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SETTING LIMITS ON AUTONOMY: SAVING MONEY IN AN AGING SOCIETY

ROBERT L. SCHWARTZ*

On her seventy-fifth birthday, Mrs. Smith and those most important to her gather together in her nursing home room. Her husband and children are there. Her close friends from both inside and outside the nursing home are in attendance. The nursing home staff arrives with a birthday cake. Finally, of course, the third party payor's fiscal intermediary, who has cared so much about her during the ten years she has been on dialysis, is there to wish her a happy birthday and to tell her that her dialysis eligibility expired on the last day of her seventy-fourth year, and that she will be dead in a week.

I. INTRODUCTION

Most of us find the above scenario inappropriate—perhaps even cruel and heartless.¹ Even if Mrs. Smith led a full and satisfying life,

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1. Although Dr. Callahan argues that his premises would not lead to this result, it is inevitable if his theory is applied consistently. D. CALLAHAN, SETTING LIMITS: MEDICAL GOALS IN AN AGING SOCIETY (1987) [hereinafter SETTING LIMITS]. Dr. Callahan does point out that “[w]hile it would now be cruel to terminate federal kidney-dialysis support for the elderly, dialysis represents precisely the kind of technology that should not be sought or developed in the future.” *Id.* at 143; *cf. id.* at 178 (evidence shows that one out of six elderly patients on renal dialysis deliberately stops treatment because of its high personal costs). Apparently Dr. Callahan agrees that dialysis for the elderly should be preserved as a general program, and that elderly people who might not qualify for dialysis because of their age should continue to get dialysis—at least under some circumstances—as long as the dialysis started earlier. He says, parenthetically “[a] grandfather clause would also be needed in some circumstances: life-extending treatment such as insulin for diabetics or dialysis, if begun in early old age, should not be withdrawn in later old age.” *Id.* at 183. Unfortunately, he provides no reason for this grandfather clause, which he discusses only in terms of “[p]atients with *mild impairment of competence.*” *Id.* (emphasis in original). It seems just as cruel to deny Mrs. Jones dialysis because she did not require it until she turned age 75, as to deny Mrs. Smith a continuation of the dialysis she needed and received earlier. In fact, the medical and social efficiency that Dr. Callahan seeks may require just the opposite result: Mrs. Jones should not be penalized because she made no early claim on our dialysis resources. Furthermore, she is likely to be healthier and to derive more benefit

we are distressed by the external imposition of the time and manner of her death; it seems more like an execution than a decision to let death take its "natural course." Unless our social values change substantially, we will continue to find this kind of arbitrary age cutoff of some kinds of medical care, which forms the basis of Dr. Callahan's proposal in *Setting Limits*,² very troubling and ultimately unacceptable. In fact, what we find troubling is not the discontinuation of dialysis per se; we would have little trouble accepting Mrs. Smith's competent decision to forego that treatment. We might even applaud her altruism or bravery in making such a decision. What is unacceptable to us is the imposition of this determination by the fiscal intermediary whose decision is unrelated to Mrs. Smith's considered determination of whether *she* would want the treatment continued.

II. AUTONOMY AND HEALTH CARE DECISIONS

In *Setting Limits* Dr. Daniel Callahan poses what has come to be accepted as a serious problem—the enormous and rapidly growing costs of providing health care.³ Dr. Callahan posits that too much of our national resources are spent on health care for which we do not get enough in return. What separates Dr. Callahan from others who have recognized this same problem is that he poses a solution—the termination of some kinds of treatment for the very elderly.⁴

from dialysis than someone whose kidneys failed long before.

Chronic conditions, like renal failure, often do not begin at an obvious and clearly defined point. They come on slowly over months or years, and the point at which treatment becomes "necessary" is uncertain. Any flat chronological age limit accompanied by a grandfather clause allowing those who have been receiving care for a chronic illness to continue to receive it, even though they would not receive that treatment if their condition were to arise subsequent to the age cutoff, would result in sensitive doctors diagnosing the illness before the cutoff and beginning treatment for it then—even if they might wait months or years under other circumstances. In other words, a grandfather clause would result in an increase in the use of high technology treatment in those just below the age limit.

