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## [Book Review of] *Setting Limits: Medical Goals in an Aging Society*

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# BOOK REVIEWS

## *Setting Limits: Medical Goals in an Aging Society*

*Simon and Schuster, New York, 1987. 245 pp. \$18.95.*

*Setting Limits* addresses matters of monumental concern to all of us. In the United States, there is a rapidly growing crisis in health care. Our average annual expenditure per individual is over \$1,500 per year for a total of some \$450 billion. We currently spend almost 11% of our gross national product on health care. This is a per capita amount greater than in any other developed country, and almost twice the percentage of our gross national product of 20 years ago. It is projected that by 1992, health care costs will exceed 12.2% of the gross national product, and 14 to 15% by 2000. The annual rate of increase in health care cost is more than twice the annual rate of increase of general inflation. In spite of aggressive measures directed at cost containment, expenditures for health care measured in constant dollars rose more rapidly in 1980-85 than they did in 1975-80. There is no evidence that our health is significantly improved because of the expenditures. Infant mortality remains too high. Many are effectively excluded from access to basic health care.

Total health care costs continue to expand at a more rapid rate than available financial resources. All segments of society feel the impact. This creates a dilemma as to how we will allocate those resources which are available. Our expectations, realistic or not, continue to expand at a still greater rate than resources. Costs are most visible, but other related forces, among them the increasing aging population, the extension of medicalization to other aspects of our society and growing entrepreneurship, are extremely important. Expectations exceed documented needs and our resources are inadequate to fund the growing costs. Chaos will result unless there is a shift in our vision about human needs and priorities. It is to this that Daniel Callahan reacts in his new book, *Setting Limits*. This is an important book because of the crisis, the topic, and because of Callahan's position as Director of the Hastings Center. His challenge that we rethink our current approach to the delivery of health care services must be taken seriously.

Callahan's and others' attempts to find ways to control health care costs continue to try to find answers primarily from an economic perspective. There is a recognition of the tremendous expenditure. Solutions typically begin by asking: How do we limit the cost? Who will pay? Or, how do we fund the program? Little attention is given to the question: "What are we buying? And, should it be bought? Callahan argues that the elderly have had an opportunity to live "the good life" and that open-ended, high technology medicine will not necessarily make old age "more meaningful and satisfying". He does not ask whether what we buy is appropriate. Another question that he might have asked is: What priority should be given to expenditures for health care, both by society and by *individuals*?

Callahan recognizes that we have a dilemma and lists three typical complaints rising out of the resultant "uneasiness". They are that an increasingly large share of health care is going to the elderly in comparison to benefits for children, that a disproportionately large portion of health-care expenditures is spent on the care of the dying elderly, and that a large and growing proportion of research and technology is devoted to the elderly (p. 21).

Callahan's answer is, in part, that since not everyone can have unlimited care, someone (the elderly) must practice austerity. It is from that perspective that Callahan calls for a rethinking of the relationship between health care services, costs and the needs of the aged. His approach, which he offers as an alternative, is one in which we must first recognize the failure of the present system, and then accept a limit to life-extending care for the elderly.

Callahan argues for a health care system that seeks to give each of us “an adequately long life”, accept death in old age and that “would be more humane for the elderly and *financially sensible for everyone else*”, (italics added). Callahan has observed three major changes attributable to biomedical advances — changes in conception of medicine, of health, and of life.

