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Target — The Elderly: A Nondiscrimination Perspective on Daniel Callahan's *Setting Limits*

by

Robert A. Destro

From: *Set No Limits: A Rebuttal to Daniel Callahan's Proposal to Limit Health Care for the Elderly* (Barry & Bradley, eds., Champaign-Urbana: U. of Ill. Press, 1991)

It is a truism that all arguments must begin somewhere, preferably at a point that would be identified by those engaged in them as "the beginning." Daniel Callahan's discussion of limiting health care for the elderly, *Setting Limits: Medical Goals in an Aging Society*,¹ is a good example of a timely and useful argument that begins somewhere other than where it should.

On the surface, *Setting Limits* is an argument for the development of an ethic governing law and medicine in a society in which the elderly are valued members of the community. It presents a case for encouraging physicians and their patients to have a clear sense of justice and proportion in the midst of life's terminal crises. It envisions a government committed to a transcendent vision of the common good and imagines a cadre of health-care bureaucrats who will not take intellectual or practical shortcuts in their well-meaning attempts to get their jobs done on time and (most importantly) under budget.

To a reader who is reasonably well informed about the medical, legal, and social ramifications of limiting access to health care, *Setting Limits* is intriguing and frustrating. It is intriguing because Callahan's recommendations represent a serious attempt to grapple with one of the most difficult bioethical and legal dilemmas facing our society. It is frustrating because the ideal world Callahan proposes as the goal of his argument will never come into being if policy-makers and families adopt Callahan's operative assumptions as their own. The reasons are as stark as they are simple.

In the real world Callahan describes, social value and the common good are too often measured in starkly political terms.² "Little thought is given in medicine to its ultimate ends" because physicians and patients, and the government upon which both rely to subsidize them, are more often captivated by technological

possibilities than by any vision of the just and compassionate in the face of individual mortality. We live in a society “which in its secular and public guise professes to have no generally binding moral traditions,”³ and in which attempts to construct a legal order based in transcendent notions of truth, justice or morality are likely to be challenged as unconstitutional “contradict[ions of] the ‘logic of secular [individual] liberty’” that guides the current majority of the U.S. Supreme Court.⁴

Callahan recognizes all of this; that is why *Setting Limits* is, ultimately, an open invitation for discussion. The book sketches out an approach — the author calls it a “trajectory”⁵ — that he hopes will lead unerringly toward the targeted goal: an enlightened social policy toward the elderly and the dying.

“Trajectory” is an apt term for Callahan’s approach more so, I believe, than he intended. He has launched an idea and set it hurtling toward an elusive target called “intergenerational equity.” Its inherent concept and design flaws will assure that it will never reach that goal.

Callahan acknowledges that weaving an integrated social tapestry requires collective effort and a common set of values.⁶ He eloquently describes (and decries) the existing values that seem to govern medical-care decision-making and accurately views them as one source of our inability to come to grips with the moral limits of health-care decisions. Finally, he makes his own suggestions regarding an alternative set of values that should guide individuals in making judgments about the limits of medical care. For all of this he is to be commended, even if one does not agree either with his approach or his suggestions.

The problem is that while he decries the present value structure that influences medical-care decision-making, he makes no effort to demonstrate that his approach rests on values that are, in any meaningful way, different from those he rejects as the source of the problem: “the virtues of youth rather than age, the new rather than the old, self-reliance and autonomy rather than community.”⁷ The result is predictable.

Like a surface-to-surface missile with a misprogrammed inertial guidance system, his idea veers off its intended course as it starts downrange and targets the very individuals Callahan considers to be at risk: the elderly. Given his initial value judgments and assumptions,⁸ it will be difficult, if not impossible as a practical matter, for society to attain the intergenerational equity he urges. An approach centered on the duties of the elderly alone⁹ is more likely to result in an increasingly overt tendency to justify devaluation of and discrimination against the elderly and other persons with disabilities.

I make two basic arguments concerning the serious questions raised in *Setting Limits*. Both underscore the importance of reaching agreement on fundamentals before embarking on the always difficult task of formulating a set of social, medical, or legal policy goals. Callahan’s quote from Michael Ignatieff’s book, *The Needs of Strangers*, captures the point nicely: “woe betide any man who depends on the abstract humanity of another for his food and protection.”¹⁰ In my view, intergenerational equity as proposed in *Setting Limits* is a potentially dangerous abstraction unless and until it is complemented by a clearly articulated vision of the place and value of the elderly and disabled in the

community at large.

The second argument is that the provision, financing, and rationing of medical services should be no less subject to scrutiny under the nondiscrimination laws than any other profit-making, nonprofit, or charitable activity.¹¹ I shall not quarrel with the fact that at the individual level medical decision-making affects important personal and familial interests. Nor shall I dispute the inability of law or constitutional principle to lay down fixed standards for the exercise of medical judgment. The argument here is that neither the personal nor the technical nature of medical decision-making exempts it from scrutiny intended to determine whether or not the criteria utilized for making health-care judgments are consistent with the ultimate goal of nondiscrimination law itself: to do justice and effectuate the common good.

Thankfully, however, my task here is limited. For present purposes, I shall leave a discussion of both the limits of autonomy and the substantive content of intergenerational justice to those more qualified than I to address such topics. My topic is nondiscrimination, and the intensely interesting question of how society sets, marks, and polices the boundaries between the exercise of legitimate judgment and the practice of illicit discrimination.

Fundamental Questions: Looking for the Starting Point

My first argument is that while *Setting Limits* raises many of the right philosophical and moral questions about medical and social goals in a just society, it analyzes them on the basis of a set of assumed principles that appear to be fundamentally at odds with the natural rights philosophy that undergirds both the civil order under which we live and Callahan's basic ethical argument about the necessity to accept nature's limits on the human lifespan. I propose to demonstrate why this is so by posing a series of questions.

Why the Elderly?

Perhaps the most basic question is why *Setting Limits* is about the elderly. Callahan answers that he wrote the book "because some significant change in our thinking about health care for the elderly is needed" and that he wanted to start a "long-term discussion" that would address the ancient question: how much is enough?¹²

But why the elderly? One can, and perhaps all of us should, ask the question "how much is enough?" far more often and in far more circumstances than we usually do, but why should the elderly be singled out for special consideration here?

If the question is "how much is enough?" it is equally relevant to ask it in the case of *any* patient, elderly or not, who has, based on Callahan's thesis about the ethical limits of health care, arguably "had enough." In his zeal to urge society to pay more attention to the question of intergenerational equity, Callahan has unjustifiably narrowed the appropriate scope of the question from "how much is enough?" to "how much is enough for an elderly person?"