Just as we have learned that removing the ventilator is morally the same as failing to start it initially, we must recognize that failing to start dialysis when it would be beneficial is morally no different from discontinuing it later.

2. Dr. Callahan's proposal is described in the paper published in this symposium, Callahan, *Health Care for the Elderly: Setting Limits*, 33 ST. LOUIS U.L.J. 557 (1989) [hereinafter Callahan, *Health Care*], and in his book, *SETTING LIMITS*, *supra* note 1.

3. See *SETTING LIMITS*, *supra* note 1, at 225-28; see also U.S. SENATE SPECIAL COMM. ON AGING, TRENDS AND PROJECTIONS 99-108 (1985), cited in *SETTING LIMITS*, *supra* note 1, at 226, 245 n.5 (discussing health care usage by the elderly and medical expenditures on the elderly).

4. It is unclear whether Dr. Callahan would limit only government requests for treatment after the age cutoff, or if he would also forbid the elderly from purchasing the forbidden treatment with their own resources. He recognizes that there are substantial problems down either road. See *SETTING LIMITS*, *supra* note 1, at 198-200. The problems caused by taking either approach represent additional reasons not to ration

For those who accept Dr. Callahan's premise that fewer resources ought to be spent on health care, his solution is an attractive one. It is simple, certain, efficient, and, politics aside, practicable. Its efficiency, however, is an efficiency that requires arbitrariness, and its simplicity is a simplicity that requires stereotyping. Ultimately, the arbitrariness and the stereotyping required by his solution to the cost problem undercut the principle of autonomy, yet autonomy is the primary protection against the problems his solution will create.

This Article describes the values served by autonomy and explains why autonomy is so basic to making health care decisions and why its importance is especially great in the United States. Of course, autonomy is not absolute. This Article will define those classes of cases in which autonomy can be trumped by other interests. The Article will next determine whether the class of cases defined by Dr. Callahan fits within that definition. Finally, the Article concludes by suggesting a more gentle and subtle alternative that will serve the same ends as the implementation of Dr. Callahan's proposal.

III. AUTONOMY

Autonomy, whatever its formal definition, has some identifiable practical consequences. A person who possesses autonomy has the opportunity to control his own destiny, to rule his own life, and to define and hold true to the values that he considers important. Whether we depend upon Dworkin's seven different meanings of moral independence,⁵ Thomasma's five different types of freedom,⁶ Collopy's six polarities of autonomy,⁷ or any other definition of what it means to be true to one's soul, the real significance of autonomy rests in the conclusion that important choices must be left to the individuals who are most significantly affected by them. My autonomy ultimately rests upon my ability (and perhaps my nondelegable responsibility) to make choices that are consistent with my own values, however inappropriate those values may appear to others.

Consequently, my autonomy is most threatened by a society that imposes upon me a particular set of values—by a society that tells me what values I *must* have rather than asking me what values I *do* have. Inevitably, the diversity and tolerance of a society is determined by the extent of autonomous decisionmaking it allows its members. An intoler-

health care by age, although a discussion of those problems is beyond the scope of this Article.

5. Dworkin, *Moral Autonomy*, in *MORALS, SCIENCE, AND SOCIALITY* 156 (H. Englehardt & D. Callahan eds. 1978).

6. Thomasma, *Freedom, Dependency, and the Care of the Very Old*, 32 *J. AM. GERIATRICS SOC'Y* 906 (1984).

7. Collopy, *Autonomy in Long Term Care: Some Crucial Distinctions*, 28 *THE GERONTOLOGIST* 10 (Supp. June 1988).

ant society will permit no minority views. A more open society will encourage and foster individual decisionmaking rather than depending on a central authority to define and formally recognize individual "rights." To the extent that Dr. Callahan's proposal limits health care choices otherwise available to elderly patients, it limits the opportunity of those elderly patients to live and die true to their own values. It requires them to live within socially prescribed and regulated norms, in ways that they may find inappropriate and morally offensive.

