



BIO-ETHICS

UAHC COMMITTEE

Program Guide VII

Allocation of Scarce Medical Resources

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Developed by

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Foreword

Shalom!

As debates continue around the topic of advancing medical technology and how those advances impact upon our lives, we come face to face with the real question of, "Who shall pay?" No matter in what system of government we find ourselves, questions arise in increasing regularity regarding the justice of care, the equality of access, the morality of who is treated and who must wait, as well as the ever-increasing debate over "rationing."

One of the issues that the UAHC Committee on Bio-Ethics, and its companion program the Committee on Older Adults, began to focus on is just how we look at the realities of scarce resources, expanding "wants," perceived "needs" and how our Reform Jewish mind can react and plan. One thing is certain. Issues regarding resources and their allocation, and our place in that discussion, will impact each and every one of us in the coming years.

This current Program Guide is designed to introduce the subject from a variety of perspectives. The opening section will focus on some brief "thought pieces" designed to start the discussions in whatever setting the Guide is used (classroom, camp, etc.). This is followed by a selection of pieces from contemporary bio-ethics writing. "Rationing" or "setting limits" is a theme of the first series of selections, while the second group focuses on the application of the traditional value of *tz'dakah* to the entire discussion. Finally, we have included an interesting group of selections drawn from "popular" press. These selections are by no means exhaustive. However, they can be easily included in programming the unit and serve as very good discussion starters.

As in the previous Guides, we've included some basic programming ideas that refer to the material and a few additional resources that are not mentioned within the body of the Guide but are readily available.

The subject of resource allocation tests our beliefs as to our responsibility for ourselves and our society; who takes precedence, why, and when. As such, it is a fitting, albeit difficult subject for this, the Bio-Ethics Committee's seventh Program Guide.

Shalom,

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Section I Thought Pieces

1. Reflections on the Allocation of Scarce Medical Resources

Rabbi Norman T. Mendel

Chair, Pastoral Care Services, City of Hope, Duarte, CA.

2. The Physician's Role in Resolving Allocation Dilemmas

Karen C. Lieberman, J.D.

Mequon, WI.

3. Redemption For the Community

Rabbi Joseph A Edelheit

Temple Israel, Minneapolis, MN.

4. Allocation of Scarce Resources

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Reflections on the Allocation of Scarce Medical Resources

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The issue of the allocation of scarce medical reserves most certainly raises critical educational issues for the '90's. The very topic itself asks us to comprehend our traditional Jewish ethics which honor life and its preservation. The toast *L'chayim*—"to Life," is more than a salutation but an ongoing reflection of the essential Jewish belief in the value of life and its inherent goodness. Even more, in our post-Holocaust era there exists a basic and fundamental sense of repulsion to the notion that third parties should, directly or indirectly, determine whether a life is worth living. Nevertheless, the reality of our time is that "managed care" in some form will be the harbinger of our immediate future as well as an essential fact of life as we strive to find a methodology that will allow our society to underwrite universal health coverage.

The issue is not alone one for American society but has already been put into practice in varying ways in Europe and Canada. As a result, we are forced to confront the moral issues involved with placing limits upon health care in the context of a society that has traditionally thought and acted in terms that are limitless and boundless.

In American life, we have always attempted to push the frontier further. The very notion of limitation and consequent capitation runs contrary to our own history, both Jewish and American. Yet it behooves us to develop a methodology for the best course of action in the context of competing options, each of which has its own benefits and burdens. The issue is not so much as one of "good and bad" as we would like to categorize them, but of "good and good" with some "bads" attached.

There are any number of instances in which seemingly limitless resources are expended on an individual who medically could not be "saved," making it fiscally difficult, if not impossible, therefore, to provide those same resources for one who could be medically helped. In such cases, the issue of futility is not so much a medical issue as a philosophical one. The medical procedures may be pragmatic and set, with the controls of protocols obtaining, while the philosophical overlay is amorphous and floating, fraught with emotional overlays. Therefore, how we approach this issue is critical if we are to successfully co-join head and heart.

There are those who have said that placing limits upon health care is immoral because it runs contrary to our culture and discriminates against the disadvantaged and minorities. In reality, there has been a form of rationing for some time, based upon access and eligibility. Now the issue asks one to look at rationing as the prioritization of that which is most necessary compared to what is least necessary to sustain a quality of a life. Certainly in a Democratic society there will be an increasing thrust towards providing a level of care for all in a manner different from our present inflationary system.

From a Jewish point of view, these issues deal with the quality of an individual's life and that individual's right to life-sustaining measures and good health. We are admonished to preserve life and hold it precious, yet that also presupposes that such a life is of a level of quality that the individual consciously chooses to affirm. When such is not the case, we have come to accept that it is permissible not to resort to "heroic measures" to preserve that life.

Already we have taken steps toward placing limits in our understanding of when a life may be allowed to “slip away.” We hear family members say, “It would be a blessing for him/her to go peacefully.” We read advance directives from patients who have requested “do not resuscitate” orders under certain circumstances, or who have specifically stated, “No respirator, no intubation” and even “No CPR.” We have accepted these wishes in the main with occasional feelings of guilt and remorse, but accepted them generally, nonetheless.

We will have to learn to accept still more in a future health care system that may well preclude certain interventions and options. Jewishly, we can rationalize that by accepting the value of the individual and the resources consumed by that individual, in the context of that individual’s role in the community. We already well understand that the Jew is not isolated and as an individual is supposed to be connected to his/her community. We accept the notion of community responsibility and of community participation.

On the one hand, we honor the individual; on the other, we place that individual in the context of community limits. Inevitably the individual surrenders some individuality for the sake of community. How can it be otherwise if ultimately both community and the individual are to exist?

Health care limits are an extension of the same notion, albeit impacted by what we view as our inalienable rights. Nonetheless, I believe the future is such as to force us to understand that prolonging life when it is not “life qualitatively” as we know it, at the expense of the opportunity to preserve and sustain life for those who might have such an opportunity would be viewed as the ultimate selfishness.

We can no longer particularize when we are need-based in the general. The cry, “Do everything—spare no expenses,” is a cry our society can not afford, and “everything” may medically make no difference anyway. Coming to grips with that reality is difficult, but necessary.

Dealing sensitively with these issues is brought about through education. Education is the challenge that confronts us and allows us to accept change. As we move from the old ways to the new, we become caught wanting what was and feeling unsure about what will be. That dilemma can be avoided by doing what the Jew has always done—going forward and making the most of each moment as though it were the last, consecrating life by our daily deeds and recognizing that limits are inevitable.

We are finite and yet that very finitude propels us towards that which is infinite within ourselves and others. Dealing with limits is not really so new. Adjusting to them in the area of health care may seem to be. Yet the challenge may well become the enabling mechanism of measuring life in terms of the quality of the deeds we perform rather than the number of days we live.

The Physician's Role in Resolving Allocation Dilemmas

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The debate over the proper allocation of scarce medical resources is unlikely to see any definitive resolution soon, but there are some things upon which we can agree. First, the resources we have available to dedicate to health care are finite. Second, we are moving ever closer to our limit. Finally, all of the above notwithstanding, the demand for health care resources is increasing, not decreasing.

The ethical dilemmas presented by these factors are myriad: Should an infant be admitted to an intensive care unit when the best medical knowledge available indicates that the child will need frequent and extensive medical treatment over the course of his/her lifetime? Should the availability of health care be limited once people have reached a particular age (e.g., offer such patients routine care and relief from pain but no intensive care, long-term life support, or organ transplants)? Should the availability of health care be limited in cases in which patients contribute to their own health problems (e.g. by excessive use of alcohol, smoking, refusing to control weight or get adequate exercise)? How should organ transplantation programs be structured to deal with the fact that there are more potential recipients waiting than there are donors? Should resources be allocated to these expensive programs or to other programs that, with the same allocation, could benefit a much larger segment of society? The list could go on for pages.

Invariably, when this topic is covered in the first-year medical ethics class, students will ask: "What is the role of the physician in resolving these ethical dilemmas?" Implicit in the question is their intuitive understanding of the potential for conflict in the decision-making process. They are, on the one hand, mindful of and sensitive to the needs of society as a whole. On the other hand, they recognize that they will be tending personally, one on one, to a particular patient who may well have needs for medical resources that exceed what would be in society's best interest to provide. What should the physician do?

It plausibly could be argued that physicians must take larger societal interests into account when practicing medicine. Physicians are best able to assess their patients' particular circumstances and to consider their needs while also considering the benefits and costs to society of providing for those needs. Moreover, as the primary source of information and advice to patients concerning medical treatment and options, physicians are well-positioned to serve as gatekeepers to access scarce medical resources. Thus, the responsibility for allocating these resources could fall on physicians within the context of their individual practices.

While this view may have some facial appeal, I find myself aligned with those who would not impose this responsibility on physicians making treatment decisions for their patients.¹ I do believe that physicians, like all individuals, must concern themselves with the communal welfare. It seems to me, however, that the appropriate place for this concern is not in the context of individual physician-patient relations. Physicians have a very special relationship with their patients, a

¹ See, e.g., "Hiatt, Protecting the Medical Commons: Who is Responsible?," 293 *N. Eng. J. Med.* 235 (1975); Fried, "Rights and Health Care—Beyond Equity and Efficiency," 293 *N. Eng. J. Med.* 241 (1975); Levinsky, "The Doctor's Master," 311 *N. Eng. J. Med.* 1573 (1984).

relationship of trust and confidence. The law acknowledges the fiduciary nature of the physician-patient relationship and imposes on physicians duties of good faith and fair dealing with patients. These heightened duties stem from the understanding that physicians have knowledge, skill and expertise in matters of great importance to patients, but about which patients generally know very little. As a result, patients necessarily place substantial trust in and reliance upon their physicians' advice and actions.

Inherent in the special duties of good faith and fair dealing is a physician's duty of loyalty to the patient, that is, a duty to remain faithful to the patient's interest in the face of conflicting interests. The law has long recognized that the physician-patient relationship can be meaningful and productive only if such loyalty is scrupulously maintained.²

If physicians are to take societal interests into account in treating their patients, the potential for conflict of interest looms large. Virtually all professions warn in their professional codes against allowing such conflicts to develop, and the medical profession is no exception. The reason is evident—conflicts of interest undermine the trust between the physician and the patient that forms the basis of the relationship. Patients who are given advice by physicians whom they know are also considering other interests that may well be in conflict with their own personal best interests necessarily receive that advice with some uneasiness. Moreover, such patients are unlikely to feel free to be completely honest and forthcoming with their physicians, knowing that physicians may use such information against the patients' personal interests rather than on their behalf. This breakdown in confidence could well lead to diminished quality of care, since physicians rely on the truthfulness and completeness of the information provided by their patients in making diagnoses and recommendations. Clearly, this result is in neither the individual's nor society's best interests.

To say that physicians must be loyal to their patients' interests is not to say that there should be no limitations on the availability of health care resources, or that physicians are excused from any responsibility to help address and resolve these ethical dilemmas. On the contrary, placing limitations on individuals' access may well be necessary to protect the welfare of the whole, and the obligation of physicians to have input into the decision-making process is apparent, given their particular knowledge, experience, and expertise. However, I believe it is our society that ultimately must make these decisions, not individual physicians. To be sure, physicians must participate in the public debate, in the legislative process, in the academic literature. They must work in conjunction with lawmakers, government agencies, clergy, and others to help set the standards by which decisions will be made. They must participate, for without them there is no hope for informed, rational processes or outcomes. But when dealing with the circumstances of individual patients, I think physicians must do all they can for their patients within the parameters set by society. The risks of doing otherwise are too great.

In our anxious and well-meaning efforts to preserve our medical resources, we must strive to maintain our humanity in the process. Patients who are ill need physicians to whom they can turn for advice, care, comfort, and reassurance. I believe we must all share in the responsibility for making these most difficult decisions. We should neither require nor permit individual physicians to make these decisions on their own.

² See, e.g., *State ex rel. McCloud v. Seier*, 567 S.W.2d 127, 128 (Mo. 1978) (“(T)he duty of the physician to exercise the utmost good faith in dealing with his patient...contemplates the physician's undivided loyalty to his patient....”).

Redemption For the Community

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The current headlines about the Lakeberg twins have created a very discomfoting ethical polarity. Amy and Angela Lakeberg were Siamese twins born sharing a heart and a liver. Immediately following birth the doctors informed the parents there was less than a one percent chance that even one of the twins would survive. Amy died following surgery while her surviving twin sister Angela lived nearly a year, 42 weeks of which were in an intensive care unit. Professor Arthur Caplan of the University of Pennsylvania Centers for Bioethics asks, "Was it right to commit more than \$2 million of medical treatment, over \$600,000 of it public Medicaid money, to a long shot effort to save a single child's life? It seems strange to perform high risk, long shot, high-tech operations when we can't get basic care out there. It's time for public policy to get beyond the sight of two small conjoined babies and realize that there are 10,000 babies anywhere else who are at risk...(who) do not get well baby visits, prenatal care, basic physical examinations, immunizations or even prompt treatment for injuries and serious illnesses." Dr. Caplan's communal view is sharply contrasted with no less a passionate ethical claim by Dr. John Lantos, a pediatrician and Associate Director of the Mackean Center for Clinical Medical Ethics at the University of Chicago. Lantos argues, "Cases like the Lakeberg's are symbolic national commitments to the sanctity of life. It's like rescuing a small boat lost at sea with a large search operation. We all feel glad about it. It speaks to our feelings about the absolute worth of the individual."

Caplan and Lantos pull us into a strong polarity of ethical imperatives. One centers on the diminished resources of the community and the ethical imperatives to allocate—"ration"—those resources for the good of the entire community. The other claims an equally absolute imperative for each individual life, and that responding to this ethical claim will have its own communal value. How are we to decide? How are we to bring Judaism and rich textual resources to bear in this contemporary debate? The question before us, the allocation of health care resources, is an issue of critical concern to all of us.

Shall we follow Daniel Callahan's argument regarding rationing of health care for the elderly as stated in "Setting Limits: Medical Goals in an Aging Society?" How should we allocate organs to those needing transplants—to those who are younger, wealthier, more able to survive because they have no other illnesses, or someone who "contributes" to society? What is the "fairness" principle in a society where "extraordinary" health care like organ transplants is now considered by many ordinary and, therefore, are we all entitled to transplants? Are we prepared to deal with the ethical implications of either a vaccine for the HIV virus or a "cure" for AIDS? Assuming that the miracle "silver bullet" were actually within our reach, how would we allocate these very rare and presumably expensive resources? Allocation of hypothetical vaccines and cures is not just a game—especially when there are tens of millions of lives worldwide which hang in the balance.