The reason for limiting the argument to the elderly appear to be fourfold:

first, the geometric increase in the number of elderly persons; second, the virtual certainty that many, of not most, will suffer from either chronic illness or age-related disability (or both) prior to their deaths; third, the increasing isolation and loneliness of many elders; and fourth, that these developments already involve enormous human and social costs that will only increase with the passage of time.¹³

All of this is true. But it still begs the question "why the elderly?" It is absolutely critical to establish at the outset whether the problem is to be defined as the elderly themselves, their excessive demands for health care, or the generally excessive demand for health care brought about by this society's tendency to view "medicine . . . as a means of trying to cure or control the problems of life."¹⁴

If Callahan is correct that the elderly mirror commonly held societal perceptions about the role of medicine, Callahan's exclusive focus on the excessive demand for medical care by the elderly is difficult to justify. And if the goal of *Setting Limits* is to lay a foundation for discussion of the ends of health care, including equity and justice for all who seek medical care (including those who cannot afford it), Callahan's focus must be broadened to include a discussion of society's vision of justice and the common good. In short, the role of the elderly in attaining intergenerational equity is an important part of the inquiry, but reference to the obligations of others is necessary, too — unless, of course, we are to assume that the elderly themselves are the problem.

Callahan seems to want it both ways. Even though he strenuously argues that the elderly should not be devalued, his express arguments and the logic from which they are derived squarely target them for special treatment. A prime example is the suggestion that insulin be denied to elderly patients with "mild impairment of competence."¹⁵ Since Callahan rightly decries the danger that excessive individualism and self-absorption pose in high-cost, high-technology medicine, there is something incongruous about this suggestion. Insulin therapy is neither high-cost nor high-technology medicine; it is routine therapy for a chronic condition that affects both children and adults.

The conclusion is inescapable: *Setting Limits* is not about excessive individualism and self-absorption, both of which lead inevitably to inequitable demands on the health-care system. The book is about dependent persons (primarily elderly), their place in community and family, "the meaning and significance of old age" in a society with an "absence of a public philosophy on the meaning of aging,"¹⁶ and the problems dependent and disabled persons create in a society that values individualism, personal autonomy, youth, and vigor.

What Do We Owe the Elderly?

This is the central question of the book, for Callahan is certainly correct in noting that "if the elderly lack an established, coherent and meaningful place in life and society, there is no real rationale for their protection" in a secular society; "it merely exists as a kind of sentimental beneficence."¹⁷ I agree that it is essential

that this question be posed directly, free of the “‘evasion, disguise, temporizing [and] deception by which artfully chosen allocation methods can avoid the appearance of failing to reconcile values in conflict.’”¹⁸ But even this formulation manages to evade the moral dilemma. Allocation methods are but one way to resolve the question. Another way is to focus on the elderly alone, without explicit regard for the manner in which such a focus will resonate in a culture he condemns.

To be sure, Callahan recognizes the “possibilities for moral mischief”¹⁹ in both *Setting Limits* and in its recently published sequel, *What Kind of Life: The Limits of Medical Progress*. In the latter, he answers the questions “why the elderly?” as follows: “In attempting to provide ever-improved health care for the elderly, we are on the greatest, and most extensive, of medicine’s many frontiers of progress. [*Setting Limits*] was as much a study of how to respond to such a frontier as it was a book about the elderly It is quite true that it is our whole system that is in turmoil, not just our attempt to provide for those who are aged.”²⁰

What Kind of Life underscores the importance of an inquiry into the general nature and extent of social obligation to those with medical needs. If the aim of Callahan’s overall project is “to set forth an alternative way of thinking about health that will lead into the devising of a reasonable and just health-care system [. . . which is] deeply rooted in a plausible understanding of the human condition and . . . coherent, feasible, and humane in its practical policy implications,” then the “trajectory” problems in *Setting Limits* arise from its focus on the elderly and what they can expect from others in the community.²¹

It makes no difference that “we begin [the discussion] in media res, in the middle of the story, with a hard, deeply ingrained set of values, a complex set of institutions, and a bewildering array of mores, folkways, interests, and predilections already in place [that] will not be easy to change.”²² As long as there is agreement on fundamentals (i.e., the ultimate starting point of the total inquiry), it makes no difference that a particular discussion starts in the middle: the goal will determine the range of possible trajectories. If the starting points are different — and they are — there can be no agreement on process until there is common ground for discussion.

Unlike Callahan, I do not believe that “we [as a society] lack good moral and cultural resources” to resolve these value questions.²³ The moral and cultural resources are as available now as they ever were.²⁴ The question is whether those in positions of authority and influence, like Callahan himself, have the insight and courage to draw upon those resources explicitly and to use them to examine “the possibilities for moral mischief” inherent in their own perspectives. Such an examination should be complete before any attempt is made to “reform” what are quite accurately described as a “bewildering array of mores, folkways, interests, and predilections already in place.”

It is precisely because Callahan suggests a change in the terms of the debate that a brief review of one of the more important sources of the “mores, folkways, interests and predilections” in American society — civil rights law — is in order. The law is both a component and a reflection of the “moral and cultural resources” of a society. An examination of “the ethics of equal protection”

highlights the essential soundness of Callahan's indictment of "an unlimited quest for individualistic pleasure" and underscores the danger of his narrowly targeted approach.

Age, Disability, and Civil Rights: The Ethics of Equal Protection

Duty and Its Relevance to Civil Rights

Duty is not a topic that receives much attention in contemporary American civil rights discourse. From the beginning, the concept of equal protection of the laws was described by the U.S. Supreme Court as "a positive immunity or right," a claim particularly valuable to its intended beneficiaries, the newly freed slaves.²⁵ The debate over the character of the equal protection guarantee²⁶ rages in similar terms today,²⁷ with no apparent end in sight.²⁸

The conceptual shortsightedness of a rights-based approach to equal protection has complicated many, if not most, discussions of issues such as affirmative action and the development of standards to govern discrimination on the basis of age and disability. The reason is simple: rights claims are assertions that collective interests are limited when they limit individual liberty and autonomy. The claims made by dependent persons on the community are qualitatively different. Thus, I begin this argument with a basic proposition: Duty, no right, is the organizing concept behind the constitutional guarantee of equal protection of the laws.

In most discussions relating to the nature of individual liberties, the central concern is whether the personal interest in question can be characterized as a matter of right, that is, shall the individual be at liberty to seek enjoyment of the claimed interest without governmental or private interference? Although the resolution of such claims involves an inevitable balancing and subordination of one set of interests to another, the sum total of governmental obligation is to refrain from acting in a manner that will deprive a person of the asserted right.²⁹ We therefore speak, quite correctly, in terms of a "right" to freedom of speech and a "right" to religious liberty.

The constitutional and legal guarantees of equal protection are different; they require more than simple restraint from interference in another's liberty; their function is to require that governments and individuals conform their behavior to a legally and socially acceptable standard.³⁰ The liberties of speaking or publishing freely can exist whether others listen or read.