Autonomy has been an especially important principle in making health care decisions. Health care decisions are personal by their nature, and they are very often value laden. The discipline of bioethics has developed for this reason. We can imagine a socially imposed limit on the efficiency of automobile engines (which we have effectively accomplished), or the size of our national corn harvest (which we have also accomplished) much more easily than we can imagine a socially imposed limit on health care to be afforded individuals. This is, in part, because the size and efficiency of automobile engines and the size of the corn crop are not as infused with important personal values as is health care. In fact, outside of what we read and say, and how and if we pray, and the way we raise our children—all of which are protected from any government definition of "right" conduct by the first amendment—there is no activity in which the application of personal values is so important as how we treat our bodies when we choose to undergo or forego medical treatment.

Further, the value of autonomy has always been especially important in the United States. Given the heterogeneity of this country, the importance of autonomy is hardly surprising. Where a society is homogeneous, and where there is little deviation from standard values, there is little fear of society imposing standards on everyone. Where, however, the society is so diverse that we cannot speak of a prevailing religious, social, or economic view, autonomy will be most seriously undercut by the imposition of required values. Even before the time of the drafting of the Constitution, the American solution to this diversity of values has not been to define a prevailing morality and require others to adhere to it where there is a substantial disagreement in the community; rather, it has been to recognize the value of autonomy—of individual control of these individual values—and to protect that autonomy from intrusion by governmental action. Decisions affecting individuals should be made by those individuals, even though the very different values they possess may lead others to make different decisions.

This American concern (some might say obsession) for autonomy is manifested in many ways. It is apparent in our economy when we compare it to the economies of most of the rest of the developed world. It is apparent in the diversity of our media, which is closely related to our diverse values. It is also reflected in our health care system, which depends upon the individual decisions of individual patients from

among choices offered by individual providers, rather than central planning, to define proper health care.

As Dr. Callahan perceptively observed, this American concern for autonomy is also reflected in the focus of our bioethics debates.⁸ From the debates and recommendations of the President's Commission earlier this decade⁹ to the almost uniform determinations of the courts,¹⁰ the issues in bioethics debates have been over who ought to decide questions, not over what the "right" answers to those questions might be. Our elevation of process over substance does not show a disregard for the substance of those decisions. Quite the contrary, it is evidence that society recognizes that the underlying substance of those questions is based in values, and that the richness of the diversity of this country makes it impossible to impose any standard values. The concern for process is important because it serves autonomy; it allows each person to control his own destiny, to be master of his own soul, to live and die true to the values he has accepted through life.

IV. LIMITS ON AUTONOMY IN MAKING HEALTH CARE DECISIONS

Despite the very high priority we place on autonomy in making health care decisions, autonomy is not absolute. We limit the authority of individuals to make health care decisions in several ways. We are more likely to approve of limits where there is an indirect effect on the community as a whole because the community is paying for the health care. For example, we have no trouble denying the request of a dying

8. Callahan, *Morality and Contemporary Culture: The President's Commission and Beyond*, 6 CARDOZO L. REV. 347 (1984).

9. See, e.g., DECIDING TO FOREGO LIFE SUSTAINING TREATMENT (1983); PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, MAKING HEALTH CARE DECISIONS (1982).

10. See, e.g., *Bouvia v. Superior Court*, 225 Cal. Rptr. 297 (Ct. App. 1986) (patient's decision to forego medical treatment or life support is a moral and philosophical decision belonging to the patient alone); *Brophy v. New England Sinai Hosp., Inc.*, 497 N.E.2d 626 (Mass. 1986) (guardian was authorized to remove ward in a persistent vegetative state from hospital, which had refused to remove or clamp patient's G-tube, to care of other physicians who would honor patient's wishes); *In Re Conroy*, 486 A.2d 1209 (N.J. 1985) (surrogate decisionmaker for an incompetent may direct the withdrawal or withholding of life-sustaining treatment under certain circumstances if certain procedures are followed); *In re Storar*, 420 N.E.2d 64 (N.Y.), cert. denied, 454 U.S. 858 (1981) (guardian was authorized to move patient in a persistent vegetative state to care of physicians who would honor the substituted judgment of patient that artificial maintenance of nutrition and hydration be discontinued). This process orientation of the courts has been predominant since *In re Quinlan*, 355 A.2d 647 (N.J.), cert. denied, 429 U.S. 922 (1976) (generally agreed to be the first "right to die" case recognized as such). For arguments that the courts should be less process oriented and decide what is "right," see the dissents in *Brophy*, 497 N.E. 2d at 640-46 (Nolan, Lynch & O'Connor JJ. dissenting), and Callahan, *supra* note 8.