Dr. Jonathan Mann has warned us that the worldwide pandemic of AIDS will have its most devastating impact on the poorest countries. As of July, 1994, 17 million people now have AIDS. The World Health Organization estimates that 30-40 million people will be infected with HIV virus by the year 2000. Africa has more than 67% of the estimated total. Who will determine how millions of people will be allowed to share a vaccine or cure? Can we afford to wait until its discovery to ask what ethical guidelines will determine how to ration this critical healthcare resource. Caplan and Lantos have a claim on our attention because the questions raised by the Lakeberg twins' case illuminates the ongoing dilemma regarding health care allocation which will eventually involve the global community.

What does Reform Judaism guide us to do? I suggest we turn to the very first commandment given to the Jewish people as a community, a commandment essential to its own redemptive destiny. In *Exodus* 12:3-4 God commands the then enslaved Israelites to take a lamb for each household and if the household

is too small for one lamb, they are required to share it with neighbors. The verse concludes with the idiom "*Ish L'fi Achlo*." "Each person according to their need to eat" shall be the means of accounting how many are needed to consume the paschal lamb. This same idiom is used in *Exodus 16:16* in the context of the manna given by God in the desert to feed the people. "Gather as much as each person needs to eat."—"*Ish L'fi Achlo*," "what an individual needs to eat."

In both cases the Torah limits the individual's for the sake of the community's redemption; the absolute value of the individual is secondary. This utilitarian ethic is not what we normally understand to be Judaism's absolute view of the sanctity of life. It is this stark difference that points us toward a different view of redemption. The Torah does not allow for or encourage consuming the paschal lamb on any basis other than an individual's needs within a household, and no one may eat of this unique sacrifice outside the communal context. All of the lamb was to be eaten—nothing was to be left—underscoring the presumption that *all* needs would be fulfilled and nothing would be wasted.

Similarly, the Biblical measurement of manna is the "*omer*," which was based on individual needs, not desires or projected needs. Strict limits were exacted so *no* wasting of this divine foodstuff was allowed. Even the double portion for the Sabbath was only what was *needed*—not what was desired.

"*Ish L'fi Achlo*"—"each according to their *need* to live" is always put within the communal context; it is this emphasis which applies to the contemporary case of scarce health care resources. Our *community* is in serious—even perilous times, no less than the ancient Israelites in Egypt or on the desert. If redemption is yet at hand then the individual's needs must, I argue, be placed *within* the community's limits. The Torah defines individual redemption within a *communal* model. No one gets *their* individual salvation prior to or at the expense of anyone else. It is the community's destiny which always has the higher priority.

Judaism's oft quoted view that each individual life is absolutely sacred must, I feel, be balanced with this communal view. We no longer (and maybe we never did) live in a time or place which can support *limitless* individual medical "desires" even when high tech medical care makes these "miracles" seem like ordinary needs. Everyone is entitled to their measure of an *omer* of manna in order to live!

If we are to survive the difficult decisions which we will face on a global proportion, then we must *now* establish some ethical boundaries, limits which will define the value of the individual *within* the community's needs and abilities. The Torah teaches us a sublime truth in its repetition of "each person according to what they eat/need." This limit of individual needs only *within* the community denies the equality of each individual's competitive desires. High tech medical specialties have made many "desires" equal to "needs," like in vitro fertilization, MRI and CAT scans, neo-natology, and "experimental" drugs for cancer and AIDS. Equitable decisions for *all* people are not possible if all individuals are equal to the community. Let us pursue the wisdom of redemption in the Torah—that individual *needs*, whatever they are, are *limited* to what a "household" within the community can sustain. The Lakeberg twins are not equal in quantity or quality to preschool immunization for thousands or HIV/AIDS counseling and education for alien immigrants. Like the Israelites whose redemption depended on taking only *one* lamb per household and *sharing* when necessary, our redemption, too, is dependent on sharing limits of our lifesaving resources and admitting when we cannot do all we want, only what we need.

Allocation of Scarce Resources³

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It was not even two full months since leaving Egypt and the “stiff necked” children of Israel had already begun to complain that basic resources needed for their survival had dwindled. Lamenting to Moses and Aaron, the people sought answers, even voiced reservations as to the wisdom of leaving Egypt. Grumbling as to their plight they questioned their leader’s vision and policy and complained: “For you have brought us into this wilderness to starve this whole congregation to death!” (Exodus 16:3).

Of course, as good social planners do, Moses and Aaron huddled and concluded a prudent social policy on allocating resources...all, with a little help from God! Follow instructions, participate in the miracle, gather the manna...but do so according to the directions given so that all can benefit. This the people did, except, of course, for the few who continued to abuse the system by disobeying Moses’ instructions. Eventually the lesson was learned and the crisis eased...resources were developed and allocated so that the group would survive...all with a little help from God!

Would that it were as easy today...allowing us to merely have our communal leaders retire to think and await the coming of a cloud wherein would be God’s presence, instead of a cloud where is uncertainty and multiple options. Yet, as we as Jews are reminded every High Holy Days, we are a religious community that sees in our ability to make choices, God’s power and creative link. Our being created *b’ tzelem elohim* (in the image of God) allows us the freedom to wrestle with difficult choices and bear responsibility for them.

Judaism looks at two aspects of choice as it relates to today’s subject: one on a social, public policy level; the other on the individual “case by case” level. Looking at the aspect of how we as a Jewish community can make choices on the communal level we understand that in our society we may have, for example, only a certain finite number of dollars. Simply stated, we must make choices between health care and associated needs and the rest of society’s demands—from missiles to roads. Each choice creates more choices. For example, what kind of health care expenditures? Do we now allocate more to wellness education and preventive medicine or continue, as some argue, to allocate increasingly scarce monies to the futile attempt to defeat the undefeatable enemy—death!

What is more difficult is how to translate these concepts from the social level to the individual case by case level. Do the same choices get made? Can we see in Jewish tradition several ways of looking at the allocation issue? Perhaps yes, for a story in the Talmud relates a problem of when hostages are taken by bandits and there is an understanding that the community may only have a certain amount of money to pay and no more. One commentator says that this is so that the captors will not be encouraged to deplete the communal resources...yet, it allows a father to pay, on his

³ Prepared for the Schlinger Institute of Ethics Program, Temple Emanu El, Dallas, Texas, January 1994. Included as part of the 1994 annual meeting of the UAHC Committees on Older Adults and Bio-Ethics.

own, whatever he may be able to bear. In discussing this, modern scholars see a division in how Judaism will approach the allocation issue from a social policy and that of an individual level.

Dr. Fred Rosner, writing in *Modern Medicine and Jewish Ethics* notes that it is not uncommon in our society to follow the principle of the greatest good for the greatest number. He notes, "The greater good of the greater number seems to be the ethical standard of lawmakers and public servants in a democratic society, since sacrificing the many for the few would only hurt the majority without substantially helping the unfortunate few."⁴

A classic example from the Talmud (Nedarim 80B) is used to illustrate the idea that society may not be bound by the same principles as individuals. There was a town, Town A, located on a hill, which owned a supply of water. Town B was located at the bottom of the hill and could not obtain water unless Town A, on top, refrained from watering their flocks or laundering their clothes. Rabbi Jose ruled that the people of Town A took precedence over Town B...the immediate danger was to the people of B who would have no water. Yet a long term danger was to the people of A. Rabbi Samuel, another Talmudist, reasoned that "Scabs of the head caused by not washing can lead to blindness; scabs arising from the wearing of unclean, i.e. unlaundered garments, can cause madness; scabs due to neglect of the body can cause boils and ulcers."

Modern authorities see in this case an understanding that society must be concerned about future generations and for long term planning. "Society must be concerned about the long range effects of its actions. This is not so for individuals. The doctor in the intensive care unit must make decisions that affect individual patients in the here and now."⁵

Can there be a Jewish value input into how society can make its choices? Yes! Writing in the *Kennedy Institute of Ethics Journal* in June of 1991, Rabbi Aaron L. Mackler asserts that the traditional value of *tzedakah* can and should be our guide. Mackler, using *tzedakah* as justice, sees that all people are entitled to a basic level of material security. He notes that traditional Jewish sources see society as having a fundamental obligation to save lives whenever possible. Writing in relationship to the desire to provide for those with acute needs, Mackler says, "Thus, the Jewish understanding of societal obligations towards those with acute needs would seem to support society's responsibility to provide life-saving medical care whenever required."⁶

Mackler links this to his understanding of *tzedakah* by writing, "The *tzedakah* model sees society as having a more general obligation, insofar as possible, to enable each individual to enjoy a reasonably full life, by restoring lacks and providing basic needs requisite to fit within the range of species-typical functioning," thus... "access to all health care needed by any individual must be assured. Those individuals with greater needs must accordingly be provided with greater health care, through available insurance or direct provision or resources. Finally, those who make choices (in lifestyle or health care) that turn out to be unfortunate or irresponsible thereby attenuate their claims to societal support, but do not forfeit all such claims...society must continue to provide some care even for those responsible for their own misfortune, especially in cases involving threats to life."⁷ We can think back now to those who chose not to heed Moses and Aaron concerning the wilderness, yet, were cared for.

⁴ Rosner, "The Allocation of Scarce Medical Resources," in *Modern Medicine and Jewish Ethics*, p. 344.

⁵ Rosner, p. 351.

⁶ Mackler, "Judaism, Justice, and Access to Health Care," *Kennedy Institute of Ethics Journal*, June, 1991, p. 148.

⁷ Mackler, p. 154.

Mackler then seems to echo Judaism's understanding that in the social sphere it is the greatest good for the greatest number. The greater the need the greater the access. Needs imply, to Mackler, a "lack" of something (health, finances, ability) and thus it is society's responsibility to respond to that lack. This Jewish view is echoed by others as well. Robert Veatch, noted contemporary ethicist, reflects Mackler's call for justice as a moral foundation in determining resource allocation citing a call for an "opportunity of equality of well being."

Yet, justice can be viewed in a wide variety of ways as readers of Daniel Callahan, director of the Hastings Center, notes. It is Callahan who, in many recent writings, calls for setting limits to society's ability to do everything for everyone. His limits include a social understanding of a natural life span, and that in setting priorities society must recognize that there comes a time when some lives are complete and that high-tech expenditures should be assigned to those more capable of receiving benefit. He would substitute caring and psychological healing for the extra high tech intervention. "Even if we agree," Callahan writes, "that everyone should have access to a decent level of health care, does this commit us to accepting whatever level of technological progress medical science brings, at whatever cost that may entail? If the only test of economic acceptability is the efficacy of treatment—if it works, that is we should pay it—then medical progress could well bankrupt us, or, more subtly, lead us to spend more on the health-care sector of the economy than on other sectors of great civic and social importance."⁸

What is the impact of all of this on the person in front of us—a congregant, family, friend? We may be able to accept the idea that Jewish tradition moves us to argue the greatest good for the greatest number over the long term enveloped in a value of justice. But what if I have people in front of me and I have to make a decision—now! What then?

We turn again to our textual tradition and attempt to ascertain the mood of that tradition. To capture the ethical mood of our people is key to approaching each and every context. That mood compels us to see in life our greatest value and then by extension, an understanding that one person's life cannot be seen as more valuable. We cannot put a value of one life over another in situations of life or death. For as we learn from the *Pesachim*: a man comes before Rava and says, "The governor of my city has given me the alternative that either I should kill so and so or the governor will kill me. What should I do?" Rava answered, "Be killed rather than kill. What makes you think that your blood is redder than his?" In situations reflecting life or death, all people are alike in status: life is equal, and one is under no obligation to sacrifice Life A for Life B.

Yet, given that life is sacred, when we are faced with having to make choices about who to save and who not, how can we be guided? Rabbi Solomon B. Freehof, in a classic *responsa*, "Choosing Which Patient to Save," propels us to a trans-denominational understanding. Freehof, as do other scholars, points to a famous story from the Talmud (*Bab Metzia* 62A) wherein two people are walking in the desert and have between them only one pitcher of water in which is contained only enough water to keep one alive long enough to cross the desert. If they share, they both will die...if one drinks, the other will die. What shall be done?

One rabbi, Ben Petura, said that both should die so that one would not be witness to the death of the other. Rabbi Akiba, a greater authority, stated however that "Your life comes first." Now the context of this story has nothing to do with the subject at hand and raises, within our context, hosts of questions. Scholars cite it to point out our understanding that we shouldn't permit both to die when one can be saved. Some choice must be made!

⁸ Callahan, *The Troubled Dream of Life*, p. 213.

Freehof goes on to note other passages which relate relative values given to different categories of individuals and the order in which each may be redeemed from captors. Authorities agree, however, that these passages are not helpful since they are not equivalent to circumstances of life or death (not to mention the sexist and social class biases that are present). Besides, we are reminded, how can we, in critical circumstances, make such valuations, for haven't we already learned that one life may not be set aside for another. How do we know that one's blood is redder than another's?

Freehof calls our attention to a standard of choice that is based upon a concept that sees decisions being made based upon the possibility of benefit. Citing an 18th century scholar, Freehof says that we may risk the few hours of a dying man and try an untried remedy if there is a fair prospect that he can be cured enough to have, say, "a year of life."

Quoting Rabbi Jacob Reischer of Metz we note that even the remaining hours of life are important and we must guard them, never doing anything to hasten death. Nevertheless, if there is a remedy by use of which it is possible to cure him, then we may risk it. Drawing upon contemporary scholars who build on Reischer, Freehof writes, "From this we conclude that the physician must endeavor to decide not on the basis of personal reasons, but on medical grounds. He must select the patient—rich or poor, good or bad—who has the better prospect of survival and of getting more of relatively healthy life. As for the others, no direct action should be taken against them. Their sickness will run its course."

Hebrew Union College Professor Dr. David Ellenson gives us another spin on this methodology of making choices by seeing as the basis for decision making not a textual foundation, but one rooted in the conventional relationship between all of us and God that is inherent in the concept *tselem elohim*. This conventional ethic seems to be a product of an ongoing dialectic between humankind, God and the vicissitudes of life. Decisions, one senses from Ellenson, would be the product of this conversation between the patient, physician, family, and God as to what is best for the patient. What is in his or her best interests—interests which would factor in quality of life issues which would be directly impacted by the allocation of a variety of resources.

The mood then that emerges from our tradition seems to follow several currents. We understand that one life is equal to the next, and that one may not say that mine is more or less important than any other life. Thus we cannot take steps to actively destroy another life for our benefit. We understand that in certain situations choices must be made regarding allocation of resources, especially in critical illness situations. Doing nothing and allowing people to die when some can be saved is not a Jewish value. As to whom to choose, "It must be on purely medical grounds, selecting the one who has a better chance of benefiting from the remedy." The mood of our tradition then underscores the fundamental value of life, its equality, and the principle that in deciding to whom to allocate scarce resources the choice is to be made based upon which person would receive the greatest benefit from those resources.