Thus, while the goal of the constitutional guarantee of equal protection of the law is equal enjoyment of the blessings of liberty, its foundation is a behavioral obligation. To state that all persons are entitled to "equal protection of the laws" is to express a social duty on the part of government that has been codified as a matter of constitutional law.³¹ Although the courts have generally rejected claims that liberty-based rights claims presuppose affirmative community obligations to support the full enjoyment of those liberties by anyone,³² there is considerably more sympathy for such claims in the equal protection context,³³ especially where the claimants are in a condition of dependency.³⁴

It is particularly relevant to note that American law has only recently added

the elderly and persons with disabilities to those deemed to be at risk from the antisocial behavior of others. In part, this development is attributable to demographic change — an increase in the number, health, and mobility of elderly and disabled persons — due to the advances in health care addressed in *Setting Limits*. Equally important, however, is the gradual acceptance of the proposition that reason rather than prejudice must govern public policy affecting persons with disabilities.³⁵

But precisely because accommodating an elder or a person with a disability requires more than merely a fair application of a set of neutral criteria, consensus concerning the nature and extent of affirmative community obligations remains fragile.³⁶

What Duty — and to Whom? Of Potential and Personhood

The basic question explored in *Setting Limits* is what is the extent of our duty — as a society and as individuals — to the elderly? Although expressed as a single question in most instances,³⁷ the structure of this question throughout Callahan's inquiry obscures the fact that this question has two parts: first, "what duty?" (the scope of the obligation); and second, "to whom is it owed?" (its object).³⁸ For this discussion, I will address the questions in reverse order.

To Whom Is the Duty Owed? Although Callahan and I approach both the nature and scope of duty in the health-care setting quite differently, we agree that the basic issue is one of duty. Our first, and most important, difference lies in our respective views concerning the people who are the subject of *Setting Limits*: the objects of society's duty.

Callahan's approach combines the questions of object and scope into a lengthy discussion about specific circumstances in which society should reach agreement about the limits of health care. This has the effect of making the scope of even the most basic legal duty of the state — to protect each member of the community from harm — depend upon the characteristics of the person to be protected. I speak simply in terms of the duty of those in authority to offer all persons an equal, basic level of protection.³⁹

Since the Constitution speaks in terms of a duty to provide protection to all persons on an equal basis, the source of our difference in perspective must be in our respective answers to the question: "who is a person?" Who are those members of the community to whom society collectively owes a duty to provide equal protection of the laws? Because *Setting Limits* is intended as an invitation for discussion of medical and social goals in a just society, the first clue that there is a programming error in Callahan's trajectory is apparent as soon as his answer to this question is examined.

Before doing so, however, it is important to note that Callahan and I do not disagree over the legitimacy of debating the standards under which decisions will be made concerning the extent and relative priority of duties alleged to be in conflict in any medical setting. Problems of priority and degree are implicit in virtually every ethical dilemma: medical and social ethics are no different.

Discussions of extent and priority of treatment in a medical setting presuppose

the existence of more basic duties to the patient. Raising the question of personhood changes the nature of the discussion because it challenges the existence of even these basic duties. Where the subject of discussion is a person, the nature of the ethical, moral, and legal duty is qualitatively different from that in which the object of the duty is not.⁴⁰

Callahan seeks to soften the significance of a discussion of personhood by stating in advance that "the crucial potentialities for personhood" present "a complex and controversial question."⁴¹ Given that the question of personhood is another way of asking who shall be considered a member of the community, such a concession is more important for what it leaves unstated than for what it says (which is not much).

The implicit message is that there are indeed some individuals now considered to be members of the community who might be better thought of as outsiders (i.e., as dead people) for purposes of public policy. Thus, not only is the substantive question — who is a person? — "complex and controversial," but so is the implicit assumption that the community has the right to define any of its living members as outsiders. Callahan, however, simply assumes the appropriateness of both questions in the context of the discussion, states three potentialities he considers crucial, and proceeds to construct the entire argumentative edifice of *Setting Limits* around them.

From Callahan's perspective, membership in the community turns upon (1) the potential capacity to reason; (2) the potential to have emotions; and (3) the potential to enter into relationships with others. A person who has lost all these capacities cannot, in a way meaningful to Callahan, be called a "person" any longer, or be said to have a "biographical life" remaining.⁴²

Cases once thought difficult, such as *In re Conroy*,⁴³ *Matter of Jobes*,⁴⁴ and *Cruzan v. Director, Missouri Department of Health*,⁴⁵ become easier through the magic of redefinition. An individual in a persistent vegetative state is no longer a person, but "a being." The nature of social duty changes because the object of that duty is no longer a member of the human community. The duty of protection that is owed a person in law and morality has vanished, and in its place exists only the duty to act with "the respect due human bodies prior to clinical death."⁴⁶

That this is a "a complex and controversial" approach is obvious, but that commentators have not appeared to notice its importance is disturbing. Callahan suggests that individuals who are not dead under any of the relevant clinical criteria are to be treated as if they were dead. Members of the community who are nearly, but not quite, dead become "bodies" because they lack "the crucial potentialities for personhood."

Such a concept of personhood is far too narrow. It defines personhood in terms of "crucial potentialities" and makes the otherwise absolute duty of law and society to provide equal protection for individuals contingent on their natural ability.⁴⁷ Under Callahan's approach, only those without disabilities are assured equal legal protection from harm.

Keeping in mind that the object of the Fourteenth Amendment was to protect all who were, by their nature, human,⁴⁸ it is appropriate to examine Callahan's

ability-based construct with a view toward determining whether it is consistent with his own argument that nature itself provides the most relevant criteria for decision-making (i.e., a natural lifespan). The inherent inconsistencies in Callahan's approach become clear when one examines not the comparative level of protection to be afforded the elderly (although that is instructive, too), but his treatment of the elderly themselves.

The Significance of Age: Disability and "Potential." Under Callahan's approach, society owes persons with disabilities very little. That which it does owe appears to be related to the type of disability and inversely proportional to the degree to which it affects the key potentialities. This much is clear from the trajectory elaborated throughout the book. But even in the case of the "physically vigorous elderly person," Callahan would support withholding care.⁴⁹

Given his focus on potential and intergenerational equity, there is no theoretical problem for Callahan here: age itself is a disability in that the "natural" lifespan operates inexorably to limit the potential of elderly people. There is, however, a practical objection to operationalizing such a suggestion. Callahan "do[es] not think anyone would find it tolerable to allow a healthy [elderly] person to be denied lifesaving care."⁵⁰

Quite so, and it is revealing that Callahan does not inquire as to the reasons for such "intolerance"; for he might just find evidence of the "moral and cultural resources" he alleges are lacking in contemporary society. My own suspicion is that society is morally and culturally unprepared at present either to write off those who "deteriorate" or become disabled, or to treat persons who are not dead as if they were.⁵¹

It is significant that, although it is the centerpiece of his entire argument about intergenerational equity, Callahan never defines the term "potential." This omission is important for several reasons. First, it converts intergenerational equity into a dangerous abstraction. Second, the duties such an equitable principle would impose seem to depend entirely on the undefined "potential" of the person whose contribution is expected. And third, the only real difference between persons with disabilities and the elderly are their respective ages. For both groups, life "potential" appears to be that which others are willing, given the nature and extent of their particular disability, to attribute to them; technologically assisted potential has already been ruled out.