person who asks to be cryogenically¹¹ preserved before death until a cure for his condition is achieved. No matter how great the patient's interest in remaining alive, no matter how important the value of continued life might be to that person, we are unwilling to allow him to decide to be thus preserved even if we think that there is a tiny chance of its scientific success.

Similarly, we refuse to honor the autonomy of a patient who asks a doctor to cut off his arm to allow him to expiate his sins. Even if we were to conclude that the amputation would, in fact, be the only way to bring tranquility and satisfaction to the patient, and even if we were to believe that only a properly trained surgeon would be able to safely remove the arm, we would not feel obliged to carry out the amputation request, even if it came from a competent and thoughtful patient. In fact, in both of these cases, our refusal to perform the required medical acts would not be limited to those whose medical expenses were paid by the government. Arguably at least, in each case, treatment would be denied even to a patient who thought that his request would be the most satisfying final use of his own trust fund. Perhaps these restrictions are based on some notion of a minimally efficient health care system, one based on some kind of essential cost-benefit analysis. Alternatively, they may be based on non-economic shared values in this society.

In any case, in addition to those cases where we are willing to limit the autonomous choice of the patient for social reasons, there is a class of cases where we would *not* permit a restriction on autonomy even though such a restriction might be based on justifiable cost-benefit analysis or some other social consensus. For example, we would not tolerate a system that allows whites to choose some form of life-sustaining treatment that would be unavailable to blacks, even though whites have a longer life expectancy than blacks in this country¹² and thus it may appear that it would be more efficient to provide more treatment alternatives to whites. Similarly, we do not allow physicians to treat women differently from men because women have a substantially longer life expectancy in this country.¹³ If a treatment option is available to a woman, we agree it should be available to a man in a medically similar situation.

In this society we start with the presumption that autonomy requires that a patient be allowed to choose any health care alternative that is consistent with the patient's values and interests. Despite this, we do limit autonomy in some cases. What factors are considered in

11. Cryogenical preservation involves preservation through the use of extremely low temperatures.

12. BUREAU OF THE CENSUS, STATISTICAL ABSTRACT OF THE UNITED STATES 70 (1988).

13. *Id.*

determining when the principle of autonomy is overcome by other interests? There are three relevant questions to address in determining whether autonomy can be trumped by other values, and in determining whether we can limit a patient's otherwise unlimited choice of medical treatment:

1. Is there a very strong social consensus that the proposed medical treatment is inappropriate, given all of the medical, social, economic, and personal considerations?
2. Is there an important social need that can be fulfilled only by denying the patient the proposed medical treatment?
3. Is the medical choice that is eliminated the consequence of some decisionmaking process tainted by stereotyping and arbitrariness?

In order to limit a patient's autonomous choice of health care alternatives, we must answer *yes* to either of the first two questions, and we must answer *no* to question three. For example, we are willing to deny patients a chance at treatment following a deep freeze, or a chance at atonement through mutilation, because these two forms of medical treatment elicit a strong social consensus. Even in this diverse and heterogeneous society, virtually everyone considers such medical treatment morally wrong and medically inappropriate, given all of the medical, social, economic, and personal considerations. In addition, there is no hint that these limitations are affected by stereotyping or arbitrariness in this case.