Perhaps the greatest lesson from the tradition remains our unflinching belief in the value of life—human life, truly our most scarce resource. We live in a world which in many ways devalues this notion. Our most precious resource, human life, is trivialized and wasted, misallocated and repressed by economic, social, political, and religious inequality. An increasingly great sin is that we have yet to understand that each human life is still our most precious resource and to the values of *tz'dakah* and *k'dushat chaim*, we must constantly seek to add that of *shalom*—societies, lives and souls of completeness, wholeness, fulfillment and peace. When this is done, or even attempted, issues such as those which brought us here shall be easier to confront, for every discussion will

begin with and be buttressed by the care for and nurturing of our most precious resource—each one of us, and every *iselem elohim* in God's creation

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Section II Study Pieces: Rationing

1. **Four Unsolved Rationing Problems: A Dilemma**
Norman Daniels
Hastings Center Report, Vol. 24, No. 4, July-August, 1994, pp. 27-29.

2. **Economics and the Care of the Dying**, from *The Troubled Dream of Life*.
Daniel Callahan
New York: Simon And Schuster, 1993.

3. **Should We Ration Health Care on Grounds of Age**, from *Ethics in an Aging Society*.
Harry R. Moody
Baltimore MD: Johns Hopkins University Press, 1992.

4. **Against Age-based Rationing of Lifesaving Medical Care**, from "Filial Duties, Intergenerational Justice and the Perils of Age-Based Rationing of Health Care" (Extrapolations), in *Justice Across Generations*.
Wechsler, author
Lee M. Cohen, Ed.
AARP, 1993.

5. **The Principle of Justice**, excerpt from "Equality, Justice and Righteousness in Allocating Health Care: A Response to James Childress," in *A Time to be Born and a Time to Die*.
Robert M. Veatch
Dr. Barry Kogan, Ed.
Hawthorne NY: De Gruyter, 1991.

6. **Ethical Implications**, from "Health Care in the United States: A Contemporary Jewish Perspective."
Marshall Kapp, J.D., M.P.H.
Journal of Psychology and Judaism. Vol. 15, No. 3, Fall 1991.

7. **Medical Needs and Societal Obligations**, from "Judaism, Justice, and Access to Health Care."
Dr. Aaron L. Mackler
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Four Unsolved Rationing Problems: A Challenge

Norman Daniels⁹

Hastings Center Report Vol. 24, No. 4, pp. 27-29

In his presentation to the inaugural congress of the International Association of Bioethics, Norman Daniels discussed four key problems that face those trying to provide medical care in a climate of scarce resources: to what extent we should favor best outcomes in allocating resources; what priority we ought to give to the neediest; when providing modest benefits to many should be privileged over providing significant benefits to fewer people; and when we ought to rely on democratic processes to determine what is a fair outcome of rationing. He argued that bioethics generally—and current theories of justice particularly—has failed to address those problems directly....

Faced with limited resources, medical providers and planners often ask bioethicists how to limit or ration the delivery of beneficial services in a fair or just way. What advice should we give them? To focus our thinking on the problems they face, I offer a friendly challenge to the field: solve the four rationing problems described here.

We have generally ignored these problems because we think rationing an unusual phenomenon, associated with gas lines, butter coupons, or organ registries. But rationing is pervasive, not peripheral, since we simply cannot afford, for example, to educate, treat medically or protect legally people in all the ways that their needs for these goods require or that accepted distributive principles seem to demand. Whenever we design institutions that distribute these goods, and whenever we operate those institutions, we are involved in rationing.

Rationing decisions, both at the micro and macro levels, share three key features. First, the goods we often must provide—legal services, health care, educational benefits—are not sufficiently divisible (unlike money) to avoid unequal or “lumpy” distributions. Meeting the educational, health care, or legal needs of some people, for example, will mean that the requirements of others will go unsatisfied. Second, when we ration, we deny benefits to some individuals who can plausibly claim they are *owed them in principle*; losers as well as winners have plausible claims to have their needs met. Third, the general distributive principles appealed to by claimants as well as by rationers do not by themselves provide adequate reasons for choosing among claimants. They are too schematic; like my “fair equality of opportunity” account of just health care, they fail to yield specific solutions to these rationing problems. Solving these problems thus bridges the gap between principles of distributive justice and problems of institutional design.

The Fair Chances/Best Outcomes Problem

How much should we favor producing the best outcome with our limited resources?

Like the other problems, the fair chances/best outcomes problem arises in both micro and macro contexts. Consider first its more familiar microrationing form: which of several equally needy individuals should get a scarce resource, such as a heart transplant? Suppose that Alice and Betty are the same age, have waited on queue the same length of time, and will each live only one week without a transplant. With the transplant, however, Alice is expected to live two years and

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Betty twenty. Who should get the transplant?¹⁰ Giving priority to producing best outcomes, as in some point systems for awarding organs, would mean that Betty gets the organ and Alice dies (assuming persistent scarcity of organs, as Dan Brock notes).¹¹ But Alice might complain, "Why should I give up my only chance at survival—and two years of survival is not insignificant—just because Betty has a chance to live longer?" Alice demands a lottery that gives her an equal chance with Betty.

To see the problem in its macroallocation version, suppose our health care budget allows us to introduce one of two treatments, T1 and T2, which can be given to comparable but different groups. Because T1 restores patients to a higher level of functioning than T2, it has a higher net benefit. We could produce the best outcomes by putting all our resources into T1; then patients treatable by T2 might, like Alice, complain that they are being asked to forgo any chance at a significant benefit.

The problem has no satisfactory solution at either the intuitive or theoretical level. Few would agree with Alice, for example, if she had very little chance at survival; more would agree if her outcomes were only somewhat worse than Betty's. At the level of intuitions, there is much disagreement about when and how much to favor best outcomes, though we reject the extreme positions of giving full priority to fair chances or best outcomes. Brock proposes breaking this deadlock by giving Alice and Betty chances proportional to the benefits they can get (e.g., by assigning Alice one side of a ten-sided die). Frances Kamm proposes a more complex assignment of multiplicative weights.¹² Both suggestions seem ad hoc, adding an element of precision our intuitions lack. But theoretical considerations also fall short of solving the problem. For example, we might respond to Alice that she already has lost a "natural" lottery; she might have been the one with twenty years expected survival, but it turned out to be Betty instead. After the fact, however, Alice is unlikely to agree that there has already been a fair "natural" lottery. We might try to persuade her to decide behind a veil of ignorance, but even then there is controversy about what kinds of gambling are permissible.

The Priorities Problem

How much priority should we give to treating the sickest or most disabled patients ?

Suppose Xs are much sicker or more disabled patients than Ys and suppose that we can measure the units of benefit that can be given each patient, for example, in QALYs or some other unit. Most people believe that if a treatment can deliver equal benefit to Xs or Ys, we should give priority to helping Xs, who are worse off to start with. This intuition is ignored by some uses of cost-effectiveness or cost-benefit methodologies which may be neutral between Xs and Ys if the benefits and costs are the same. Similarly, we may be willing to forgo some extra benefits for Ys in order to provide lesser benefits to Xs. We favor Xs in more than tie-breaking cases, though we intuitively reject giving full priority to them. How much priority we give to Xs rather than Ys may also depend on whether Xs end up much better than Ys after treatment.

¹⁰ Frances M. Kamm, "The Report of the U.S. Task Force on Organ Transplantation: Criticisms and Alternatives," *Mt. Sinai Journal of Medicine* (June 1989): 207-20.

¹¹ Dan Brock, "Ethical Issues in Recipient Selection for Organ Transplantation," in *Organ Substitution Technology: Ethical, Legal, and Public Policy Issues*, ed. Deborah Mathieu (Bolder: Westview, 1988), pp. 86-99.

¹² Frances M. Kamm, *Morality, Mortality*, vol. 1., *Death and Whom to save from It* (New York: Oxford University Press, (1933); see also Kamm, "Report of the U.S. Task Force."

As in the previous problem, we intuitively reject extreme positions but we have no satisfactory theoretical characterization of an intermediary position.

The Aggregation Problem

When should we allow an aggregation of modest benefits to larger numbers of people to outweigh more significant benefits to fewer people ?

In June of 1990, the Oregon Health Services Commission released a list of treatment-condition pairs ranked by a cost-benefit calculation. Critics were quick to seize on rankings that seemed completely counterintuitive. For example, as David Hadorn noted, tooth capping was ranked higher than appendectomy.¹³ The reason was simple: an appendectomy cost about \$4,000, many times the cost of capping a tooth. Simply aggregating the net medical benefit of many capped teeth yielded a net benefit greater than that produced by one appendectomy.

As David Eddy pointed out, our intuitions in these cases are largely based on comparing treatment-condition pairs for their importance on a one-to-one basis.¹⁴ One appendectomy is more important than one tooth capping because it saves a life rather than merely reducing pain and preserving dental function. Our intuitions are much less well developed when it comes to making one-to-many comparisons, though economists have used standard techniques to measure them.¹⁵ Kamm shows that we are not straightforward aggregators of all benefits, though we do permit some forms of aggregation. Nevertheless, our moral views are both complex and difficult to explicate in terms of well-ordered principles. While we are not aggregate maximizers, as presupposed by the dominant methodologies derived from welfare economics, we do permit or require some forms of aggregation. Are there principles that govern the aggregation we accept? Failing to find justifiable principles would give us strong reason to rely instead on fair procedures.

The Democracy Problem

When must we rely on a fair democratic process as the only way to determine what constitutes a fair rationing outcome ?

There is much that is appealing about relying on people's preferences and values in deciding how it is fair to ration medical services. Which preferences and values must we take at face value, however, regardless of the outcomes they imply? In Oregon, for example, people's attitudes were included in the process of ranking medical services in several ways. Adapting Kaplan's "quality of well-being" scale for use in measuring the benefit of medical treatments, Oregon surveyed residents, asking them to judge on a scale of 0 (death) to 100 (perfect health) what the impact would be of having to live the rest of one's life with some physical or mental impairment or symptom; for example, wearing eyeglasses was rated 95 out of 100, for a weighting of -0.05, which is about the same as the weight assigned to not being able to drive a car or use public transportation and to having to stay at a hospital or nursing home. Are these weightings the result of poor methodology? If they represent real attitudes, must we accept them at face value? Whose attitudes should we rely on, the public as a whole or the people who have experienced the condition in question? Those who do not have a disabling condition may suffer from cultural biases,

¹³ David Hadorn, "Setting Health Care Priorities in Oregon: Cost-Effectiveness Meets the Rule of Rescue," *JAMA* 265, no. 17 (1991): 2218-25.

¹⁴ David Eddy, "Oregon's Methods: Did Cost-Effectiveness Analysis Fail?" *JAMA* 266, no. 15 (1991): 2135-41.

¹⁵ Eric Nord, "The Relevance of Health State after Treatment in Priorities between Different Patients," unpublished manuscript in author's possession.

overestimating the impact of disability. But those who have the condition may rate it as less serious because they have modified their preferences, goals, and values in order to make a “healthy adjustment” to their condition. Their overall dissatisfaction—tapped by these methodologies—may not reflect the impact that would be captured by a measure more directly attuned to the range of capabilities they retain. Insisting on the more objective measure has a high political cost and may even seem paternalistic.

The democracy problem arises at another level in procedures that purport to be directly democratic. The Oregon plan called for the OHSC to respect “community values” in its ranking of services. Because prevention and family planning services were frequently discussed in community meetings, the OHSC assigned the categories that included those services very high ranking. Consequently, in Oregon, vasectomies are ranked more important than hip replacements. Remember the priority and aggregation problems: it would seem more important to restore mobility to someone who cannot walk than to improve the convenience of birth control through vasectomy in several people. But, assuming that the commissioners properly interpreted the wishes of Oregonians, that is not what Oregonians wanted the rankings to be. Should we treat this as error? Or must we abide by whatever the democratic process yields?

Thus far I have characterized the problem of democracy as a problem of error: a fair democratic process, or a methodology that rests in part on expressions of preferences, leads to judgments that deviate from either intuitive or theoretically based judgments about the relative importance of certain health outcomes or services. The problem is how much weight to give the intuitive or theoretically based judgments as opposed to the expressed preferences. The point should be put in another way as well. Should we in the end think of the democratic process as a matter of pure procedural justice? If so, then we have no way to correct the judgment made through that process, for what it determines to be fair is what counts as fair. Or should we really consider the democratic process as an impure and imperfect form of procedural justice? Then it is one that can be corrected by appeal to some prior notion of what constitutes a fair outcome of rationing. I suggest that we do not yet know the answer to this question, and we will not be able to answer it until we work harder at providing a theory of rationing.

Acknowledgments

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Economics and the Care of the Dying

from *The Troubled Dream of Life*

Daniel Callahan

New York: Simon And Schuster, 1993.

There is a certain peculiarity in the economics of American health care that poses some serious threats to a peaceful death. It is the view that physicians owe it to patients to provide the most aggressive life-extending treatment, regardless of cost. Public-opinion polls have shown a public willingness to affirm the value of lifesaving treatment even at a tremendously high cost. Seventy-one percent of respondents to one survey said: "If it takes a million dollars to save a person, that should be spent." The problem with this sentiment, otherwise admirable, is that it elevates the saving of life for its own sake to a level that is good neither for patient welfare nor for the economy. It thus tends to confirm the view that the saving of life is *the* purpose of medicine.

In a market economic system, moreover, where there are already profitable financial incentives in place to provide expensive lifesaving technologies, the combined force of money and morality can make it all the more difficult to find a way to a low-cost, nontechnological death. The latter is treated as a form of neglect, a profitless and anachronistic return to the ways of an era thought long passed. This general attitude creates a social context that powerfully reinforces the already present medical pressures that work against the goal of a peaceful death. The present economic system, in effect, blesses the wild death, the one that throws unlimited money and resources at death.

Nothing seems so much to disturb people as the idea that money, or the ability to pay, should stand in the way of lifesaving treatment. Human life, it is commonly said, is priceless; that belief reflects the great value attached to life in a culture with deep religious roots. Yet, of course, the daily reality of life in America, as well as in every other culture, requires economic limitations in all spheres, including lifesaving medicine. Even if there is no obvious shortage of money, no society allocates all of its resources to health care; and it is difficult to think of any developed society where, at least statistically, the investment of a few million dollars, or a few hundred million, could not save some additional lives—just as, we know, increasing the safety features on automobiles, or airplanes, or houses, could, at great expense, also save additional lives. The ordinary allocation of resources across a wide range of societal sectors—housing, education, welfare programs, defense, fire and police protection, and so on—means that money is, and must be, diverted from health care.