This is the real significance of Callahan's three "crucial potentialities for personhood." The potential capacity to reason, to have emotions, and to enter into relationships with others cannot logically be limited to the elderly. In fact, the case for denying treatment to a young person without much potential for reason, emotion, and relationships would be even stronger under Callahan's logic than it would be for elderly patients with "mild impairment[s] of competence"⁵² or to unborn children. Elderly patients with mild impairments of competence have actual (although limited) capacity to reason, they have some, if not all, of their natural capacity to experience emotions, and actual (although again perhaps limited) capacity to enter into relationships with others. Unborn children have immense capacity for all three,⁵³ assuming they are allowed to be born.

Nevertheless, Callahan suggests that the intergenerational equity proposed in *Setting Limits* requires that only the elderly should be denied treatment. Such equity would prefer the young patient with potential (perhaps a poet) who suffers, for example, from end-stage HIV infection (AIDS) in the allocation of medical resources. If this person should have access to expensive, high-technology medical treatment in an effort to prevent or retard the inexorable result of the disease because of an assumed potential, what then should be the societal response to another person with severe AIDS-related dementia? If there is to be a choice, on what basis will it be made? Age or potential? The answer to that question would have to be potential, however defined (probably politically). A grandmother who has diabetes and (arguably) no potential because she is old will get nothing, not even insulin. She loses on both counts, no matter how much actual potential she has remaining.

And thus we return to the starting point of this discussion: the ethics of the equal protection guarantee. If, as Richard John Neuhaus has said, our jurisprudence of civil rights holds that "human rights are coterminous with the individual's ability to claim and exercise such rights,"⁵⁴ the law is in a difficult position indeed. By its very terms the equal protection clause of the Fourteenth Amendment imposes a duty to provide protection regardless of one's capacity to demand it.

The conclusion is inescapable: despite Callahan's strenuous arguments and exhortations to the contrary, acceptance of his related concepts of a "natural" lifespan and a "tolerable death"⁵⁵ as a matter of public policy will inevitably result in the discrimination against and devaluation of the elderly he fears. Because both concepts proceed from implicit assumptions about the requisites of a "good life" and the potential one must have to be a person, they can also serve as the intellectual basis or justification for discrimination against persons of any age who have severe disabilities.

What Duty and How Much? Of Nature and Extent

Nondiscrimination Generally. The law governing discrimination on the basis of handicap, disability, and age is developing rapidly. Federal law requires that any federally funded program or activity must refrain from discriminating against an "otherwise handicapped" individual "solely on the basis of his handicap."⁵⁶ Many state and local laws provide similar protection. The newly enacted Americans with Disabilities Act⁵⁷ will effectively bring persons with disabilities under the full protection of the civil rights laws in employment, transportation, and public accommodations, including hospitals and health-care facilities.⁵⁸ The coverage of law governing discrimination on the basis of age is also expanding.⁵⁹ Without attempting a detailed analysis of current federal case law on the related, but distinct, topics of disability and age discrimination, it seems clear that the trend in enacted and decisional law governing both the elderly and persons with disabilities is to treat them with greater, not lesser, respect and concern.

These are welcome trends, for they reflect not only the law's increasing

awareness that the number of elderly Americans is growing, but also an increasing societal affirmation of the natural rights ethic under which neither age nor disability should serve as a morally or socially adequate basis for denying equality before the law. The law correctly requires more narrowly tailored justifications for treating individuals as outsiders in their own community.

Age, Disability, and Capacity. For the purposes of this essay, it is useful to consider discrimination on the basis of age and disability as related rather than separate categories. The central inquiry in both cases is twofold: individual capacity, and the extent of the duty to accommodate.

In a series of cases expanding on the meaning of federal laws governing the rights of persons with disabilities, the U.S. Supreme Court has pointed out that Congress was motivated by two concerns: to protect the handicapped from the intentionally discriminatory acts of others⁶⁰ and to eliminate what might be called "benign neglect" based on "thoughtlessness and indifference."⁶¹

Setting Limits, by contrast, is both thoughtful and thought-provoking. The standards Callahan proposes are active ones, although they will operate in a medical milieu in which "benign neglect" based on "thoughtlessness and indifference" remains all too common with respect to the treatment of persons with disabilities.⁶² For practical purposes, this means that the exercise of discretion to deny treatment must be closely monitored.

Regulating Medical and Social Discretion in an Age of Limits. We now reach my second argument: health-care decision-making, including the exercise of judgment by medical personnel, is not exempt from regulation in the public interest. Callahan agrees. Decisions to end life, whether voluntary or not, are not simply private matters. Society can and should demand medically and socially legitimate reasons for health-care decision-making.

On what basis are we to determine the extent of the duty to provide medical care? The answer is easily framed in the negative: the extent of duty must not depend solely on the patient's age or level of disability. This is not because the law forbids making judgments on these grounds — in fact, it all too often permits them⁶³ — but rather because neither age nor disability alone is a demonstrably legitimate standard for medical or health-care decision-making by physicians or anyone else, especially government.

In my view, the selection of age or disability (i.e., potential) as the primary standard for allocating scarce medical resources is unjust. Because it is also unreasonable to take the position that the physical characteristics of patients are irrelevant to the medical-care decision-making process, the real question is: what weight should age and disability be given in that process? My answer is precisely the opposite of Callahan's.

Callahan correctly points out that there is a distinction between medical and moral decision-making. The problem, as he sees it, is that traditional medical-care decision-making treats age as a physical factor influencing technical judgment. His proposal is that it should be viewed as an appropriate moral factor as well.⁶⁴ Given that Callahan's argument is a moral one, this is a logical suggestion. Given its legal implications if accepted, it is appropriate to examine it in light of the legal duties governing professional service providers.

Since the nature of a relationship generally governs the legal and ethical duties that inhere in it, the focus here will be on the kind of relationship established between the decision-makers and the individual to whom they owe a professional duty. Lawyers, for example, have duties that are both technical and ethical and these arise both from the nature of their relationship with their clients and from their position as officers of the court.⁶⁵ The same can be said for parents and families: legal and moral duties arise from the nature of the familial or parental relationship. The duties of medical professionals have similar legal and moral roots.

When the law undertakes to scrutinize the legitimacy of professional behavior, the inquiry is necessarily broad: the action, decision, or proposal is to be viewed in the context of the professional relationship and community in which it takes place. The burden and allocation of proof in professional malpractice and civil rights cases proceeds in this fashion.