While it is difficult to point to a specific example of a case where a *yes* answer to the second question has trumped autonomy and limited health care alternatives, certainly some Medicaid coverage determinations and our national policy on heart transplants are based upon "breaking the bank" fears. On the other hand, we refuse to treat blacks differently from whites, or men differently from women, or rural people differently from city dwellers, or former uranium miners differently from former office workers, based on those characteristics alone, even though there might be a rational cost-benefit basis for doing so. Our society would not permit such discrimination because it does not permit limitation of autonomy in health care based on stereotyping. Blacks and whites, men and women, farmers and urban academics each must be treated as individuals. We are not permitted the arbitrariness of assuming that health characteristics follow from other characteristics, even if there is some statistical relationship between the two characteristics.

V. IS AGE A LEGITIMATE EXCEPTION TO AUTONOMY?

Dr. Callahan's proposed age cutoff limits the choice available to some patients. Because it thus intrudes upon the value of autonomy

that is so important in the provision of health care in this country, it ought to be entertained only if it survives scrutiny in light of the three factors that can justify a limitation on autonomy in health care. Such an intrusion is appropriate only where there is either a strong social consensus that the questioned medical treatment could not be chosen by those above the cutoff or where there is some important social need that can be fulfilled only by limiting the choices of the elderly. In addition, the intrusion is inappropriate if it is justified by stereotyping the elderly and results in their arbitrary treatment. In fact, none of the three factors that can justify an exception to the general rule of autonomy supports limiting an elderly person's choice of medical treatment solely because of age.

First, there is no social consensus that any currently available and widely used medical treatment is inappropriate for the elderly, even the very elderly. Quite frankly, I doubt that we will achieve any such agreement on even the most significant and expensive treatment Dr. Callahan discusses—expensive high-technology life-sustaining treatment. The vitalist position¹⁴ is a strong one in this country, and it has manifested itself in almost every facet of public policy.¹⁵ The fact that a number of states are still unwilling to pass right-to-die statutes,¹⁶ and that many that have passed them have acted to amend and weaken them over the past two years,¹⁷ is evidence of the ambivalence over the *right* to forego the treatment Dr. Callahan would *require* the elderly patient to forego. This ambivalence is reflected in the medical profession as well, where there are still many who equate appropriate beneficent conduct with extending life under all circumstances.

The uncertainty over the propriety of discontinuing life-sustaining treatment on elderly patients is not a consequence of a lack of consideration of the issue or a belief in the issue's relative unimportance. Quite the contrary is true; those who oppose the discontinuation often have very deep feelings about it, often the consequence of long held religious beliefs or carefully considered opinions of the importance of life in this world or the next. Sometimes the reasons for these views can be articulated, and sometimes they cannot—just as Dr. Callahan cannot articu-

14. For a discussion of vitalism, see *SETTING LIMITS*, *supra* note 1, at 179, 219.

15. Ironically, while autonomy is not an important value for the vitalists, the vitalists' right to choose life for themselves is very important to those who believe autonomy is a significant value.

16. States without such statutes include Kentucky, Massachusetts, Michigan, Minnesota, New Jersey, New York, North Dakota, Ohio, Pennsylvania, Rhode Island, and South Dakota.

17. For example, statutes prohibit withholding or withdrawing artificial feeding and hydration in Connecticut, Georgia, Idaho, Maine, Missouri and Wisconsin. *See, e.g.*, MO. REV. STAT. § 459.010(3) (Supp. 1989). For an account of the legislative history of this change in Missouri, see Johnson, *The Death-Prolonging Procedures Act and Refusal of Treatment in Missouri*, 30 ST. LOUIS U.L.J. 805 (1986).

late the reason that he would not remove the choice to continue receiving nutrition and hydration, even by nasogastric tube, from an elderly patient, except to say that it is inconsistent with our nurturing nature.¹⁸ Indeed, *Setting Limits* itself provides us with strong evidence of how hard it will be to change the inconsistent views on the sanctity of life and the quality of life that are deeply imbedded in our medical culture. The various critical reactions to *Setting Limits* demonstrate how far we are from consensus on this issue.¹⁹

Because it is important to have a social consensus that a patient should be denied a medical treatment option before that patient's right to choose that treatment is withdrawn, and because that consensus ought to be especially strong when limiting treatment will result in the death of the patient, it is inappropriate to limit the autonomy of elderly patients to choose life-sustaining treatment that can be chosen by younger people. In a society with such diverse values, it seems cruel to require a patient, who wants treatment that would extend life, to forego treatment just because most others would find treatment inappropriate and death appropriate under the same circumstances.