I cite these obvious facts to distinguish two situations, sometimes confused. One of them, just mentioned, is that no culture can allow health care to pre-empt all other societal needs totally. It cannot turn itself into a large hospital. This means that, however indirectly, some lives are lost that might otherwise be saved if *all* resources were devoted to health care. The other situation occurs when, consciously and directly, a decision is made to deny lifesaving care merely in order to save money, typically on the grounds that the expenditure is "not worth it." This kind of denial of care is most feared, for here it seems that human life is being given a price tag and, if its cost is too high, not protected by medicine from death. If the former situation is inevitable in any and all societies, however affluent—not all money can go to health care—the latter seems both unacceptable and avoidable.

Yet the growing costs of health care, particularly those of caring for an aging society in the company of ever more expensive technological medicine, are tending to bring the two situations together. The technological advances raise, in a stark and direct way, the question of whether they can

be applied to all patients—or whether, if they are applied to all patients threatened with death, they will take money away from other medical conditions that are important but not life-threatening.

There is no doubt that we could, as a society, afford the level of technology available twenty or thirty years ago. But developments in contemporary technology, constant and steady, have made medicine much more costly per capita than it used to be. Bypass surgery for those in their eighties, or neonatal care running into the hundreds of thousands of dollars, represents a new problem for both ethics and economics. I would phrase the issue this way: even if we agree that everyone should have access to a decent level of health care, does this commit us to accepting whatever level of technological progress medical science brings, at whatever cost that may entail?

I do not see how this can be either affordable or defensible. Some limits must be set, limits that may make it perfectly clear in advance just who will not receive potentially lifesaving treatment. Yet the real question here is not the denial of health care as such, but the denial of some of the endless fruits of medical progress. If we now think it appropriate to offer bypass surgery for an octogenarian whose life may thus be saved, will we be equally obliged to offer an artificial heart to a nonagenarian when (as is certainly likely) that also becomes available? If the only test of economic acceptability is the efficacy of the treatment—if it works, that is, we should pay for it—then medical progress could well bankrupt us, or, more subtly, lead us to spend more on the health-care sector of the economy than on other sectors of great civic and social importance.

How can this situation be avoided? A start could be made by working toward a health-care system that has consensually and democratically developed a clear set of priorities, beginning first with a decision about how much to spend on health care as a general social expenditure. A health-care system that began with decent caring and social services for the sick, then guaranteed good pediatric and maternal care, general public-health measures, and primary and emergency medical care would, I believe, have the most defensible and economically sound priorities, those most likely to ensure a decent common level of health. Thereafter, with whatever funds remained (which would be significant), expensive technological medicine could be pursued, the form of medicine that has great benefits for some or even many individuals (kidney dialysis and organ transplantation, for example), but does not greatly improve overall societal health.

A clear priority system would recognize the need for some economic limits, thereby forcing a society to determine its most important needs and, when limits must be set, to do so in a way that does not select out some individuals as not “worth it.” If, for example, a society decided it could not afford to follow medical progress to artificial hearts for those over age ninety, it would not be because those of such an age are disvalued, but because of a priority system that assumed the first task of a health-care system to be helping the young to become old, not seeking ever-longer life through medical progress for those who have already become old.

The trouble with an open-ended system, of the kind existing in the United States, is not only that it admits of no natural boundaries to health expenditures, but also that it in effect refuses to accept death. Treating each and every death as an equal threat to the human good, equally to be resisted, creates two harms. One of them is the expenditure of a disproportionate amount of money on a comparatively few conditions, those that turn out to be amenable to expensive technological interventions. The other is the expenditure of a disproportionate amount of money at the fringes of life, working to save lives where the costs are high and the results, if good at all, marginal and short-term. In both cases—ironically, given the alleged dedication to life—money is diverted from health care for the many to serve the needs of a few. Only a society unduly fearful of death, and unduly captured by the notion that an unlimited amount of money should be spent on individual cases even at the neglect of public health, could end up with such a strange set of priorities.

Against Age-based Rationing of Lifesaving Medical Care

Extrapolation from "Filial Duties, Intergenerational Justice and the Perils of Age-based Rationing of Health Care"

Wechsler

In Justice Across Generations

Lee M. Cohen, Ed.

The language of intergenerational "conflict" and of justice "between" generations is regrettable. Age-based rationing of lifesaving medical care, for example, cutoffs at age eighty, violates the covenant between generations in a manner that is unrivaled by other proposals. Obviously, some approaches to health care cost containment are less painful than others. Few could be more disruptive of essential social harmonies than age-based systems.

First, age-based rationing threatens to fragment the covenant between young and old, since it builds on an adversarial construct of intergenerational relations. Instead of pursuing justice for all vulnerable people regardless of age, our attention is diverted to a fabricated war between the generations, as though resources made available to the young must be stripped away from the aged. Respect for elderly people is needlessly threatened as the final stage of their lives becomes dispensable. I can think of no policy that would more powerfully spell a "broken covenant" between younger generations and elderly people than categorical age-based rationing.

Second, such rationing weakens the fragile veneer of human equality. As Amitai Etzioni argues, "Like all allocations, bans, or prohibitions based on irrelevant criterion—be it race, religion, gender, or age—rationing health care to the elderly is clearly discriminatory"(1991, 94). Elderly people are segregated into a separate category on the false assumption that they have lived out their best years. Equal regard would then apply only to those under some arbitrary age cutoff. Some proponents of age-based rationing suggest that equality would not be threatened because rationing would apply to everyone, so it is unlike discrimination on the basis of race, religion, and gender. However, a universal application of a reprehensible practice does not make it just. Age-based rationing is clearly discriminatory and ageist.

Third, such rationing is a threat to human freedom, an essential feature of any common good. Elderly people are heterogeneous, and a just society will respect their reasonable choices regarding medical treatment. Before the point of medical futility is reached, or of low probabilities of success for costly interventions, each individual should be free to make his or her own personal decision that life has run its course, that it is time to throw in the towel. To impose age-based cutoffs is to lose ground for personal conscience, and reflects an undue pessimism about the ability of older people to make good decisions. I know of no ethical theory so compelling and uncontroversial as to justify, for reasons of so-called justice, the imposition of an obligation to die before one personally thinks that "the flame is no longer worth the candle."

Fourth, through age-based rationing, the contributions of elderly people would be lost to society. So many people have made their greatest contributions to society, family, and friends in their old age. Proponents of age-based rationing seem to assume that the "extra time" is

dispensable. But regardless of our culture's "cult of youth," human beings are often at their generative best artistically, culturally, and socially in life's final stage.

Fifth, age-based rationing proposals are likely to encourage preemptive suicide among elderly people. No longer allowed access to interventions that would restore them to a reasonable quality of life, they would be condemned to an avoidable and unnecessary downward course that makes assisted suicide or even mercy killing attractive. Abstract theories tend to obscure the brutal fact: it is this person who, simply because he or she is old, must face needless relegation to hospice-like care and death.

Sixth, because women outlive men on average, age-based cutoffs immediately raise questions about justice between men and women. It is particularly interesting that the proponents of age-based cutoffs are men. As I have pointed out elsewhere, it has been estimated that by the year 2000, there will be 37.2 men for every 100 women age eighty-five and older (Post 1991, 124). Thus, when we consider the population most affected by age-based rationing, clearly women are largely the vulnerable ones. To my knowledge, the philosophical proponents of age-based rationing are men who have not given much attention to feminist literature. They are not antifeminist, but clearly nonfeminist and uninterested in gender studies. My own position is that women, who spend so many of their years fulfilling the needs of others through direct caregiving, deserve to have their final years of sisterhood or solitude respected as recompense.

Having made these arguments in a general way, I hasten to suggest that proponents of age-based rationing turn their idealism toward measures to curb health care costs that are more respectful of persons. Age-neutral definitions of medical futility or of poor quality outcome specific to particular disease conditions would be worth considering. But setting limits on the basis of age alone is the wrong approach. As C. Everett Koop warns in the foreword to *Too Old for Health Care?*, "I offer one closing admonition: Be careful! Your decisions about someone else's life might affect your own sooner than you think" (1991, x).

Should We Ration Health Care on Grounds of Age?

from *Ethics in an Aging Society*

Harry R. Moody

Johns Hopkins University Press, 1992

By the end of the 1980s a remarkable consensus had grown up among a diverse group of prominent leaders in the field of biomedical ethics. Figures such as Daniel Callahan, Norman Daniels, Margaret Battin, Dan Brock, and Robert Veatch—philosophers who might agree on little else—had come to agree that social justice could require that scarce health care resources be rationed, deliberately withheld, solely on grounds of chronological age.¹⁶ The details and arguments differ, but these and many other ethicists had come to a startling and disturbing conclusion.

It would be going too far to suggest a consensus among all writers in bioethics on this point. But the convergence of the views of so many distinguished figures is enough to give one pause. Age-based denial of health care is no longer a “wild” idea and no longer obviously “unethical.”¹⁷ Let me acknowledge that while I happen to agree with this general proposition supporting age-based allocation, I disagree with what Daniel Callahan, in particular, thinks should follow from it. I take issue with what Callahan, in *Setting Limits* and in his subsequent book *What Kind of Life*, includes as two corollary propositions to his main idea.¹⁸

Callahan argues (1) that it is time to begin a public national debate that, he hopes, will lead to a public consensus in favor of withholding scarce life-prolonging care on the basis of age; and (2) that we ought to implement this policy consensus by cutting off treatment for people beyond a certain chronological age.

I disagree with both propositions and see the debate about rationing health care in an aging society as fundamentally flawed and misdirected. Critics of age-based rationing, as well as defenders of the idea, have confused what are logically separate propositions: the plausibility of the natural life course framework as a basis for *allocation* and the specific tactic of age-based *rationing*.

Let me begin this discussion by supposing that these philosophers are, in essence, right in their general view about what's wrong with health care in American society. At bottom what does their view amount to? It comes down to a few propositions. We spend money on the wrong things. We lavish vast sums keeping alive the debilitated elderly, while we spend too little on quality-of-life interventions such as home care for other old people and still less on the very young to assure that everyone has a chance to a decent minimum of health care and an opportunity to live out a full life.

In the discussion to follow I take for granted that these general propositions are correct. I further presume that something approximately like the “natural life course” urged by Norman Daniels and

¹⁶ On the “inevitability” of rationing, see Henry Aaron and William B. Schwartz, “Rationing Health Care: The Choice before Us,” *Science* 247 (January 26, 1990): 418-22. The trend in favor of rationing among ethicists is discernible across a broad spectrum of opinion. See for example Paul T. Menzel, *Strong Medicine: The Ethical Rationing of Health Care* (New York: Oxford University Press, 1990); Robert H. Blank, *Rationing Medicine* (New York: Columbia University Press, 1988); Larry Churchill, *Rationing Health Care in America: Perceptions and Principles of Justice* (South Bend, Ind.: University of Notre Dame Press, 1987).

¹⁷ See also Timothy M. Smeeding, *Should Medical Care Be Rationed by Age?* (Totowa, N.J.: Rowman and Littlefield, 1987).

¹⁸ Daniel Callahan, *Setting Limits: Medical Goals in an Aging Society* (New York: Simon and Schuster, 1987).

Callahan does make sense as a standard for guiding our decisions to allocate scarce resources.¹⁹ I will not further argue for this starting point but rather take it for granted in order to explore what policies may, or may not, follow from it.

What I want to argue is that publicly endorsed age-based rationing need not follow from this framework at all. Specifically, agreeing with the global principle—the social justice argument for age-based allocation—does *not* necessarily require agreement with either of the propositions that Callahan urges on us. We can agree with the global idea without endorsing what Callahan proposes as the means urged to achieve it. One can accept in theory the regulative ideal of a “natural life course” as a standard for allocating resources. But a regulative ideal is not the same thing as a pragmatic principle or a basis of political action. One can adopt very different pragmatic principles for how a regulative standard should influence practice. And the choice of pragmatic principles is crucial if the theoretical debate about age-based rationing is to have any positive effect on policy or practice in years to come.²⁰

In this instance, “practice” means two things: namely, speech and action. Specifically, it denotes: (1) the terms of the national debate, the rhetoric of “rationing”; and (2) the means of implementing an age-based allocation policy. In this chapter I want to provide an argument based on pragmatic principles that lead to very different practice than what Callahan and other proponents of “rationing” urge on us; examine the ethical imperative of cost containment and look carefully at national health policies that could be consistent with it; consider what forms of “indirect” political practice are morally and prudentially justified, and look at how the language reflects and distorts our ability to consider a realistic course of action.

The gap between theory and practice, speech and action, is at the center of Callahan’s failure to make good on his own hope for “setting limits” in a publicly acceptable way. It is a curious fact that when Callahan gets around to the point of telling us just *how* age-based allocation will be put into practice, he fumbles badly. In Callahan’s case, he waffles, he backs away from his original provocative proposal. We sense that he really *does* want chronological age *alone* to count, and for good reasons of simplicity, consistency, and fairness. But he also recognizes that in individual cases—for example, withholding penicillin for pneumonia from the otherwise healthy 90-year-old—it will prove difficult to withhold treatment.

The result is, at a crucial point in his book, Callahan begins to throw into the decision to withhold treatment a variety of other standards besides chronological age alone, such as expected quality of life, health factors, and the expense of the treatment. In other words, he gives ground to critics who reject his framework and insist that individual factors alone should be responsible for treatment decisions. As a result of this waffling, readers come away not sure exactly what Callahan would urge in practice. Those who give him the benefit of the doubt suggest “he can’t really mean it” about age-based allocation, whereas those hostile to his approach simply deride his waffling as a sign that the scheme as a whole is

¹⁹ The full statement of Daniels’s views is to be found in Norman Daniels, *Am I My Parents’ Keeper?* (New York: Oxford University Press, 1987). See also Norman Daniels, ed., “Justice Between Generations and Health Care for the Elderly,” *Journal of Medicine and Philosophy* 13 (1988). While Daniels and Callahan do not argue in the same way nor reach exactly the same conclusions, both accept something resembling a “natural” life course as a normative principle for the ethics of health care allocation.

²⁰ The literature generated by Callahan’s proposal is already extensive. On the debate, see the two volumes of collected commentary: Paul Homer and M. Holstein, eds., *Exploring the Limits* (New York: Simon and Schuster, 1990); and Robert Binstock and Stephen Post, eds., *Too Old for Health Care?* (Baltimore: Johns Hopkins University Press, 1991). See also D. Callahan and M. Kapp, “Different Viewpoints: Rationing Health Care: Will It Be Necessary?” *Issues in Law and Medicine* 5, no. 3 (1989): 337-51; Larry Churchill, “Should We Ration Health Care by Age?” *Journal of the American Geriatrics Society* 36, no. 7 (1988): 644-47; David C. Thomasma, “Moving the Aged into the House of the Dead: A Critique of Ageist Social Policy,” *Journal of the American Geriatrics Society* 37, no. 2 (1989): 169-72; John F. Kilner, “Age as a Basis for Allocating Lifesaving Medical Resources: An Ethical Analysis,” *Journal of Health Politics, Policy and Law* 13, no. 3 (1988): 405-23; and Nancy S. Jecker, “Towards a Theory of Age-Group Justice,” *Journal of Medicine and Philosophy* 14 (1989): 655-76.

misconceived. In short, practical difficulties around age-based rationing are a stumbling block for any scheme to cut off health resources on grounds of age alone.