He notes in regard to the first:

Contemporary medicine is an area for constant high-technology innovation, a massive and profitable industry, and an inescapable element in national economic prospects and welfare. The needs of the elderly, themselves redefined by the medical advances, offer the richest possible terrain for medicine to exercise its powers and its inspirations. (p. 16)

And on health:

Ever-improving good health as a realistic goal, has had a number of consequences. It has stimulated the development of a notion of health that encompasses mental as well as physical well-being, and . . . the hope and belief that happiness, not simply bodily welfare, can be encompassed as well. The support of biomedical research and access to health care have as a consequence taken on the high status of basic human rights and entitlements. (pp. 16-17)

On life, he writes:

An extended life span means thinking about the stages in life, and the possibility of life, in new ways. Not only are the facts of life changed, but also the meanings associated with them. (p. 17)

What Callahan does, then, is note that these changes have brought about three consequences which alter

. . . our perception of our capacity to control our life, strengthening a . . . belief that our medical destiny lies in our own hands — by virtue of better personal health care . . . and . . . by a commitment to basic biomedical research and improved healthcare delivery . . . Second, an alteration in the way the consequences of our actions are understood. By breaking . . . fixed cause-effect relationships, actions once hazardous can now yield tolerable outcomes . . . The biological sundering of sexual activity and procreation is more than matched by the . . . sundering of illness and old age . . . A third consequence has been to encourage the belief that the . . . inherent finitude of the body — and, through drugs, of the mind and emotions — can be overcome. (p. 19)

Recognizing these fundamental forces and their results, he comments that “an expansionary vision of health, because of its *proved value* (italics added) to change life will continue to shape our understanding of medicine and its possibilities” (p. 19). Callahan accepts that *medicine* should define and exercise its power; that medicine should be the source of happiness and that we should accept the premise that the meaning of life embedded in these changes is correct must be challenged, that the vision he describes as of proven value must also be challenged. *His* plan does not sufficiently question how we define health care, nor require a fundamental critique of how we deliver health services. It does not correct its real failures. Callahan’s approach is to reallocate within the current system. His rethinking is inadequate, in part, because it does not consider radical solutions. He does ask that we read his book in “the tentative vein in which it was written” (p. 23) and that it be taken “seriously but not literally”. Perhaps he is too cautious.

Shortly after the publication of his book, Callahan published an Op-Ed essay on limits in the *New York Times* (Sept. 25, 1987). He was likened to Hitler and accused of writing “devious nonsense”. It was suggested that he did not respect the life of the elderly. It was

unfortunate that he tried to present his concerns and thoughtful reflections so briefly in such a manner. Some, who may only skim through his book, may make similar unwarrantable charges as those which appeared after his brief essay. That he has not gone far enough, or deep enough, even in the book, may explain some of the tension and ambiguity which are present.

Callahan sees the importance of community. He recognizes the importance of a special vision about the meaning of life rooted in our "narrative" when he reflects on the words of Alasdair MacIntyre. Callahan, however, suggests that answers should come from the aged. Why doesn't he propose a conversation between all of us who are still searching, young and old? It is easy to find in his writings values which are important to him as well as to most others. He asks that our burdens be pooled and shared. He conceives of himself as capable of making a radical sacrifice for another. He understands the interrelationship of mutual needs and vulnerabilities and the need of social institutions to respond to them. But again, why just a few, or just the aged and not all of us?

Callahan is correct in seeing the necessity of defining limits. Limits do not mean "not caring" and abandonment, nor "no progress". It may be with the recognition of limits that there may be more freedom, more community, and less cultural and technical enslavement. This would be a better definition of human progress than one associated with greater *dependence on technology*.

Vividly in *The Limits of Altruism*, Garrett Hardin relates a fictional conversation between a Chinese peasant and a priest in a temple courtyard. Implicit is the need to recognize limits and to contemplate a deeper meaning:

A peasant from the deforested countryside, desperate for fuel to cook his rice, has slipped into a temple courtyard and is breaking twigs off the dawn redwood when he is apprehended by the priest.

"Here, here! You can't do that!"

"But, honorable sir, I have to. See, I have a little rice in this bowl, but it is uncooked. I can't eat it that way. I'm starving. If you'll only let me have a few twigs I can cook my rice and live another day."

"I'm sorry," says the priest, "but it is forbidden. This tree is sacred. No one is allowed to harm it."

"But if I don't get this fuel I will die."

"That's too bad; the tree is sacred. If everybody did what you are trying to do there soon wouldn't be any tree left."