Second, there is no important social need that can be filled by denying elderly patients the proposed medical treatment. There are very few cases when society requires someone to give up his life for the good of the whole, and this ought not be one of them. The cost of health care is unlikely to be significantly affected by Dr. Callahan's proposal, and there is no reason to believe that the existence of the generally popular social insurance programs that benefit the elderly have any "blocking" effect on less popular welfare programs designed for the indigent.

Dr. Callahan argues persuasively that there is an appropriate time for death, and that we ought not try to prolong life when death is both appropriate and inevitable. Although vitalists and some others disagree, most of our society agrees with this premise of Dr. Callahan's argument. Most of us would choose to forego treatment when Dr. Callahan would prohibit us from accepting it. Unfortunately, health care institutions and providers are not always prepared to accept those decisions, and they may effectively veto those choices, thus negating both the efficiency of Dr. Callahan's plan and the autonomy interests of the patients. When public and medical education incorporate the perspective on aging and medical care that is so carefully worked out in *Setting Limits*, and when more health care professionals come to recognize that death need not always be avoided, the application of the principle

18. SETTING LIMITS, *supra* note 1, at 187-92.

19. See, e.g., Binstock & Kahana, Book Review, 28 GERONTOLOGIST 424 (June 1988); Hook, *The Uses of Death*, N.Y. REV. BOOKS, April 28, 1988, at 22. See generally, Otten, *Ethicist Draws Fire with Proposal for Limiting Health Care to Aged*, Wall St. J., Jan. 22, 1988, at 29, col. 4 (briefly outlines Callahan's thesis and highlights some opponents and their criticisms).

of autonomy, which will allow patients to forego expensive and useless treatment, will serve the same purposes that would be served by Dr. Callahan's compulsory system. If Dr. Callahan's argument that there is an appropriate time for death is persuasive—and I think that it is—Dr. Callahan's cutoff will have an effect only in those increasingly rare cases where there have been considered judgments by elderly patients to continue treatment that most others would find inappropriate. Assuming that saving health care resources *is* an important social need, it is hard to believe that the need to limit the allocation of those resources can be served only by requiring the deaths of those few patients. If Dr. Callahan's notion of a natural life span is accepted by most of the community as morally right, compelling adherence to its medical consequences will be unnecessary; if it is not accepted, compelling adherence to its medical consequences and requiring the deaths of elderly patients would be disastrous.

Even if a required discontinuation of medical services to the elderly would save money, there is no reason to believe that the resulting savings would be spent on appropriate programs. The fallacy of the annually promulgated Children's Defense Budget,²⁰ which demonstrates how the defense budget could be used for children's services, is that a cut in the defense budget is unlikely to lead to an increase in children's programs. Dr. Callahan might be happy to see money moved from Medicaid to Medicare, but would he be just as satisfied to see it moved from Medicaid to the interstate highway fund or the CIA?

There is, further, no reason to assume that substantial amounts spent on health care for the elderly through Medicare or Medicaid (which pays for extended care) effectively "blocks" other programs. In fact, quite the reverse might be true.²¹ The fact that Medicaid provides substantial services to the elderly may encourage legislative approval of general medical plans that would otherwise look too expensive. It is unlikely that most legislators even understand the difference between Medicare and Medicaid; they may be supporting Medicaid welfare programs because they mistakenly believe that they are supporting the nation's most politically popular medical "insurance" program. In the end, there is simply no way to conclude that any important social need

20. CHILDRENS' DEFENSE FUND, A CHILDRENS' DEFENSE BUDGET (1988).

21. Long term care, which is generally provided by Medicaid and *not* by Medicare, is available to all qualified people in need of long term care services. The chief qualification is poverty. Medicaid is politically popular because it assists the elderly who are the recipients of long term care provided by Medicaid. Others who need long term care (like the severely retarded) are swept along on the coattails of the elderly and therefore they also receive reasonably adequate Medicaid benefits. In fact, supporters of Medicare and long term care benefits of Medicaid have tended to support welfare programs generally, and those opposed to programs that benefit the elderly tend to oppose programs that benefit children and others.

to cut down the cost of health care can be served by limiting the health care choices available to elderly patients.