For writers like Daniels and Battin,²¹ a different problem of practice arises. They too step up to the brink of advocating age-based allocation but then shrink back in recognition of the practical dilemmas. Their strategy is different from Callahan's. They suggest that an age-based allocation scheme may be justified in theory but it neither can or should be put into practice until we have a society where the background institutions are "fundamentally just." When that will ever happen is anyone's guess. No one has identified such a society to date. Thus, Daniels, for example, is very uncomfortable about endorsing the covert practice of age-based rationing in Britain. One reads Daniels's book with the impression that it is difficult, if not impossible, to find any society in the world where age-based allocation could be put into practice in the foreseeable future.

Battin, on the other hand, does not like a compulsory age-based rationing at all, so she has opted for another approach: promoting "voluntary" age-based rationing through tolerance for rational suicide among old people. But, obviously, there are abundant problems putting this plan into practice as well. Because many, if not most of the debilitated elderly will lack the mental competency for voluntary suicide, there is no evidence that Battin's scheme will actually end up reducing costs. Theory and practice again remain far apart.

As we shall see, this divergence between theory and practice severely limits the usefulness of all these philosophical proposals for policy makers eager for guidance in making cost containment decisions. Callahan, at least, offers chronological age as a clear, simple criterion for the distribution of health care resources. But it is not so easy as one might think to say what this actually implies in practice. There are various ways in which chronological age might be used as an allocation criterion. For example, we can distinguish between an *overt* use (putting the Eskimos out on the ice floe) and a *covert* use (the British policy on kidney dialysis, never publicly proclaimed). We can also distinguish between a direct use (no heart transplants for patients over age 75) and an indirect (not putting an intensive care unit in a nursing home).²²

Finally, we can distinguish between a *distributive* use of an age criterion (deciding about Medicare coverage for organ transplantation) and a *developmental* use (deciding about how much research funding to provide for specific diseases, such as sickle cell anemia versus stroke, or AIDS versus Alzheimer's disease). In the latter case, we are deciding not how to distribute present goods but about what sort of goods we want to create in the future. Thus, research on stroke or dementia will benefit the elderly, just as research on sickle cell anemia or AIDS tends to benefit younger people.

The importance of these distinctions is evident as soon as we consider rules of political prudence that might give guidance on what sort of age-based criteria, if any, could be adopted in practice. For example, it is easier to use age in a covert, indirect, or developmental way than it is to use age in an explicitly negative way, such as consciously allowing people over a certain age to die. A parallel can be seen in debates about active versus passive euthanasia. Regardless of the ultimate justification of this distinction, no one doubts that, pragmatically, it is easier to approve omissions rather than to endorse outright killing. Similarly, it would be easier not to start up a new program (such as research on the artificial heart) than it is to get rid of an existing entitlement (kidney dialysis under Medicare in the United States). The same point holds true in defense appropriations just as much in medical technology: it is always easier to stop a project such as a new weapons system) before it gets underway. This is probably the most effective way

²¹ Daniels, *Am I My Parents' Keeper?* and "Justice between Generations and Health Care for the Elderly," p. 13. Battin has expounded her view in Margaret P. Battin, "Choosing the Time to Die: The Ethics and Economics of Suicide in Old Age," in Stuart Spicker, ed., *Ethical Dimensions of Geriatric Care* (Dordrecht: Reidel, 1987), pp. 161-89.

²² On issues of ageism in covert or indirect forms of rationing, see Jessica Dunsay Silver, "From Baby Doe to Grandpa Doe: The Impact of the Federal Age Discrimination Act on the 'Hidden' Rationing of Medical Care," *Catholic University Law Review* 37 (1988): 993-1072.

one might want to introduce an age-based allocation principle: that is, by using it to shape new medical technology for the future rather than cutting off resources in the present. But there may be other indirect ways of enforcing age-based allocation today.

If one is persuaded that the idea of a natural life course is defensible as a principle of social justice, then it makes a great deal of difference how this principle is introduced. Proposals to set limits based on a natural life course sound alarming. But some of the alarm disappears as soon as we apply the principle to entitlement programs aimed exclusively at the elderly themselves. For example, consider our current Medicare budget and then ask yourself, is this how you would spend \$110 billion if you were trying to do the best by our aging population? The answer will probably be no, and that remains true even if we were to expand the Medicare budget. Do we really want to spend the money on expensive life prolongation for 90-year-olds when it means little is left over for health promotion, home care, and other "soft" services for 70-year-olds?

But then the question arises: what sort of prudential principles could permit public debate on reshaping the Medicare budget? Even if one accepts the broad principle that some kind of age-based allocation is reasonable, as I am prepared to do, then we need to look at the prudential principles cited previously: for example, the distinctions of overt/covert, direct/indirect, distributive/developmental. Crude images of an age-based cutoff sound alarming but actually miss the point. Intermediate-level principles and rules of prudence are most needed here.

We must note that Daniel Callahan, for one, does not favor covert action. Instead, he urges on us a full-scale public debate which, he hopes, will conclude in favor of age-based rationing. Similarly, Daniels, in keeping with the social ethics of John Rawls, urges that any political principles adopted be those that can be publicly defended. If age-based denial of treatment is to be justified, it will have to be publicly espoused and endorsed.

The problem, of course, is that it almost is impossible to imagine a situation in which, say, the U.S. Congress or a state legislature were to debate and adopt a policy of overt age-based rationing. We need to remember that the Congress was only able to act on Social Security reform in 1983 when public opinion had been whipped up with the rhetoric of crisis.²³ Without an atmosphere of crisis and without a special commission to take the heat for making the proposals, Congress was unable to solve the financing problem. Just a few years ago Congress, by a 98 percent majority, passed legislation eliminating mandatory retirement beyond a specific age-limit. Can we really imagine a congressional representative trying to defend to his elderly constituents a vote to terminate life sustaining care for people above a specific age-limit? A direct and overt action like this is impossible. But, as I have suggested, *indirect* policy options, and perhaps other practices based on intermediate-level principles, can be adopted in order to implement the ideal of a natural life course. Age-based rationing, however, will not be one of the practices adopted.

WHAT IS "RATIONING" ANYWAY?

My argument so far has resolutely rejected, on prudential grounds, all proposals for "rationing" health care on grounds of age. But a discussion about "age-based rationing" eventually needs to reflect on a basic semantic problem: namely, what *is* "rationing?" How would we know it if we saw it? There is a temptation to define "rationing" in terms so broad as to mean any deliberate denial of treatment for those who might benefit from it.²⁴

But that loose definition would include waiting lists, reliance on market forces, or use of medical criteria to eliminate marginally beneficial treatments. Those who subscribe to this vague definition end up

²³ See Theodore Marmor, *Social Security: Beyond the Rhetoric of Crisis* (Princeton: Princeton University Press, 1988).

²⁴ D.J. Besharov and J.D. Silver. "Rationing Access to Advanced Medical Techniques," in K. McLennan and J. Meyer, eds., *Care and Cost: Current Issues in Health Policy* (Boulder, Colo.: Westview Press, 1990), pp. 41-66.

announcing that rationing is already in effect in America.²⁵ But if that's the case, then what's the fuss about? Why are we debating it now?

We should begin, I believe, with ordinary language. The most important fact about ordinary language is that we almost never use the concept of rationing to describe the various distributional decisions that arise in everyday social practice, including access to health care.

Rationing in fact is a term that belongs to the discourse of crisis. Most cases in which rationing is publicly defended are those in which an acknowledged public crisis is at hand: for example, butter rationing in World War II or gas rationing during the oil embargoes of the 1970s. When rationing is announced, everyone already agrees that a condition of scarcity is in effect. Moreover, the condition is usually understood by all to be temporary. Admittedly, a practice of permanent rationing might be said to be in effect in the Soviet Union where long waiting lines, instead of prices, have been used to distribute scarce consumer goods. But leave that case aside for the moment.

We do not need to go beyond our shores to find instances that some would call rationing. Within the American health care system, there are several *prima facie* cases that resemble something we might legitimately call rationing. These include the following:

- the distribution of organs for transplantation
- the practice of triage in admission to hospital emergency rooms
- extensive queuing for health care services provided through the Veterans Administration.

Several properties of these *prima facie* instances of rationing are worth noting:

1. Organ transplantation involves an *intrinsic* scarcity: the desired object cannot simply be produced in greater quantity by spending more money, so scarcity is unavoidable. Scarcity could be reduced by more aggressive policies of organ procurement, but it would still exist. When scarcity is absolute or intrinsic, no one disputes the need to distribute the limited resource fairly, so some type of rationing is preferred. But even here, under publicly endorsed allocation policies, one feels that no individual would simply be turned away from an organ transplantation because of personal attributes other than medical suitability. Instead people should assume a place on a waiting list. In practice, of course other considerations, like money or appeals to public sentiment, do influence organ transplantations. So, in effect, we have in the United States covert access rules coexisting with an overt rationing policy.

2. Emergency room triage is not a matter of turning people away from the health care facility because of some attribute (age, money) but rather of distributing limited staff time in accordance with need. It is a pure case of rationing by need, which again seems to present few issues of fairness. Of course, money or health insurance coverage can play a role here, but officials are usually uncomfortable about that fact and hospitals, by law, cannot turn away anyone needing life-sustaining care. In the case of emergency treatment, the distributional decision is made at the point of entry into the system. It is not a decision about availability of a specific treatment, like organ transplantations. Moreover, the rationale for the distributional decision, or place on the queue, is never publicly announced to the patient in the emergency room, although one might discover it if one asked. Here, then, we have a covert rationing policy.

3. Finally, along with the triage case, the queuing practice in the Veterans Administration is not a matter of rejecting a specific class of persons according to their attributes but rather of setting up a waiting list.²⁶ Presumably, need plays a part in one's position on the waiting list but so does first-come first-served standards, as in other queuing cases such as nursing home admission. The effect of a waiting list, as in national health care systems like those of Canada and Britain, may well be to enforce some broader

²⁵See Victor Cohn, "Rationing Medical Care: It's Here—and This is Just the Beginning," *Washington Post* (July 31, 1990, Health, Science and Society, pp. 10-13.).

²⁶Norman G. Levinsky, "Health Care for Veterans: The Limit of Obligation," *Hastings Center Report* 16, no. 4 (1986): 10-15.

allocation scheme. This kind of allocation scheme does not originate from global health policy as much as it simply reflects budget limitations. Unlike other entitlement spending, Veterans Administration appropriations from Congress are limited to a fixed budget. Once the money is spent, no more service is provided for that year. Thus, queuing practice can vary from year to year, and from one hospital to another.

An important feature of these *prima facie* instances of rationing is that they involve a discrete class of goods (organs, emergency room provision) or a separate entitlement system (the Veterans Administration). As policies, they are not embodied in a unified health care system of the type that exists in mature welfare states where something resembling a unified budget for health care exists. This fact is important because both rationing and allocation are sometimes justified in terms of trade-offs among competing goods. Yet intelligible trade-off decisions are only possible within relatively unified systems: for example, organ transplantations versus home care within the Medicare system. In the United States, a highly fragmented payment system for health care makes both explicit trade-offs and allocation decisions difficult.

Still, within subsystems of health care provision, there are cases in the United States where allocation policies have been put into effect or could be proposed. We may consider one such subsystem a logical candidate for strict allocation policies and cost containment: namely, Medicare itself. Within Medicare alone, some notable examples exist. Probably the best-known cost containment policy is the *prospective payment system*, which in 1984 introduced diagnosis-related groups, imposing limits on hospital reimbursement and, indirectly, on the length of the patient's stay in the hospital. Another policy entails *price controls on physician charges under Medicare*. A number of states have introduced some form of "ban on balance billing" under Medicare—that is, a limitation on price of service to the amount reimbursed by Medicare. This policy has now been congressionally mandated at the national level. A third example involves the setting of *reimbursement limits*. Recent legislation reflects physician payment reform and amounts to more than simply a cost limitation policy, since it changes the incentives for medical practice in accordance with a so-called relative value scale for services provided.

If this discussion were extended beyond Medicare we might look at the state level where there are other examples, such as the denial of Medicaid coverage for organ transplantations in Oregon or limits on physician visits for Medicaid introduced by New York. These experiments with "rationing" at the state level are important, but I want to leave them aside for the moment to look instead at national allocation policies.

In the recent experience of Medicare we have the most instructive example of what tough-minded allocation policies might look like in the American scene. Hospital cost containment, physician price controls, and physician payment reform are seen in different ways by the various interest-groups concerned with the health care system. Diagnosis-related groups, for example, were widely attacked by interest groups representing not only hospitals but also the elderly. More recently, others have charged this system has been ineffective in reducing costs. Yet evidence suggests that the prospective payment system, when measured in constant dollars on a per enrollee basis, kept Medicare expenditures essentially flat from 1985 through 1989.

Were diagnostic-related groups, then, a form of "rationing" health care, as aging advocates feared? Would expenditure targets for physicians inevitably lead to "rationing," as the American Medical Association has publicly charged? The answers to these questions are not clear. But what is clear is that "rationing" has already become a convenient label invoked in order to discredit cost containment policies disliked by specific interest groups. It is not my purpose to defend this or any other specific form of cost containment. Specific proposals may be wise or unwise. They should be debated in terms of equity and efficiency. My purpose is simply to indicate that present allocation policies within the age-tested Medicare system are potentially effective in restraining costs; capable of being accepted in American political life; and different in kind from "rationing."

The last point is crucial. None of these different allocation policies, and others that I would favor based on the "natural" life course (such as limiting organ transplantations under Medicare), resemble

"rationing." To be sure, these policies may bring about *gate-keeping* behavior at lower levels in the health care system: that is, diagnosis-related groups mean that some individuals do not get to stay in hospitals as long as they want to or perhaps as long as they should. Then too, since all of these cost containment steps were undertaken within the Medicare system, none is comparable with the age-based rationing proposals recently debated. People over an arbitrary age are not denied treatment. Instead, allocation decisions taken at the highest level turn out to entail painful choices, even denial of service, at lower levels.

The resulting pattern of denial is indirect and often unpredictable in its consequences. But for just that reason it may be easier to legitimate. To describe it in these terms is not necessarily to justify it; it is simply to say that this pattern is far, far different from anything resembling "rationing" and, further, that this pattern, this style of *indirectly* enforcing policy decisions, is the one we are likely to be seeing more and more in the foreseeable future. Not age-based rationing, I would predict, but the "tyranny of small decisions" is the shape of things to come.

