to die" might subtly be felt by the elderly; the establishment of sufficient social support for the elderly in other areas so that this limitation is not perceived as abandonment; the possible sense of injustice felt because only *some* persons may be able to pursue extended life apart from public funding; and pressures felt by families of those who wish to pursue extended life, but who are unable to afford it themselves.

Callahan leaves many questions still open. But the author knew this was the case. His goal, he said, was to "stimulate a public discussion of the future of health care for the aged" (23). It is possible to find in this volume a thoughtful and sensitive attention to the broad underlying issues which should frame future debate on this topic — the meaning of aging, decline, and death; the relation of life extension and life enhancement as goals of medicine; a *social* ethic of mutual moral relations among generations; and an acceptance of distinguishing levels of appropriate care in achieving a tolerable death.

In advancing this public debate, I see several necessary steps: 1) Callahan has limited his analysis to setting medical limits for the elderly. Justice and the reality of the broad expanse of medicine will call for extension of this debate to other areas of health care also. The discussion may ultimately have to be framed in terms which, though they may include age considerations, cut across age boundaries *per se*. The recent Hastings Center report on "Ethical Challenges of Chronic Illness", (Jennings, Callahan, Caplan), may be an example of such a formulation. Similarly, one may be able to work toward a concept parallel to Callahan's "natural life span" which could refer to those at earlier points in the life cycle who

are facing more limited chronological expectations. This would allow the application of some of his principles regarding extension and enhancement of life to other persons for whom relief of pain and suffering may also take moral priority over mere prolongation of life.

(2) It is not clear that the limits Callahan is proposing actually would produce absolute limits of resource usage. The pursuit of a natural life span and a quality-enhanced tolerable death may be just as expensive as following after life extension. The debate would more honestly, and therefore more productively, be cast in terms of reallocation of medical resources. In this context, issues of efficiency, technical advances, examination of other social priorities, etc., may have more of a role than Callahan seems to give them.

(3) Finally, in terms of Callahan's specific interest in old age, further work is needed on defining the meaning and significance of aging. A clarification of the relation between serving others and self-fulfillment is necessary. Furthermore, the increased opportunity for personal growth and life enrichment among the elderly can be given greater examination as to its implications for the concept of "experiencing life's possibilities".

The significance of Callahan's discussion for the emerging public debate over allocation of medical resources, especially in relation to the elderly, will probably not be known for some time. Callahan himself recognizes that this debate, since it must result in a changed social consensus in order to have any serious structural effect on the provision of medical care in society, will not take place easily or quickly. But that he has drawn our attention to fundamental philosophical issues which *should be* as consciously addressed as they *are* subconsciously assumed is, to my thinking, already an important contribution.