The purpose of *Setting Limits* is to suggest standards for the exercise of medical judgment.⁶⁶ That social consequences flow from medical judgments is a given, but at the basic decision-making level the first consideration is always technical: "can it be done?" Callahan's focus in *Setting Limits* is the ethically necessary second step of the decision-making process: "should it be done under the circumstances?" To this point, Callahan and I agree that "the problem [at this stage] is distinguishing between medical and moral judgment."⁶⁷ We differ from this point onward because Callahan fails to take his own advice.

The purpose of medical-care and decision-making is medical, that is, to affect the physical or mental condition of individual patients, including the relief or palliation of pain. Whatever decision is made will have moral consequences as well, but the character of the decision remains medical. The question posed in *Setting Limits* is whether the moral issue will be addressed directly and, in Callahan's own words, free of the "evasion, disguise, temporizing [and] deception by which artfully chosen allocation methods can avoid the appearance of failing to reconcile values in conflict."⁶⁸ The conflict of values becomes apparent only after the question is first correctly identified as one of medical judgment. Only then are the important moral consequences seen in context.

This is where the trajectory sketched out in *Setting Limits* misses the mark. In his zeal to condemn the trend toward greater and greater individual freedom of choice in medical matters, Callahan entirely ignores the question of personal responsibility. Whether the decision is made at the individual or at the societal level through allocation of resources,⁶⁹ the decision-maker bears personal, moral responsibility for every decision. This means that whatever decision is made must be explained, and that the person or entity making the decision must be prepared not only to defend the explanation, but also to justify the source of his, her, or its competence to make it in the first place.

I would argue that civil rights law has already rejected Callahan's argument that doctors — or legislatures, for that matter — should be making moral judgments about the protection to be afforded entire classes of persons. The law requires that medical judgments, like other professional judgments, be made on the basis of medical rather than social criteria. Otherwise, there is no effective

standard for review.

To the extent that age or disability is demonstrably relevant to medical decision-making, both are legitimate criteria for the exercise of medical judgment, both technical ("can it be done?") and ethical ("will it serve its intended purpose in these circumstances?"). The same is true respecting moral or social judgments concerning the relevance of age and disability as criteria that define the nature of one's relationship to the larger social community and the reciprocal duties that flow from it. While age or disability is sometimes relevant to one's ability to participate meaningfully in all aspects of the life of a community (e.g., voting, driving a car, viewing art exhibits), neither should ever be relevant to membership in the community in the first place. The touchstone for the legitimacy of using such factors depends on what one wants to use them for. This is the problem with Callahan's book.

The real question posed by Callahan in *Setting Limits* is this: "even though some treatments are technically feasible and will likely serve their intended purpose, should they nevertheless be denied to persons on the basis of age?" There is no easy answer to this question, but *Setting Limits* suggests two responses, both of which are equally evasive of the critical moral question of when the duty stops.

Neither a redefinition of the operative content of society's concept of the person nor the elaboration of an abstract concept of intergenerational equity provides an adequate response. Both seek to resolve a difficult moral dilemma by placing the focus on the individual for whom the treatment is sought. Neither addresses the issue of duty directly. If the duty can be avoided either because the patient is no longer to be considered a member of the community or because the elder can be accused of overstepping the bounds of intergenerational equity, then we will never reach the truly difficult question of how to balance our collective commitment to individual rights against our equally important (but far less considered) individual duty to refrain from making inequitable claims on the community. It is sad that the increasing cost of medical services has brought us to the brink of considering the elderly and the disabled as obstacles to social cohesiveness and progress, but, given our fixation on individual rights and our devotion to the cult of youth, it is not surprising. Old people simply get in the way.

Thus, the legal question that must be answered by Callahan is: for what purpose did you focus on the elderly and potential of those from whom you would withhold care? What is the end for which the suggested classification is to be used?⁷⁰

Rethinking the Role of Autonomy

Is Autonomy the Basis of Community Membership?

We have now come full circle, to what might be considered the launchpad of Callahan's intended trajectory. What is the real reason for using age and age-related disability as a limit on health care? Although my full answer would require another paper, I here propose a brief answer.

Although *Setting Limits* may represent the first crack in the intellectual foundation of Callahan's view of individual rights, the capacity to act autonomously, that is, to reason, to have one's own emotions, and to form relationships, is the essence of one's humanity. Adopted as a key assumption of a public law, which rests on a natural rights view of the primacy and worth of the individual, the result is that the individualism condemned in *Setting Limits* replaces the more duty-based natural rights principles found in the Declaration of Independence and preamble to the Constitution of the United States as the foundation of public law. (This is especially true in what is known in constitutional law as the right to privacy.) Since autonomy is the ultimate personal right, dependency necessarily becomes the ultimate juridical and social tragedy. The social dying process has already begun, and for those with severe disabilities social death has already occurred. This is why one can treat a person in a persistent vegetative state as "[a] human bod[y] prior to clinical death."⁷¹ Those who are no longer autonomous are simply "being[s],"⁷² not people. This is why, in my judgment, it is fair to state that Callahan's actual subject is the rationing of health care on the basis of age and disability.

Although we approach the subject from very different starting points, Callahan and I thus agree that setting appropriate limits on personal autonomy is the great missing link in recent discussions of the rights of competent patients."⁷³ However, I would go one step further — and, implicitly, so does Callahan — to raise the ultimate question: do rights of autonomy and privacy even exist if their exercise is inconsistent with either justice or the common good? Thomas Jefferson gave us a hint when he expressed his conviction that man "has no natural right in opposition to his social duties."⁷⁴

Callahan is quite correct that even as the clamor continues for greater and greater freedom of choice in medical matters, the choices presented often amount to little more than a discussion of the merits or demerits of a given technological intervention. Moral concerns have given way to technological ones: "what can be done medically ought to be done."⁷⁵ Individual wants take precedence over human need.

That personal responsibility in matters of medical care has been ceded to a small army of medical professionals, lawyers, bureaucrats, cost-accountants, and sundry social engineers, including the U.S. Supreme Court,⁷⁶ cannot be denied. What is at issue is my contention that these surrogates have been invited (if not encouraged) to play the game strictly "by the numbers," and that Callahan's basic argument lends support to this trend. Only two questions are generally relevant to government officials in Washington and elsewhere: (1) who gets the money? (2) who is in charge? The political and practical truth is that whoever controls the money will be in charge.

A Suggested Approach: Social Duty and Personal Responsibility

Read together, the recent developments in the law of both aging and disability noted above stand for the proposition that the elderly and disabled are entitled, at a minimum, to equal treatment whenever they stand to receive the intended

benefits of services offered to those without disabilities. Phrased another way, the burden is on those who would deny needed services to the elderly to do so on grounds demonstrably related to the individual case.

Thus, for equal protection purposes, there is no necessary connection between age per se and providing a lesser degree of legal protection or public services: age is both an over- and underinclusive classification. The same is true with respect to disability. Ultimately, the question is whether the most basic of public goods (protection from harm at the hands of others) will be apportioned on the basis of actual or presumed individual capacity. In my view, capacity cannot be the measure of membership in the community.