Can we, then, give a plausible definition of "rationing?" Yes, rationing is a clear and direct limitation on individual access to a scarce good or service according to some categorical criteria other than the market.

"Clear and direct" means that we can discern a predictable pattern in the distributional scheme, a pattern visible in denial of benefits to individuals: the aggregate pattern or intent of the policy may or may not be publicly acknowledged. Hence, we can speak of overt versus covert rationing. But a scheme that distributes resources in unpredictable or chaotic ways should not be described as "rationing." A pattern that results from chaotic or improvised practice may be a way of coping with a temporary shortage. But it is unlikely that a "clear and direct" limitation—that is, "rationing"—will arise without a coordinated and explicit decision.

An example will illustrate the point. It is implausible to describe food corporations as "rationing" the availability of supermarkets in urban ghettos, nor should we describe the "red lining" practices of banks in terms of rationing. We might disapprove of both these practices and feel that private agents acting in this way are acting unjustly. But these actions are not plausibly described as rationing, even if they were carried out by a public authority.

What about tight budget limits on expenditures in a specific program? This is hardly an unusual state of affairs. Most public programs operate under budget limits. But scarcity or a budget cut is not the same thing as a rationing scheme. For instance, we would hardly think of a cut in the annual subsidy for Amtrak as a scheme for "rationing" railroad service in the United States. Perhaps, as a result of budget cuts, Amtrak will decide to discontinue service to a specific city or deny service to a group of cities. But Amtrak has not "rationed" its services. We might not like the policy decision, we might debate it. But the allocation decision, and subsidiary policies resulting from it, does not for all that become "rationing."

On the other hand, suppose Amtrak decided to cut its trains to a particular city to one train per week and then introduced a lottery or used alphabetical order of names or some such scheme to decide who would get to ride the train. Then we would indeed start to describe the scheme as "rationing" railroad service. Why? Because now we are explicitly controlling individual access to the scarce service at the individual level. By contrast, when the decision is made at a higher collective level, far from individual access, the practice is more properly described as allocation, not rationing.

There are of course analogies in health care. Medicare, for example, does not pay for any form of dental care: yet no one has described the denial as a form of rationing. Similarly, we might decide as a matter of allocation policy that Medicare will not now, perhaps never, pay for the availability of the artificial heart. Some people will die as a result of that decision. But it would not be a form of rationing because we are not controlling individual access but instead making collective decisions, at a higher, aggregate level: in short, allocation decisions.

To clarify the intermediate case, let us return to the Amtrak example. Suppose subsidies are cut and train service is curtailed. Now, access to the train is available on a first-come, first-served basis. Does such

a waiting list count as "rationing?" Not necessarily. Do we ordinarily describe waiting on lines for popular movies as a form of "rationing" of seats? No, but if the practice were a permanent state of affairs, we might be inclined to. Then we would be in a situation where we would come closer to controlling individual access, day by day, according to nonmarket criteria or place on the line. Again, we can look to health care examples of the same problem. Admission of patients to desirable nursing homes is one case where neither pure market forces nor pure categorical criteria such as need or the waiting list are supreme.²⁷ Here actual decisions are usually blurred and diffuse. Even if "allocation" and "rationing" can be analytically distinguished, there are practices that are ambiguous and schemes where *both* are in effect simultaneously.

One solution to shortages is obvious: charging a price that clears the market without rationing schemes. Indeed, an important feature of rationing is that it is a scheme for distributing resources outside the market system. In our market economy, "rationing" is a signal that something is drastically wrong, that the distribution system has broken down and a crisis is at hand. But the strange thing is that we almost never find instances of rationing around us, except in wartime or national crisis. Indeed, much of the meaning of "rationing" lies in its rhetorical force. I believe that the term "rationing" is, almost always, a red herring that serves to confuse the debate on whether a specific allocation policy is wise or desirable.

With these considerations in mind we can return to the age-based rationing debate. In the case of Callahan's proposal, it is clear that we really *do* face a proposal on behalf of rationing in the full sense of the term. But, based on all historical experience, there is no plausible way in which such an overt, age-based rationing scheme could ever be introduced in the United States, even if it were theoretically justified, say, along the lines discussed by Norman Daniels.

The real question, I argue, is not whether a hypothetical age-based rationing scheme is ethically justified but whether it is *prudent or feasible*. The answer, I believe, is no. Callahan's proposal, as it stands, is unnecessary, impracticable, and unwise.

By contrast, an age-based *allocation* scheme is eminently prudent and feasible. The proof of it is just the fact that twenty five years ago in America we introduced an age-tested allocation scheme and called it Medicare. The program has won wide public acceptance. Medicare as an age-based allocation scheme approves coverage for some services and denies it for others. The very fact that people are provided some, but not all, medical services under Medicare on the basis of age means, correlatively, that people are *denied* other services—also on the basis of age. And of course people just under age 65 are also denied eligibility on the basis of age.

This pattern of approval and denial is just what defines the boundaries of the Medicare system as such. There is nothing to prevent us from making the pattern of approval and denial consistent with a framework of the prudential or "natural" life course or some other regulative ideal. For example, in 1990 Medicare decided to pay for liver transplantations, a decision that in a few years will be costing an estimated \$120 million a year, if not more.²⁸ That same amount of money—at the margin, so to speak—could have been allocated to provide more generous home care services or for some other purpose within Medicare more consistent with a natural life course perspective. Nothing prevents us, at least at the margin, from making these decisions on behalf of quality of life and against life prolongation. Since new money of this kind is made available *within* the Medicare system, there would be no political argument in terms of generational equity because we would not be taking money from the old to give to the young. If we introduced more rigorous cost containment measures into Medicare, more such marginal choices might become possible at the level of allocation.

Moreover, as against Callahan's pessimism, there is evidence that cost containment can work. In the diagnosis-related groups, we have introduced some partially successful cost containment measures and are

²⁷On allocating admission to nursing homes, see H.R. Moody, "Finding a Home," in R. Kane and A. Caplan, eds., *Everyday Ethics: Resolving Dilemmas in Nursing Home Life* (New York: Springer, 1990), pp. 245-57.

²⁸ See, "Medicare to Cover Some Liver Transplants," *New York Times* (March 10, 1990), pp. 245-57.

likely to devise others, such as physician payment reform. The best proof that age-based allocation schemes are prudent and feasible is the experience of other countries. Virtually all mature welfare states make priority allocation judgments and enforce these through production decisions, access controls, definition of services, and compensation for health care providers. They do so without the crisis rhetoric of "rationing," whether by age or other categorical criteria.

All of these allocation judgments result in *indirect* limits on what services will actually be available to those who want them. For example, in Canada, a national health plan means long waiting for elective surgery. Inevitably, many of those decisions establishing limits have consequences for people of different ages. For example, long waiting lists are more of a hardship for people of advanced age and limited life expectancy. In addition, where there is a preference for more "soft" services, such as home care, rather than "hard" services, such as "high-tech" medicine, some acutely ill people who would otherwise live will die²⁹ The elderly will benefit from home care but are more likely to die than if "high-tech" services were available in profusion. And of course the wealthy in the population may even travel to the United States to arrange organ transplantations or may "buy out" of the public system in their own country. Such "buy outs," within limits, do not necessarily compromise the basic fairness of those public systems of provision.

Last but not least, those systems of public provision in mature welfare states also include, in many cases at least, schemes of age-based rationing, of which the most famous is kidney dialysis in Britain. But it is hard to believe that age-based rationing, as covertly practiced in Britain, is a necessary or unavoidable element of a system that practices age-based *allocation*. In short, I believe we can have age-based allocation, much along the theoretical lines endorsed by Callahan, Daniels, Veatch, and others, but *without* espousing either overt or covert age-based rationing.

Indeed, I argue that the virulent debate over age-based rationing distracts our attention from what is in reality the more serious debate: namely, how to introduce cost controls and how to distribute the burden of paying for health care in an aging society. All of the serious policy debates of the 1980s, from diagnosis-related groups (1984) to the Medicare Catastrophic Coverage Act (1988), have revolved around cost containment and tax policy. The debate about age-based rationing is not, in this sense, a "serious" debate at all. It is not a debate about a proposal that anyone contemplates enacting into law.

²⁹ Of course, that too would be the result of favoring home care as against liver transplantations within Medicare, as already proposed.



The Principle of Justice

Excerpt from "Equality, Justice and Righteousness in Allocating Health Care: A Response to James Childress"

Robert M. Veatch

In A Time to be Born and a Time to Die

Dr. Barry Kogan, Ed.

Deciding what is just or fair entails understanding whether there is a moral right-making characteristic of actions or policies or practices that is independent of the other usual considerations we take into account in deciding about right conduct. In particular, is the right allocation simply a matter of spreading resources around so that they produce the greatest amount of good in aggregate or so that people are free to act autonomously in using their private property; or is there some unique and independent consideration separate from these factors that pulls on us in deciding who should get a kidney or a scarce hospital bed or Medicare dollar?

Many ethical traditions have recognized that there is a moral principle independent of utility that bears on how resources should be distributed. They variously hold that there is a natural law, a law created by God, or that reason requires that one thing to consider in allocating resources is that they be distributed justly. One approach that admits some convergence of these disparate views is to ask what reasonable people would recognize as just if they had general knowledge of the facts of nature and human psychology, but no knowledge of their particular interests or needs. This approach does not necessarily require us to agree on why people under such circumstances would agree. Some might say they would agree because there is a preexisting moral law, others because reason would require it, or because it is a prudent way to protect self-interest. Regardless, there seems to be considerable convergence that, at least in certain circumstances, justice has something to do with an allocation that is not based solely on getting as much total or average utility out of the resources being allocated. Our sense of justice has something to do with recognizing the fundamental equality of persons. Although the argument cannot here be developed in detail, virtually all the ethical traditions participating in the current discussion recognize that the principle of justice creates a presumption in favor of equality. In my view, people under the circumstances I have described would agree that one right-making characteristic of an allocation practice would be that it gives people an opportunity for equal well-being. This is what I shall refer to as the egalitarian principle of justice. Recall that whether it is right, on balance, to give people such an opportunity for equality of well-being will have to be settled later.

The only major variant on this formulation outside the utilitarian tradition is the Rawlsian maximum formula that commits society to practices that distribute goods—at least primary goods—equally except in cases in which everyone, especially the least well-off groups, would be benefited by unequal distributions. For purposes of health care allocation policies, the difference is minimal. The underlying difference, however, may be important. What is at stake is whether people's sense of justice (or God's sense of justice for those theologically inclined) includes an innate preference for people to be equal in their well-being, or whether equality is simply a device for maximizing individual well-being that should be waived when necessary for increasing the well-being of the least well-off. Rawls cannot imagine why anyone would find equality inherently preferable. He can only attribute a choice in favor of equality as resulting from envy. Surely, however, some relatively well-off persons have some inclination in favor of equality that is not based on envy. It is my interpretation that the pure principle of justice rests simply on our awareness that morality includes opportunities for equality as one of its right-making characteristics. If so, abandonment of equality when it is beneficial for the least well-off rests not on our sense of justice, but on some other moral consideration, something I will take up when we discuss the relation of justice to rightness.

This egalitarian principle of justice insists only on opportunities for equality of well-being. Thus an important and complex problem arises when people have such an opportunity but squander it with voluntary, risky life-style choices. In theory, I see no reason why justice requires using scarce medical resources to treat medical need resulting from such voluntary choices. Of course, other reasons may require covering such needs—the fact that it would be offensive to society to turn people needing such care away or terribly difficult to determine which needs were the result of truly voluntary choices. That does not imply, however, that justice is what requires providing such coverage. Furthermore, if we could develop a strategy to get voluntary risk takers to pay for their own care, it would be ethical to do so; in fact, justice would seem to require it. Thus, a health fee on smoking, alcohol consumption, skiing, and any other health risky behaviors deemed voluntary would be required by justice. The fee would not be designed to be a paternalistic deterrent. It would be calculated simply to reimburse the health system for the costs involved in providing care.

A second problem with the egalitarian principle of justice is that it requires opportunities for equality of well-being, not equality of health status. Thus, in theory it would be perfectly just for a health care system to permit two groups to have very unequal health status, provided the losing group was adequately compensated by advantages in other spheres of well-being. This means that, in theory, any discussion of justice in health policy has to take into account that unequal health can be compatible with the principle of justice.

As a practical matter, however, health is a unique entity, and in social organization it is quite separate from other spheres of well-being. In all other spheres of well-being (education being the exception), needs are distributed more or less equally. In health (and education), resources needed to approach equality are very unequal. Moreover, health care practices are administered as a more or less independent institution. Thus a good practical argument can be made that, in health policy, we should strive for opportunities for equality of health insofar as this is possible, leaving other social practices to deal with the best strategy for providing equality opportunities in other spheres of life. Thus, for practical purposes I will focus on justice in health care as requiring opportunities for equality of health. In doing so, I hold open the theoretical possibility that people should be able to trade their health resources for goods in other spheres. If such a practice were permitted, those making the trades would still have had the opportunity for equality of health.

There is one remaining theoretical problem. People evaluate purported benefits very differently. A ventilator providing support for a permanently vegetative patient may be perceived as of no benefit by most of us, while to some minority groups—some Orthodox Jews, for example—maintenance of permanently vegetative life may be a great good because life created by God is sacred regardless of consciousness. That is to say there is inherently subjective variation in what counts as a good. In spheres other than health care, we can resolve this matter rather easily by striving to distribute primary goods equally, letting people do their own allocating on the presumption that the result will be approximate equality of well-being or at least opportunities for it.

In health care, however, that clearly will not work. We simply must introduce a concept of objective well-being in the health sphere. People should have no moral claim of justice to a health resource—Laetrile, for example—simply because they believe it will increase their opportunity for well-being. Society will have to tackle the very difficult problem of determining what will be taken as contributing to objective rather than subjective well-being. We should not underestimate the difficulty of the importance of this task. Especially when we recognize that these judgments cannot be based on medical science and must rest on fundamental theological and metaphysical beliefs about what counts as a benefit, our society will have to confront a very difficult set of decisions in deciding how to promote opportunities for objective well-being in the health care sphere.

Ethical Implications

Marshall B. Kapp, J.D., M.P.H.³⁰

from "Health Care in the United States: A Contemporary Jewish Perspective"

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The discussion of ethical implications of various proposals for explicit rationing of services within the American health care delivery system may be valuably informed by reference to the rich normative, right/wrong tradition that derives from various sources of Jewish law on medical and other matters. Guidance emanating from these sources sheds light on the main ethical issue at stake in health care rationing—in modern language, the question of social or distributive justice.