The peasant thinks a few moments and then gets very angry: "Do you mean to tell me that the life of a mere tree is more valuable than the life of a human being?" (pp. 76-77)

The priest did not de-value human life, but rather recognized reality, the need for limits, and the importance of both in preserving the dignity of human life. I accept that Callahan is sensitive to the dignity of human life. To say that either Callahan or the Chinese priest found human life meaningless is to misunderstand them. Callahan recognizes the reality, as many do not, the need for limits *and* the dignity of the aged. I primarily question his strategy.

Callahan argues that he is not an "ageist." He would, however, take "acute care medicine" from the elderly and transfer the emphasis "to other forms" of unspecified health care. This is not a viable alternative. To transfer resources to other kinds of care does not solve the cost problem. In fact, resources transferred from one program to another would only increase the expenditure of funds for the high technology medicine that Callahan deplors. Callahan recognizes that we "lack a system designed to be a just way of allocating scarce resources, either within the health care system itself or between health and other social needs." (p. 127) Yet, he calls for reallocation.

Callahan recognizes that there is a "technological imperative" driving medicine and at the "heart of the modernizing project is an attempt to deny limits" (p. 35). What is most

needed, is an examination of these issues and their relationship to health care, not only for the aged, but for *everyone*. We must find what are true alternatives. We need to examine how similar changes and their results have affected not just health care, but all of society. Callahan is correct in saying that "the elderly do not have an unlimited claim on health resources" (p. 176). No one does. Callahan's setting of limits is appropriate, but to do it out of financial motivation, for a single segment of society (the aged), and presumably by fiat, is neither acceptable nor just. Callahan suggests that, if necessary, society set limits for the elderly (no government-supported life extension beyond a certain age) p. 186. Callahan asks that we admit that we cannot "continue on the present course of open-ended health care ..." He should have stopped there but continues "... for the elderly." A real alternative is that society set limits for itself.

Callahan's final three proposals (pp. 222-223) do lay a foundation for a new approach. The first is that we no longer pursue "without prudent limits, medical goals" which involve high costs, slight "population-wide" benefits, seek indefinite life extension, and primarily benefit the elderly (sic). (Why not rather: allocate our resources to provide universal access to basic health services?) Secondly, he proposes "an integrated perspective on a natural life span." Finally, he argues for a "pervasive cultural agreement" that death is "a condition of life to be accepted", rather than "an enemy to be held off at any cost."

This is an important book. It should help us focus on the most important health care issues that we will have to deal with in the coming decades. The issues present themselves as issues related to cost. The real issues are the values of our society and the denial of limits. The problem is not an economic one; the answers are not economic. This book is a beginning. I hope that Callahan and others will continue the dialogue. The dialogue must move beyond costs and deal with the more fundamental issues which Callahan himself raises.

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## ***Catholic Identity in Health Care: Principles and Practice***

by Msgr. Orville N. Griese

*Braintree, Mass. 1987 419 pp. + appendices*

The original concept of a "hospital" was developed by the Catholic Church in the Middle Ages. The earliest hospitals were developed for the specific purpose of health care delivery to the poor. The "poor" were defined not only by their economic condition, but also by their social status or a medical condition which might lead to ostracism. The woman pregnant out of wedlock, the leper, the insane, the carrier of sexually transmitted disease or plague were all disadvantaged with regard to their access to medical care. Various orders of nursing sisters made a new apostolate of establishing hospitals for the poor as broadly defined. It has become a cliché of some spokesmen for the so-called post-conciliar Church to suggest that the Church's social mission was more or less discovered after Vatican II.

In this superb volume, Monsignor Griese brilliantly discusses the 20th century identity of the Catholic Church in American health care. The search for minimal standards to upgrade the quality of health care facilities in the United States was begun contemporaneously by two newly formed organizations - the American College of Surgeons and the Catholic Hospital Association. The College of Surgeons developed a publication setting down professional standards, particularly for surgery, in 1915 and this was endorsed by the