But none of this reaches the heart of Callahan's question "how much is enough?" I cannot answer that question, and I would argue strongly that society should not attempt to do so either. This question is, in fact, a question of duty, and the answer depends on the facts and circumstances of each case. "How much is enough?" is an impossible question to answer at the societal level.

What I can say is that before asking questions of broad social import, it is appropriate to focus on personal responsibility. The law is well equipped to scrutinize the legitimacy of the reasons given by individuals for their decisions. That they are personal (in the none-of-your-business sense) or medical (in the technical sense) makes little difference: patients, their families, medical professionals, bureaucrats, and legislators have arrogated to themselves a piece of a huge social program. Decisions that affect others must, at a minimum, be explained.

Conclusion

Callahan rightly questions the inevitable clash between claims for autonomy and the goal of setting limits on health care. Autonomy can be limited in only four basic ways: (1) exhortation (teaching) leading to self-control; (2) eliminating it altogether in certain instances (rationing); (3) limiting the class of persons who will be permitted to make valid claims (redefining personhood); or (4) moderating it with a competing operative principle of social relations (a social duty approach).

If rationing is necessary due to lack of resources and the legitimacy of competing demands, exhortation is out and a choice will be necessary from among the final two. But what choice? If individual autonomy is the highest value and there is no inclination to limit it as an operative principle of law and social relations (thus requiring otherwise autonomous individuals to justify some of their private choices), the logical (and most cost-effective) place to start is with those who are not autonomous. When the savings at that stage are exhausted, the next logical step is to consider potential (natural lifespan) and fairness (tolerable death) as criteria for rationing. Given the starting point and the desired target (rationing), the trajectory is obvious.

This is what is wrong with Callahan's trajectory. It scores a direct hit on those whom he claims to value, rather than upon the self-absorption he decries as the source of the problem. In my view, the advocates of Callahan's *Setting Limits*

approach fail for the simple and wise observation made by the cartoon character Pogo: "We have met the Enemy and it is us!"⁷⁷ The wisdom of Jefferson's observation that there is no natural right in opposition to social duty has yet to be disproved, even if it remains unpopular at the moment. Striking a balance between autonomy and duty is always a delicate task, but *Setting Limits* is as good an argument as any about why we should get about the task as soon as possible. Excluding anyone, including the elderly, from the community simply will not do.

References

1. Daniel Callahan, *Setting Limits: Medical Goals in an Aging Society* (New York: Simon and Schuster, 1987), 6.
2. Commenting on the repeal of the catastrophic health insurance program signed into law on July 1, 1988, Senator Alan K. Simpson of Wyoming noted that "the whole U.S. has been swung around on their tails by the 5.6 percent who don't want to pay for these benefits . . . We [the Congress] re not confused; we're terrorized . . . Yeah, it's a social experiment: it's called pay for what you get." S. Rich, "Health Law Surtax Defeated; Senate Votes to Lower Catastrophic Benefits, But Rejects Repeal," *Washington Post*, Oct. 7, 1989; A1. The program was repealed in its entirety when Congress adjourned on Nov. 22, 1989. See T. Kenworthy and D. Phillips, "Hill to Face Health, Deficit Issues Anew; In Rush to Adjourn, Bills of Varying Significance Were Passed," *Washington Post*, Nov. 23, 1989, final ed., A4. See also, R. P. Hey, "Lawmakers Brace for Next Round on Health-Care Issue," *Christian Science Monitor*, Dec. 19, 1989, U.S. section, 7.
3. Callahan, *Setting Limits*, 52, 16-20, 37.
4. *County of Allegheny v. A.C.L.U.*, 492 U.S. 573, 109 S.Ct., 086,3111 (1989). See *Webster v. Reproductive Health Services*, 492 U.S. 490, 109 S.Ct. 3040, 3079 (1989) (Stevens, J., concurring in part and dissenting in part). Cf. *Bowen v. Kendrick*, 484 U.S. 942 (1987).
5. Callahan, *Setting Limits*, 13, 141.
6. *Ibid.*, 52.
7. See *Ibid.*, 39. Callahan recognizes this problem in others when he notes that the starting point of the "seeds of the later ageism of the twentieth century were being sown" by those who "emphasiz[ed] . . . the virtues of youth rather than age, the new rather than the old, self-reliance and autonomy rather than community . . . But while repudiating ageism, we have not rejected those values which stimulated it in the first place."
8. See, e.g., *ibid.*, 43: "Their indispensable role as conservators is what generates what I believe ought to be the *primary* aspiration of the old, which is to serve the young and the future" (emphasis in the original).
9. Cf. *ibid.*, 47, quoting Edmund Burke's *Reflections on the Revolution in France* (London: Dent, 1910), 93-94: "Society is a partnership not only between those who are living, but those who are dead and those who are to be born."
10. Callahan, *Setting Limits*, 101 and n. 36, quoting M. Ignatieff, *The Needs of Strangers: An Essay on Privacy, Solidarity, and the Politics of Being Human* (New York: Viking Press, 1984), 52-53.
11. Compare the approach adopted by a majority of the U.S. Supreme Court in *Bowen v. American Hosp. Assn.*, 476 U.S. 610 (1986) with that of the U.S. Commission on Civil Rights in *Medical Discrimination against Children with Disabilities* (Sept. 1989).
12. Callahan, *Setting Limits*, 10 (preface), 13 (ch. 1, "Health Care for the Elderly: How Much Is Enough?").
13. Included in this calculation is Callahan's view that medical care for the elderly takes place on the most technically advanced and costly frontier of medicine.
14. *Ibid.*, 19.
15. *Ibid.*, 183.
16. *Ibid.*, 32-33.