In traditional Jewish law, the idea of triage or rationing potentially beneficial health service is fundamentally evil. Human life in this tradition is of infinite value, and not expendable. Our bodies are not our own, but are only on loan from God. Thus, as human beings, we have an obligation to maximize life—both our own and that of others.

Judaism traditionally has incorporated a strong commitment to equality, since every human life is of the same finite value. A strong presumption reigns against treating one individual differently from another. For example, Jewish religion generally condemns the concept of martyrdom in the sense of sacrificing oneself even to save another person. Talmudic maxims on the subject include: "What makes you think your blood is redder than the blood of your neighbor?" and "We do not set one life over and above another life." Jewish abhorrence to the notion that some persons are worth less socially than others has been shaped decisively by vivid memories of the Nazi policy of genocide; the shadow of the Holocaust casts a deep shadow over the Jewish approach to these kinds of issues.

There is also a robust tradition in Judaism of doing *Tzedakah* (righteous charity) or *Mitzvot* (divinely revealed commandments on behalf of the less fortunate. The Talmud states, "All Israel is responsible one for the other." It is an interesting query whether there is a meaningful distinction between this emphasis on charity, which depends ultimately on the goodness or generosity of the giver, on one hand, and declaring that each individual has a right to health care, on the other. It is instructive that recent American public opinion polls indicate the public's general willingness to fund a universal health care program correlates closely with the health of the overall economic climate.

Additionally, central to traditional Jewish teachings is respect and even reverence for the elderly, holding to a commitment to the longest possible life expectancy at the highest achievable quality. This approach fits with the modern secular position of the American Medical Association, which unequivocally rejects all age-based rationing proposals because they represent improper categorical judgments about social worth without accounting for differences among individuals. Under this view, rationing medical care according to relative worth to society violates basic norms of distributive justice. Age-based rationing, it is argued, would also devalue and stigmatize the elderly, damage the physician/patient trust relationship, and violate legitimate expectations that older citizens have developed based on past promises by society.

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Strict adherence to traditional Jewish bioethical principles thus would lead to the conclusion that the only morally acceptable resolution of the health care access versus cost containment tension would be a significant—indeed an unlimited—increase in society’s allocation of resources devoted to health care. Proponents of this position urge that, since resource scarcity is a relative rather than an absolute concept, the perceived problem will disappear if society takes more seriously its obligation to its members and abandons its artificial, arbitrary limitations on health care expenditures.

Is this conclusion valid in the face of modern economic and social realities and dynamic secular values? For those like this author, who respond, at least partially, in the negative, the challenge is to identify an ethically acceptable alternative that would allow for some form(s) of health care rationing.

The position that we can successfully solve the dilemma of health care cost explosion in the United States simply by expending even greater amounts of money fails in today’s world on several counts. First, there are a panoply of other, competing goods to be funded, such as education, social programs, national defense, and physical infrastructure. This “war of goods” is considerably more compelling ethically than would be a simplistic battle between good purposes versus waste or junk. Scarcity of resources is real and, at a certain level, absolute; given modern technology, demand—whether driven by need or desire—must inevitably exceed society’s capacity (not just willingness) to satiate it.

Second, there is an obligation to future generations that must be honored. The traditional Jewish commitment to interdependence among different generations—the notion of *L’Dor v’Dor*—is well established and supports the idea that equitable triage or conservation decisions must be made among, as well as within, the generations. In the same manner that society refrains from cutting down all available trees for current consumption, we must judiciously steward health resources for the benefit of future generations who will take our place. It is important, though, to guard against pushing this duty too far, to the point where its fulfillment would entail undue, unreasonable personal sacrifice and devaluation of current persons in need.

Third, a realistic acceptance of modern medicine’s limitations and the development and proliferation of “half-way technology,” which is capable of keeping people alive and in need of chronic health care services for long periods of time but without curing or returning them to a normal functioning life, prompts a need to pose hard questions about relative cost/benefit ratios, and perhaps will force us to make decisions on the basis of such calculations even where complete futility is not at issue. The federal government is on the verge of proposing that it be permitted to consider the costs of new medical treatments in the calculus of determining whether a treatment will be covered under public health care financing programs. Rabbi Moshe Tendler has observed insightfully that, in a real world of resource scarcity, there may be a need to discount the infinite worth of each person down to bargain prices.

Fourth, and probably most importantly, rationing health care in the United States is nothing new. Rationing of health services, particularly by ability to pay (personally or through health insurance) and by geography, has been pervasive her for years. It has been acknowledged, though, in an implicit (“soft rationing”) rather than an acknowledged, explicit (“hard rationing”) fashion. Forcing ourselves to confront and implement a rationing program explicitly may lead to greater fairness and public accountability. As one leading health law and medical ethics expert argues, “...If we are going to engage in rationing care, that must be accomplished by a full and public debate and be conducted through explicit policy at the institutional or government level. We cannot

leave individual practitioners to engage in silent rationing according to principles that may be utterly misinformed and never exposed to public scrutiny.

Conclusion

American public and private health care policymakers and providers should continue to exert reasonable efforts to contain costs as much as possible by minimizing waste and inefficiency within the health care delivery system. Such efforts will defer and soften the necessity to ration potentially beneficial resources. At some point and at some level, however, rationing will prove inevitable. Thus, the meaningful issue is how to do it equitably.

Other developed nations to whose health care systems that of the United States frequently is compared unfavorably all have had implicit rationing schemes in effect for some time. These schemes usually are disguised as queues for services or veiled in the language of "medical contraindications." It would be preferable ethically to engage in rationing explicitly, in a publicly accountable manner, openly incorporating basic principles of social or distributive justice. For some modern rabbis, this could mean a lottery or arbitrary, random system for those who meet specified medical criteria; this approach is consistent with *Responsa* literature. For this author, explicit rationing ought to occur through some type of National Health Insurance system to bring every citizen to an acceptable minimum level of health care coverage, but with strict and clear standards regarding the availability of financing for medical services beyond the basic social safety net. Once such a safety net has been strung to break the fall of each person for whom the contingencies of life may interpose serious medical problems, we must learn to tolerate candidly the multiple tiers of health care at which we have silently winked for decades. Equity need not require absolute equality.

Ethics, both secular and religious, must refer to traditional teachings to inform and illuminate current discussions and debates about health care financing alternatives and societal and individual reactions to the dilemma of resource scarcity. At the same time, to remain relevant and credible, religious as well as secular contributors to this dialog must adapt to modern realities and contemporary secular considerations.

Medical Needs and Societal Obligations

from "Judaism, Justice, and Access to Health Care"

Dr. Aaron L. Mackler

Kennedy Institute of Ethics Journal, Vol. I No. 2, June 1991

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The implications of the Jewish understanding of justice for access to health care are clear in their broadest outlines. Society has the responsibility to ensure that needed medical care is provided to those who would otherwise be unable to receive it, as society has the responsibility to ensure that all basic needs of the poor are met. Medical care for the potentially life-threatening conditions justifies extraordinary expenditures, and represents an urgent obligation of society. While health care needs may generally be defined from an objective perspective, personalized factors must be considered in at least some cases. Access to health care should be provided in a manner consistent with personal dignity and self-respect.

Jewish views of justice provide a set of models and insights that are instructive to the consideration of health care policy, offering clear guidance on some points, while remaining open to a variety of interpretations and applications on others. Resolution of specific issues in health care policy would depend on a complex process involving empirical research, policy analysis, and political deliberation. While such a process is beyond the scope of this paper, three important though unresolved substantive issues will be briefly considered: the level of health care to be provided; possible limits on society's obligations; and means of health care provision.

In determining society's responsibility for the provision of health care, as in other areas, the standard of need is clearly asserted by the Jewish tradition. This can be seen in the above discussion of *tzedakah* in general, and the provision of health care in particular (Tamari 1987, pp. 242, 302). In contrast to contemporary philosophers, traditional Jewish sources find concepts analogous to "need" relatively unproblematic, and devote little attention to specifying the levels of food, shelter, or medical care required by justice. The key to the understanding of need seems to be the idea of lack, or that which is missing. Thus, the Talmudic exegesis, "'Sufficient for his lack'—you are commanded to support him, and you are not commanded to enrich him" (B. *Ketubbot* 67b). In his legal code, Maimonides paraphrases the guideline, "according to that which is lacking for the poor person, you are commanded to give him.... You are commanded to fill in for his lack, and you are not commanded to enrich him" (*Mattenot Aniyyim* 7:3). As seen above, the *Shulhan Arukh* similarly asserts the standard of need or lack (Y.D. 250:1). Individualized cases of persons coming to lack that which they had previously possessed are considered in the codes. The general standard against which lacks are evaluated, though, is largely implicit, and difficult to formulate with precision.

This generally implicit standard of the codes at least roughly corresponds with the concept of "natural function" or "species-typical functioning," developed by Christopher Boorse (1975), and utilized by Norman Daniels in discussing allocation of health care. For Daniels, basic, or

course of life needs, would include food, shelter, clothing exercise, rest, companionship, a mate,....[A] deficiency with respect to them "endangers the normal functioning of the subject of need considered as a member of a natural species..."

Health care needs will be those things we need in order to maintain, restore, or provide functional equivalents (where possible) to normal species functioning. (Daniels 1985, pp. 26-32)³¹

As Daniels notes, the model may be controversial at the theoretical level, and is insufficiently precise to decide on all cases. He claims, though, that "the line between disease and the absence of disease is, for the general run of cases, uncontroversial and ascertainable through publicly acceptable methods;" that in general, we are able to distinguish restoration to a normal range from more elective enhancement.

Daniels's list of paradigmatic needs generally corresponds with that found in the *Shulhan Arukh* and other codes, and his understanding of need in terms of lack relative to a general norm corresponds as well. Unlike the *tzedakah* model, however, Daniels bases society's responsibility to provide needed health care on the concept of fair equality of opportunity (1985, p.57). The *tzedakah* model sees society as having a more general obligation, insofar as possible, to enable each individual to enjoy a reasonably full life, by restoring lacks and providing basic needs requisite to fit within the range of species-typical functioning.

Neither Daniels nor the *Shulhan Arukh* claims to provide criteria adequate to specify determination of need in all cases. Though providing such a claim is beyond the scope of this paper, both seem instructive for "the general run of cases." A particularly problematic area for the determination of health care needs, both in the Jewish tradition and contemporary bio-ethics, is that of preventive care. Paul Menzel, for example argues that even granting that "people need to avoid suffering or dying does not mean that they need all the things which reduce the chances of suffering or dying" (Menzel 1983, p.83).

The provision of preventive medical care is less clearly mandated by traditional Jewish sources than is curative care or rescue. Such sources recognize the importance of personal preventive care, and Maimonides asserts a positive obligation "to avoid anything that is injurious to the body, and to conduct oneself in ways that promote health" (*Deot* 4:1ff).³² The need to allocate significant resources for the provision of preventive care, though, does not seem to have arisen in the classical legal sources. The provision of some preventive care, such as vaccination and prenatal care, could be supported on the basis of fiscal prudence, as cost effective given society's obligation to provide all curative care needed. Louis Russell, however, notes that the relative cost effectiveness of preventive and curative care varies greatly, and that many preventive measures cannot be justified solely on the basis of cost effectiveness (Russell 1989; 1986, p. 110). The assurance of some preventive care could be supported as meeting a basic need of the poor. While the Jewish understanding of justice would mandate provision of at least some types of preventive care, the exact determination of the care required by justice requires further consideration.³³

The *Shulhan Arukh*, and the Jewish tradition in general, acknowledge limits on the obligation to provide even for the needs of others in exceptional cases. In the most extreme case, one does not have to endanger one's own life in order to save the life of another. As seen above, each individual is generally not obligated to pay more than 10 or 20 percent of income toward the provision of the needs of the poor. While the obligation to provide all resources necessary to save lives generally

³¹ Daniels cites Braybrooke (1986, p.90).

³² *Deot* is a section of Maimonides' *Mishneh Torah*.

³³ Baruch A. Brody (1987, p.44) similarly notes special problems with measures such as routine screening that produce benefit in a reasonably small percentage of cases. See also Golding (1983, p. 269).

supersedes all such limits, the *Shulhan Arukh* can envision cases in which not all lives can be saved, and the tradition offers various sets of priorities to consider in such extreme cases (Y.D. 252:5-12; see also Dichowsky 1976; Golding 1983, pp. 276-79; Rosner 1986, pp. 339-54).³⁴ Finally, while the Talmudic consideration of a limit on payments for the redemption of captives in order to avoid an onerous burden on the community has been accorded little weight by Jewish legal authorities, it might be argued that modern medical technology has revived the need for consideration of such limits on societal obligations, at least in extreme cases.

The relevance of such limits to the contemporary United States requires further consideration and empirical research. Given the relative affluence of the United States, though, much more could be done for the poorest and most disadvantaged without approaching the above limits on minimal obligations. In particular, the United States does not face the absolute poverty that would force it to allow otherwise preventable deaths. While there is some room for consideration of limits on expenditures in exceptional cases, the strong presumption of the Jewish tradition is for provision of all resources necessary to preserve and save life.

Recent years have seen a growing consciousness of limits to the resources of United States society, and arguments that the rationing of health care is unavoidable. At the same time, the Persian Gulf and savings and loan crises have shown United States society ready and able to quickly allocate tens of billions of dollars of resources in order to protect national security, and to fulfill a moral obligation to keep promises to allied nations and individual investors. As seen above, Judaism understands fulfilling the requirements of justice as both morally obligatory and crucial to national security. While full evaluation of arguments for rationing health care is beyond the scope of this paper, rationing that denies needed health care is a last resort, and at best premature, given the lack of serious efforts to provide needed health care or to limit that which is unneeded.

Recent years have also seen the development of a variety of proposals intended both to expand access to health care, and to contain health care costs by reducing inefficiency and waste (see National Leadership Commission on Health Care 1989; Enthoven and Kronick 1989; Beauchamp and Rouse 1990). As Rabbi Waldenberg notes in his responsum, the requirements of the Jewish understanding of justice for health care can be met in a variety of ways. These might include direct provision of care in public hospitals and clinics, an expansion of Medicaid, universal health insurance, a system involving vouchers and market competition, government contracting with medical providers, or some combination of the above. Further research and evaluation are needed to determine how to most effectively and efficiently meet society's obligation for assuring access to health care.

Still, some requirements are clearly implied by the *tzedakah* model. Access to all health care needed by any individual must be assured. Those individuals with greater needs must accordingly be provided with greater health care, through available insurance or direct provision of resources. Finally, those who make choices (in lifestyle of health care) that turn out to be unfortunate or irresponsible thereby attenuate their claims to societal support, but do not forfeit all such claims. As seen above in the case of an individual who sells himself into captivity, society must continue to provide some care even for those responsible for their own misfortune, especially in cases involving threats to life.³⁵

³⁴ Some sources argue that those with viable lives takes precedence over those suffering from a fatal condition (*terefah*) in an exceptional forced-choice situation in which not all can be saved; see Sinclair (1989, pp. 47-63).