Finally, any plan that would limit health care choices to the elderly simply because of their age is the result of improper stereotyping. Stereotyping consists of the use of one characteristic to presume another characteristic, and then making distinctions rationally related to the second characteristic because of the existence of the first. Stereotyping, by its nature, leads to arbitrary action—action not necessarily related to the characteristic that gives rise to it.

Dr. Callahan argues that his proposal is not ageist—an invidious kind of stereotyping—because age is a relevant characteristic in deciding on the propriety of the use of some kinds of medical care. The problem with Dr. Callahan's argument is that he uses "age" to mean two different things.²² He bases his argument on the relevance of biographical age,²³ but he bases his conclusion on the application of limits to biological age.²⁴ He points out that we should not expect more than a decent, long, and balanced biographical life span that provides the time to love, to raise a family, to travel, to think, to read, to enjoy nature, and to make sense of our lives and destinies. It is true, as Dr. Callahan suggests, that most people have a chance to experience these things by the time they reach their late seventies or eighties. Some, of course, do not. Some have done it all by the time they are forty. Others, however, cannot make sense of their lives and destinies until they reach their nineties. Many of us do not expect to ever reach that understanding.

Dr. Callahan's underlying suggestion, that the lives of those between age eighty and ninety are not as rich and not as worthy of preservation as those between fifty and sixty, is as unrelated to his concept of a "natural life span" based upon a complete biographical life as life expectancy is unrelated to race or gender. There is some statistical correlation between biographical and biological age, but it is ageist stereotyping to conclude that one of advanced biological age also possesses advanced biographical age. To decide that a particular seventy-five year old patient should be denied dialysis because most other seventy-five year olds have led a full life is arbitrary and inconsistent with respect for and dignity of the individual that have been represented by the principle of autonomy. Rationing by biological age simply does not provide a "fairer, more uniform standard" than alternatives.

22. In fact, he may use the term "age" in more than two ways. Age may be defined by chronology, biology, biography, experience, or other factors relevant to the values of the culture.

23. For a discussion of age as a biographical standard, see *SETTING LIMITS*, *supra* note 1, at 164-67, 170-71.

24. See *SETTING LIMITS*, *supra* note 1, at 164-66.

VI. ALTERNATIVES TO RATIONING BY BIOLOGICAL AGE

Even if some sort of limitation on access to health care resources is necessary, the solution need not be so harsh and blunt as rationing by age. As Dr. Callahan points out, “[m]any of the elderly are already terrorized by the prospect that modern medicine will effectively keep them alive *too long*”²⁵ There is simply no justification, on any grounds, for medicine’s imposition of this continuing terror, especially if it will, as Dr. Callahan argues, “divert money from the health and other needs of younger age groups”²⁶ If we respect the autonomy of those terrorized patients and their long suffering families and refrain from providing them the treatment they do not want, we will go a long way towards overcoming the problem. Before we impose terror on the elderly who do not want to die, we ought to respect their wishes and avoid the terror of those who believe that their time to die has come. In fact, limiting health care choices, if necessary at all, can be tailored to the needs of individual patients.

In addition, arguments like those in *Setting Limits* will help people make decisions that are likely to serve our social needs. As more people realize that they are without any social or moral obligation to live beyond their biographical life, as more families recognize that they are not obliged to extend the suffering of their relatives, as more physicians are trained to recognize that refusal of life-sustaining treatment is an appropriate medical choice, as more courts recognize that such choices are appropriate and that the principle of autonomy requires that they be honored by health care professionals, there is every reason to believe that the judgments of patients, made with their families and physicians “will in their aggregate be just what is economically feasible for society.”²⁷ It does not “fl[y] in the face of logic and experience”;²⁸ rather, it is supported by logic and experience.