17. *Ibid.*, 32.
18. *Ibid.*, 222, quoting Guido Calabresi and Philip Bobbitt, *Tragic Choices* (New York: W. W. Norton, 1978), 26.
19. Callahan, *Setting Limits*, 221.
20. Daniel Callahan, *What Kind of Life: The Limits of Medical Progress* (New York: Simon and Schuster, 1990), 12.
21. *Ibid.*, 12, 30.
22. *Ibid.*, 12.
23. Callahan, *Setting Limits*, 220.
24. Callahan correctly points out that "our secular morality (though perhaps not our religious traditions) provides few resources for living lives of unchosen obligations, those which through mischance lay upon us overwhelming [sic] demands to give our life over to the succor and welfare of someone else." *Ibid.*, 96-97. What he ignores is that the "common coherent vision of the wellsprings of moral obligation toward the elderly in general and our elderly parents in particular" we "lack" must either be developed afresh or redeveloped from non-secular sources.
25. *Strauder v. West Virginia*, 100 U.S. 303, 307-8 (1880).
26. U.S. Const. Amend. XIV 1 (1868).
27. See, e.g., *Plyler v. Doe*, 457 U.S. 202 (1982); *San Antonio School Ind. Dist. v. Rodriguez*, 411 U.S. 1 (1973).
28. See, e.g., *Metro Broadcasting Co. v. E.C.C.*, — U.S. —, 110 S.Ct. 2997 (1990); *Astroline Communications v. Shurberg Broadcasting*, — U.S. —, 110 S.Ct. 1316 (1990); *Martin v. Wilks*, 490 U.S. 755 (1989) (5-4 decision); *Lorance v. A.T.&T. Technologies, Inc.*, 490 U.S. 900 (1989) (6-3 decision); *Patterson v. McLeon Credit Union*, 491 U.S. 164 (1989) (6-3 on the disputed issues); *Wards Cove Packing Co., Inc. v. Atonio*, 490 U.S. 642 (1989) (5-4 decision); *City of Richmond v. J. A. Croson Co., Inc.*, 488 U.S. 469 (1989) (5-4 decision). Compare S. 2104 and H.R. 4000, 101st Cong. 2d Sess. (The Civil Rights Act of 1990) and 136 Cong. Rec. S.991-01 (Feb. 7, 1990) (remarks of Senator Kennedy) with 136 Cong. Rec. S.457-07 (Jan. 29, 1990) (remarks of Senator Hatch). See also H.R. 3035, 3455, 101st Cong. 1st Sess. (1989) (proposed amendments to the civil rights laws in light of the foregoing cases).
29. This explains in part the U.S. Supreme Court's unwillingness to require the government to provide the means by which such rights can be enjoyed. See, e.g., *Harris v. McRae*, 448 U.S. 297 (1980).
30. Some of the most intractable problems in American constitutional law have been caused, in part, by the U.S. Supreme Court's unwillingness to read the equal protection clause as a standard of conduct for those not claiming its protection. See, e.g., *Brown v. Board of Education* (II), 349 U.S. 294 (1955) (remedial phase: "all deliberate speed"); *Korematsu v. United States*, 323 U.S. 214 (1944) (Japanese interment); *Plessy v. Ferguson*, 163 U.S. 537 (1896) ("separate but equal").
31. A similar duty has been imposed by statute upon certain individuals and institutions for the benefit of persons who are deemed to be particularly at risk. See, e.g., Title VII of the *Civil Rights Act of 1964*, 42 U.S.C. § 200e, et. seq.: *Age Discrimination in Employment Act* (ADEA), 29 U.S.C. §§ 621-633a (1989).
32. See, e.g., *Texas Monthly v. Bullock*, 489 U.S. 1 (1989); *Lyng v. Northwest Indian Cemetery Protective Assn*, 481 U.S. 1036 (1987); *Regan v. Taxation with Representation of Washington*, 461 U.S. 540, 544, 549 (1983); *Aboud v. Detroit Board of Education*, 431 U.S. 209 (1977).
33. See, e.g., *City of Richmond v. J. A. Croson Co., Inc.*, 109 S.Ct. 706 (1989) (nonremedial affirmative action); *San Antonio School Ind. Dist. v. Rodriguez*, 411 U.S. 1 (1973) (equalization of public school resource allocations).
34. See *Plyler v. Doe*, 457 U.S. 202 (1982).
35. See *City of Cleburne, Texas v. Cleburne Living Center, Inc.*, 473 U.S. 432 (1985) (invalidating a statute on the basis of "an irrational prejudice against the mentally retarded").
36. This also accounts for the deep divisions in society over quota-based affirmative action plans in civil rights. The dispute is over the nature of government obligations to those whom the law considers deserving of special protection against discrimination (i.e., minorities), and those who are to be treated under generally applicable standards governing social conduct. Detailed examination of this topic, however, is beyond the scope of this paper.

37. E.g., Callahan, *Setting Limits*, 115: "What is the extent of the government's obligation. Or, to put the matter more precisely, what is the extent of our common obligation as a society using the instruments of government to provide health care for the elderly?"

38. There is, in fact, a third and critically important question: "whose duty is it?" Although Callahan discusses it extensively, a critique of his answer is beyond the scope of this paper.

39. See, e.g., R. Destro, foreword, "The Religious Foundations of Civil Rights Law' and Religion in an Interdisciplinary Framework" in a symposium entitled *The Religious Foundations of Civil Rights Law*, *Journal of Law and Religion* 5 (1987): 39; R. Destro, "Equality, Social Welfare and Equal Protection," *Harvard Journal of Law and Public Policy* 9 (1986):53.

40. See, e.g., *Roe v. Wade*, 410 U.S. 113 (1973). See also R. Destro, "Abortion and the Constitution: The Need for a Life-Protective Amendment," *California Law Review* 63 (1975): 1250, 1282-92 (discussing the history of the Fourteenth Amendment's concept of "person"); J. A. Parness, "Social Commentary: Values and Legal Personhood," *West Virginia Law Review* 83 (1982):487 (arguing that the interests of others would be adversely affected by conferring legal personhood on the unborn). See generally R. B. Stewart, "Federalism: Allocating Responsibility Between the Federal and State Courts," *Georgia Law Review* 19 (1985): 917, 932, and n. 45 (differentiating between status as a "citizen" and as a "person" with respect to basic rights); D. R. Ratner, "Corporations and the Constitution," *University of San Francisco Law Review* 15 (1981); 11; Note, "Constitutional Rights of the Corporate Person," *Yale Law Journal* 81 (1982); 1641.

41. Callahan, *Setting Limits*, 179.

42. *Ibid.*, 179-80.

43. 98 N.J. 321, 486 A.2d. 1209 (1985).

44. 108 N.J. 394, 529 A.2d 434 (1987).

45. 110 S.Ct. 2841 (1990).

46. Callahan, *Setting Limits*, 182.

47. The implications of Callahan's views for the status of unborn children are beyond the scope of this paper.

48. The natural rights argument is developed at greater length in two articles: R. Destro, "Guaranteeing a Minimum Quality of Life through Law: The Emerging Right to a Good Life," *This World* 25 (Spring 1989); 73, and R. Destro, "Quality of Life Ethics and Constitutional Jurisprudence: The Demise of Natural Rights and Equal Protection for the Disabled and Incompetent," *Journal of Contemporary Health Law and Policy* 2 (1986); 71.

49. Callahan, *Setting Limits*, 484.

50. *Ibid.*

51. *Ibid.*, 220. There are, however, exceptions to every rule. In certain circumstances, such behavior is, in fact, gradually becoming more tolerable, but only because the reality of the acts or omissions is masked behind arguments for personal autonomy. See, e.g., *Cruzan v. Harmon*, 760 S.W.2d 408 (1988) (en banc) cert. granted 109 S.Ct. 3240 (1989); *Bowen v. American Hosp. Assn.* 476 U.S. 610 (1986); *State by Bowers v. McAfee*, 259 Ga. 579; 385 S.E.2d 651 (1989). This is evidence not of a lack of moral and cultural resources, but of a shift in the tenor of the debate. Such evasion is not a welcome development for those who have devoted years to altering societal attitudes toward persons with disabilities.

52. Callahan, *Setting Limits*, 183.

53. Callahan and others have argued that an unborn child might become a subject of legal protection as its brain develops, that is, as its potential increases. See Daniel Callahan, *Abortion: Law, Choice and Morality* (New York: Doubleday; 1970), 378-409, and B. Brody, *Abortion and the Sanctity of Human Life: A Philosophical View* (Cambridge, Mass.: MIT Press, 1975), 100-115. For a critical view of Callahan's moral argument see, e.g., P. Ramsey, "Abortion: A Review Article," *The Thomist* 37 (Jan. 1973): 174-226.

54. R. Neuhaus, "Nihilism without the Abyss: Law, Rights, and Transcendent Good," in a symposium entitled *The Religious Foundations of Civil Rights Law*, *Journal of Law and Religion* 5 (1987); 53, 57 [referring to *Roe v. Wade*, 410 U.S. 113 (1973)].

55. Callahan, *Setting Limits*, 66.

56. Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. Section 794 (1989).

57. P.I., 101-336, 104 Stat. 327, codified at 42 U.S.C. §§ 12101-12213 (1990). The act was signed by President Bush on July 27, 1990.

58. Americans with Disabilities Act, Section 301 (7)(F), 42 U.S.C. § 12181 (7)(F) (1990).

59. Beginning with the Older Americans Act in 1965, 42 U.S.C. § 3001 (1989), and continuing with the enactment of the Age Discrimination in Employment Act (ADEA), 29 U.S.C. §§ 621-633a (1989), the U.S. Congress has expressed a clear policy that the elderly should be accorded both the attention required by their special needs and equality of treatment in the work place. A number of recent cases expand the coverage of the ADEA. See, e.g., *Gregory v. Aschcroft*, 898 F.2d 598 (8th Cir. 1990) (application of ADEA to mandatory retirement of state judges); *E.E.O.C. v. State of New York*, 729 F. Supp. 266 (S.D. N.Y. 1990) (same); *E.E.O.C. v. State of Illinois*, 721 F. Supp. 156 (N.D. Ill. 1989) (same); *E.E.O.C. v. State of Vermont*, 717 F. Supp. 26 (D. Vt. 1989) (same); *Myrick v. Devils Lake Sioux Mfg. Corp.*, 718 F. Supp. 753 (D.N.D. 1989) (application of ADEA to Indian tribal entities); *E.E.O.C. v. Cherokee Nation*, 1989 WI 83776 (E.D. Okl.), 49 *Fair Empl. Prac., Case* (BNA) 1072 (E.D. Okl., 1988) (same).

60. See: *Alexander v. Choate*, 469 U.S. 287, 105 S.Ct. 712, 718-20 (1985) (holding that Section 504 would clearly cover cases of intentional discrimination against the handicapped, but refusing to hold either that the regulations promulgated under the statute are limited to such cases or that the statute necessarily comprehends the use of "disparate impact" analysis); *Consolidated Rail Corp. v. Darrone*, 465 U.S. 624 (1984) (coverage of funded programs); *Smith v. Robinson*, 468 U.S. 992 (1984).

61. *Alexander v. Choate*, 469 U.S. 287, 296, 105 S.Ct. 712, 718, and nn. 12-16. (1985). The sources cited by the court make it clear that it was drawing a bright line between "thoughtlessness and indifference" that, though neglecting the needs of the disabled, might be considered "benign" in that they are not intentional, and that which is truly "invidious."

62. U.S. Commission on Civil Rights, *Medical Discrimination against Children with Disabilities*, supra note 11, ch. 1-3, 9-10.

63. Compare, e.g., *Bowen v. American Hosp. Ass'n.*, 476 U.S. 610 (1986); *In re Estate of Longeway v. Community Convalescent Center*, 133 Ill. 2d 33, 549 N.E.2d 292 (1989); and *State by Bowers v. McAfee*, 259 Ga. 579; 385 S.E.2d 651 (1989), *In re Conroy*, 98 N.J. 321, 486 A.2d. 1209 (1985) with *In re O'Connor*, 72 N.Y.2d 517, 531 N.E.2d 607, 534 N.Y.S.2d 886 (1988), *In the Matter of Doris Wickel v. Spellman*, No. 2359E, 1990 N.Y. App. Div. LEXIS 2746, (Sup. Ct. App. Div., 2d Dept., filed March 12, 1990); *Cruzan v. Harmon*, 760 S.W.2d 408 (1988) (en banc cert. granted 109 S.Ct. 3240 (1989)).

64. Callahan, *Setting Limits*, 168.

65. See, generally, *A.B.A. Model Code of Professional Responsibility* (Chicago: American Bar Association, 1989).

66. See Callahan, *Setting Limits*, ch. 6, "Allocating Resources to the Elderly," and ch. 7, "Care of the Elderly Dying."

67. *Ibid.*, 168.

68. See note *supra*, quoting *ibid.*, 222.

69. The state of Oregon has recently adopted a plan for explicit rationing of health care. See W. King, "Cancer Treatment: Who Gets Left Out?" *Seattle Times*, Jan. 31, 1990, B1; R.S. Boyd, "Rationing Health Care," *ibid.*, Jan. 8, 1990, F1. See also Editorial, "Rational Maybe, Moral Never: Health Care Shortages Vividly Illustrate Heartbreaking Dilemma," *Los Angeles Times*, May 5, 1990, B6, col. 3 (discussing failed attempt by Alameda County/Oakland, Calif., to set up a health-care rationing program).

70. In equal protection parlance, this is known as the "means-end fit." The U.S. Supreme Court has resisted making what is, in effect, a moral rule under the equal protection clause that age and disability are inherently illegitimate (i.e., constitutionally suspect) classifications because there are times when they are demonstrably legitimate criteria for private and public decision-making. See, e.g., *City of Cleburne, Texas v. Cleburne Living Center, Inc.*, 473 U.S. 432 (1985) (invalidating a statute on the basis of "an irrational prejudice against the mentally retarded").

71. Callahan, *Setting Limits*, 182.

72. *Ibid.*

73. Ibid., 176.
74. From the letter to the Danbury Baptist Association, *Works of Thomas Jefferson*, ed. H. Washington (1861), 8:113.
75. Callahan, *Setting Limits*, 17.
76. *Bowen v. American Hosp. Ass'n.*, 476 U.S. 610 (1986); *Roe v. Wade*, 410 U.S. 113 (1973). See *Cruzan v. Director, Missouri Department of Health*, — U.S. —, 110 S.Ct. 2841 (1990), aff'd; *Cruzan v. Harmon*, 760 S.W.2d 408(1988) (en banc).
77. The Pogo cartoon series was drawn and written by the late Walt Kelly.
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