The use of individual need as the standard does not bring inevitable inconsistency and unfairness to the allocation of health care resources. Those who want to see a fairer allocation of housing, food, clothing, and other necessities in this country argue that we must meet the needs of individuals and families—needs that our current categorical welfare system fails to meet. The “vagaries of changing social expectations” and “the different judgments of individual patients and physicians” ought not be suppressed; they ought to be recognized and honored in a society that wishes to respect the diversity of its population. The fact that different people have different values will inevitably mean that different people will make different claims on our health

25. Callahan, *Health Care*, *supra* note 2, at 562 (emphasis in original).

26. *Id.* at 562.

27. *Id.* at 565.

28. *Id.*

care system—just as different people make different claims on our public school system, our highway system, our welfare system, and our police.

Finally, a policy that provides for individualized choices would not mean that any patient could choose every imaginable medical treatment. Patients will always be limited to medically appropriate treatment, and medically appropriate treatment has always been defined by a host of factors including social consensus, professional judgment, and patient desires. If there are fewer resources available for health care, the medically appropriate alternatives may be diminished, just as the availability of effectively unlimited health care resources has undoubtedly increased the range of medically appropriate alternatives offered to patients. Any change in what constitutes medically appropriate treatment will occur slowly though and it will occur in the context of the continuing social debate over the allocation of health resources. Surely biographical age and biological age will both be relevant factors in determining what constitutes medically appropriate treatment for an individual, as will physical and mental condition, personal values, family relationships, and other attributes we cannot now foresee.

Just as patients now are not asked if they want to be cryogenically preserved, because that is not a medically appropriate alternative, soon a patient's family may not be asked if their terminally ill and irreversibly comatose eighty-five year old relative ought to be kept on antibiotics, or on the ventilator, or on nutrition and hydration. The continuing debate is revealing that such treatment, under such conditions, may not be medically appropriate. We are likely to have a more humane and respected health care system if those decisions are made deliberately and, ultimately individually, than if they are made by general administrative order. The diverse character of our society does not allow us to make any other life and death decision categorically and arbitrarily. It should not permit us to make health care decisions in that manner either.

VII. CONCLUSION

Perhaps the greatest contribution of *Setting Limits* is that it has provoked a principled discussion of health care rationing in a society previously unwilling to discuss the sensitive issue. In *Setting Limits*, Dr. Callahan suggests an efficient and simple solution to the perceived problem of mounting health care costs—an absolute age limitation on the availability of some sorts of expensive medical treatment. This solution removes some health care choices from the elderly, and it is thus a limitation on their autonomy. Autonomy is an especially important principle in making health care decisions in the United States because of the diversity of our values surrounding health care. A health care system that denies autonomy, that sacrifices the respect and dignity of

the individual for the good of society, ought to be tolerated only if the limitations it imposes are: (1) those recognized by a very strong social consensus as inappropriate; or (2) those necessary to fulfilling an important social need that cannot otherwise be fulfilled; and (3) those which are not the consequence of the arbitrariness that results from stereotyping. An absolute limit on access to certain kinds of health care based on age alone cannot satisfy any one of these three factors, and thus cannot be justified as a limit on the autonomous choice of the patient.

In fact, much of the end sought by Dr. Callahan can be achieved through the *recognition* of autonomy, not by its *limitation*. If those who wish to forego treatment—those now “terrorized” by the prospect of its imposition—are permitted to have their wishes honored, a great deal of the medical treatment Dr. Callahan finds unwarranted by its expense will cease. In any case, a more gentle and more humane system that considers the physical and mental condition of each patient and recognizes the value of that patient is likely to create a less arbitrary health care system. If the resources for health care are to be trimmed, they can be trimmed slowly and thoughtfully, consistent with current and changing ethical analysis, through the social redefinition of what constitutes appropriate medical treatment in individual cases.