³⁵ For a complete list of references to this article, refer to original publication.

Section III Study Pieces: Choosing Whom To Treat

1. Choosing Which Patient to Save

Solomon B. Freehof

American Reform Responsa, CCAR, 1889-1983

Vol. LXXVIII, 1968, pp. 111-118.

2. Priorities in Medicine: Whom to Treat First.

Abraham S. Abraham, M.D.

In Medicine and Jewish Law, Vol. 1, edited by Rosner.

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Choosing Which Patient to Save

Solomon B. Freehof

American Reform Responsa, Vol. LXXVIII

CCAR, 1968

QUESTION: The head of a clinic in Boston asked, following a forum session at the last Biennial Convention of the Union of American Hebrew Congregations in Montreal (November, 1967): "What guidance can Jewish tradition give us in the excruciating, ethical dilemma of selecting one patient over many others to keep him alive by means of a mechanical kidney machine? Since such facilities are extremely limited, many patients must be rejected and are certain to die. The same question may also be raised with reference to the very limited supply of organs for transplantation. On what basis can a conscientious doctor make the decision as to which patient is to live or die?"

ANSWER: Solomon Landau, in a responsum embodied in the collection of his father Ezekiel Landau's responsa (*Noda biYehuda*, vol. II, #74), was asked whether a man sought by the government as a criminal should be turned over or not. He says at the outset: "It is difficult to make a decision in matters which involve the life of a human being." Such a decision is always a difficult one in any decent tradition, religious or social. The question asked here by the physician of the clinic is especially difficult to decide on the basis of Jewish traditional literature. Obviously, there were in those days no such remarkable inventions, or the means for the preservation of vital organs, as there are today. In those days, when a person was dying, they would discourage any artificial attempt to keep him alive for another hour or so, because a man has a right to die when the time comes (cf. "Ran" to Nedarim 40a). But nowadays it is possible, in the case of moribund patients, to effect what often amounts to a cure. So there is no real precedent for the problem in the traditional literature.

Nevertheless, there are quite a number of somewhat different discussions which involve the question of choosing one person to live or another person to die. In the discussion of these various dilemmas there may perhaps be found an ethical principle, or at least an ethical mood, which might help indicate what Jewish tradition would have said in a situation such as this one which now occurs frequently in modern hospitals.

The Mishna (in *Oholot* VII.6) deals with a question which involves the choosing between one life and another. A mother is apparently dying because of the childbirth. Either she or her child can be saved. Which one should it be? The law is that the child is looked upon as an assailant and therefore may be destroyed before he kills the mother. Therefore, the unborn child should be destroyed, and the mother saved. If, however, the child puts forth its head, then it may no longer be destroyed. It is now considered a separate person, and now the law is thus stated: "We do not dispose of [or push aside] one person in favor of another" (cf. also *Sanhedrin* 72b). This is stated as the fixed law in the *Shulchan Aruch*, *Choshen Mishpat* 425.2).

This clear-cut principle that we may not save one life at the expense of another seemed at first glance to be somewhat contradicted by the discussion in the Mishna and the Talmud as to the relative respect to be paid to a father and to a teacher. This Mishna (*Bava Metsi-a* II.11) says that if a person finds an object lost by his father and another object lost by his teacher, he must first return the one lost by his teacher. The Mishna explains the reasons as follows: "For his father has brought him into the light of this world, while his teacher, who teaches him wisdom, has brought

him into the light of the world to come.” Upon that basis the Mishna continues to say that if both his father and his teacher are held in captivity, he must first redeem his teacher and after that redeem his father. This is discussed in the Talmud in Bava Metsi-a 33a, and is codified as law by Maimonides in Hil. Aveda 12.2 and in the Shulchan Aruch in Yoreh De-a 242.34. All this seems to contradict the principle that you may not choose one life to save in preference to another, but actually this is not so. The Rabbis do not speak here of such an irreversible fact as death, but only at most of captivity in which both are to be saved (except, of course, that they give the order as to who should be saved first). When it comes to an actual matter of life or death, in which a choice is final, the principle remains that one life is as precious as another.

This principle that we do not destroy one life in order to save another is further exemplified in a discussion in Pesachim 25b. A man comes before Rava and says: “The governor of my city has given me the alternative that either I should kill so-and-so or the governor will kill me. What shall I do?” Rava answered him: “Be killed rather than kill. What makes you think that your blood is redder than his?”

This Talmudic phrase, “Your blood is redder than his,” was used in rather a reverse sense in the latest volume of Tsits Eli-ezer, vol. 9, 45, Eliezer Wildenberg, Jerusalem, 1967. In this volume, devoted to a large extent to modern medical questions, the author concludes that a person is certainly not required by law to donate an organ of his body in order that it may be planted into the body of another. If he is endangered by the removal of the organ, then he is actually forbidden to risk his life. Of course, if the danger to him were minimal, it would be a good deed; but, otherwise, one should not endanger his life in this way because one life—in this case his own—is as valuable as the life he wishes to save. Wildenberg then uses the Talmudic dictum cited above: “What makes you think (that his blood is redder than yours)?” But whichever way the phrase is taken, its meaning is clear enough: Every life is as equally valuable as any other life.

The two instances—that of the infant and that of the man ordered to become a murderer—both differ from the case inquired about here because these two cases involve actually taking steps to put people to death, while the case of the clinic involves merely allowing dying people to die. Nevertheless, in spite of this difference, this much at least is relevant: we have no right to say that one person’s life is more important than that of the other—the mother’s or the child’s, or the man’s or his intended victim’s. From the standpoint of religion, all people are alike in status as to the right to life.

There is still another set of circumstances developed in a series of discussions in the literature, all of which spring from the same Biblical account. These discussions, different from those above, do not deal with the worth of one person rather than another, but with the safety of a social group as against the life of one person. The question now is whether a city or a group may save itself by handing over one of its number to death. In the Second Book of Samuel, chapter 20, Sheva ben Bichri, who rebelled against King David, takes refuge in the city of Abel. There he is pursued by Joab and his army, which surrounds the city and threatens to destroy it. The wise woman of the city gives up Sheva to Joab, and thus the city is spared. This incident is discussed in the Tosefta (Terumot, end of chapter 7) and in the Palestinian Talmud (Terumot, end of chapter 8), where it is cited as a guide in the following situation. A group of travelers is stopped by brigands who say to the travelers: “Give us one of your number. We will kill him and let the rest of you go.” May they do so? This, now, is a case of saving a large number of people by having one person die. The decision is that they must say: “No, we would rather all be killed than give up one of our number to death” (since the shedding of blood is one of the three sins for which a person must be willing to die rather than commit it, the other two being idolatry and immorality). The conclusion is, so far, that

rather than commit what amounts to one murder, we would rather be killed ourselves, even though there are twenty of us and the victim would be only one.

However, the discussion in the Tosefta and in the Talmud continues as follows: This wholesale self-sacrifice applies only when the brigands are not specific and merely say "one of you," thus compelling us to choose the man to be killed. But if they are specific and they are searching for a certain man who they mention by name, then we do not all have to be killed for his sake, since it is not we who selected him for death. This, however, is only one opinion. The opposite opinion is that this one man, even though specifically named, may not be turned over to the brigands unless he is criminal, as Sheva was in the Biblical account, since he rebelled against King David. This distinction is embodied in the law (see Maimonides, *Hilchot Yesodei Torah* V.5). There is some disagreement about whether the man needs to be a known criminal before he is surrendered to save the lives of all the others, or whether it is sufficient if the brigands named him and it is not we who have selected him. See the discussion by Joseph Caro in *Kesef Mishneh* to the law in Maimonides.

The bearing of this discussion on the case in point is that actually the other patients, who will not be given the rare remedy, have not been directly selected for death. They have already been marked for death by forces beyond the physician's control (as by the brigands in this case), and if they die, it is not directly the physician's fault. They would die anyhow. It is not he who has really named them for death.

It is also clear from this aversion against turning someone over to death in order to save someone else, or even a group, that it would be absolutely forbidden by the spirit of Jewish law to hasten the death of some terminal patient already marked for death in order to take something from his body in order to save another patient or for the increase of medical knowledge.

But so far all of the incidents cited involve a direct choice between living and healthy people as to who should live and who should die. The case involved in the question asked is of people who are dying. Is there any guidance in the law for choosing between people who are already marked for death? It is possible to say that, since they are already dying, we should just let them all die and not attempt the bitter choice of picking one of them to live. Is such a "hands-off" attitude permissible?

This very question, by close analogy, is discussed in the Talmud (*Bava Metsi-a*, 62a). The case is stated as follows: Two men are walking (presumably in the desert). They have one pitcher of water which contains enough to keep only one of them alive long enough to cross the desert safely. If both of them drink, they will both die. If one drinks, he will be saved and the other will die. What shall be done? Ben Petura said: "Let them both die and let not one be a witness to the death of his fellow man." But Rabbi Akiva's greater authority is cited to refute this opinion of Ben Petura. He says: "Your life comes first." In other words, a man must strive to save his own life. Although this narrative is cited in a discussion about the taking of interest and whether it should be returned, nevertheless it constitutes an independent homily (see the statement of Asher ben Yehiel to the passage). While, of course, Akiva's decision is not directly helpful to the question of deciding which shall live (since it does not indicate in which manner the matter will be settled with each one trying to save his own life); nevertheless, this much is clear: We may not permit both men to die when at least one of them can be saved. The passage is unfortunately too terse, and therefore we cannot tell the method of selection, but it is clear enough that a selection will and should be made, and that it is not right to allow both of them to die merely because it would be painful to make a decision. Thus, the final problem still remains. He should choose, but which one?

As to whom he chooses, there is, in a sense, a negative guideline. The passage which speaks of the brigands or captors demanding one of the group of men to be given up for death, speaks first of a group of captive women. The captors ask for one woman to be given to them for sexual abuse. The sexual fate of a captive woman receives considerable discussion in the law. The married status of the captive wife may be affected by what had happened to her during her captivity. If one of the women in the group has already been abused, the other women may not say that since this unfortunate one has already been abused, she is the one who should be given up. (See *Kesef Mishneh to Yad*, Hil. Yesodei Torah, V. 5, where Caro cites the responsa of Solomon b. Aderet to this effect.) They have no right to decide on the basis of her unhappy past and so select her in order to save themselves.

In other words, in matters which are equivalent to life or death (as this was considered to be), the past status or character of the prospective victim may not be considered. We may not say: "This one's life may be set aside in favor of the other's." All are of equal status in relation to life or death.

There is, however, some other standard of choice before the physician, one which is precisely relevant. There is a discussion in the Talmud (in *Avoda Zara* 27b) which is developed in the legal literature into a principle. It can be stated as follows: [When there is a chance for a cure] we do not put too much value upon the last hours of a dying man ("*Ein mashgichim lechayei sha-a*"). In other words, these last few hours are not so valuable that we may not risk them if we want to try out some new and hitherto untried remedy. These last hours are fading anyhow. So Jacob Reischer Rabbi of Metz (died 1733), in his responsa (*Shevut Ya-akov III*, #75) concludes that we may risk the few hours of a dying man to try an untried remedy, if there is a fair prospect that he can be cured enough to have, say, a year of life. He says at first that even the *chayei sha-a* (the remaining hours of life) are important and we must guard them (i.e., we never *hasten* death); nevertheless, if there is a remedy by use of which it is possible to cure him, then in that case we may risk it. The same decision was arrived at in a responsum published this past year by Mordecai Jacob Breisch (*Chelkat Ya-akov III*, #141). From this we conclude that the physician must endeavor to decide not on the basis of personality reasons, but on medical grounds. He must select the patient—rich or poor, good or bad—who has the better chance of survival and of getting more of relatively healthy life. As for the others, no direct action should be taken by him against them. Their sickness will run its course.

This same conclusion, i.e., that the one who will benefit most should receive the remedy, was arrived at over a hundred and fifty years ago by Joseph Teomim (1727-1793). Of course, he could not have had any knowledge of modern transplants, nor of the special problems involved in them. He came to his conclusion purely on the basis of the spirit of the law. His statement is in his commentary *Peri Megadim* to *Orach Chayim* 328 (commenting on the *Magen David*). The *Shulchan Aruch* at that point deals with the question of which patients may have the Sabbath violated for them and to what extent. The discussion involves the question of which patient is in real danger and which is not in immediate danger. Joseph Teomim then widens his conclusion from the Sabbath law to a more general application and says: If there is doubt about whether one patient is in danger, and there is no doubt that the other patient is in danger—if there is not enough medicine for both of them, we give it to the one who is in greater danger.

From all this discussion in the Talmudic and later literature, a certain mood emerges. First, that one life is as important as another; and this must certainly be so in the eyes of the physician. Second, that actively to take steps to destroy another life for our own benefit is not permitted. Third, that when it comes to a choice between people who are dying anyway, the choice cannot be

evaded, but *must* be made (nothing is gained by allowing both men to die in the desert!). But as to whom to choose for survival, it must be on purely medical grounds, selecting the one who has a better chance of benefiting from the remedy. Of course, this is not an absolute test, because out of ten patients there may be two or three who could greatly benefit from the remedy. But at least this principle narrows the choice and in many cases can decide the case. So, while there is no case in Jewish legal tradition precisely like this modern question, there is enough in it to give at least this much guidance.

Addendum

Dr. Julius Kravetz, a member of our committee, calls my attention to a sequence of passages in Mishna and Talmud which points in the opposite direction from the conclusion arrived at above. These passages should be mentioned, not only for the sake of completeness, but also as a possible balance to the opinion expressed in the responsum.

The Mishna (in Horayot III.7,8) says that a man precedes a woman (i.e., has prior right) "to be kept alive" (*lehach. yot*) and to have his lost articles returned. But a woman precedes a man in being provided with clothing and being redeemed from captivity. A Cohen has precedence over a Levi, a Levi over an Israelite, and an Israelite over an illegitimate, etc.

The Talmud discusses this Mishna in two places: Horayot 13bff and Nazir 47b. In both passages the Talmud gives the reasons for the various priorities. There is however, a further development in the passage in Nazir. Mar Ukba says that the priority (of the Battle-priest over the *Segan*) means that he has precedence in our duty to keep him alive. The *Tosafot* are still more specific, saying that if a heap has fallen on both, it is he who must be rescued first. Rabbi Untermann (in *HaTorah Veba-medina* IV, 22-29) takes this as the meaning of the discussion in the Mishna and applies it in the case of a pharmacist having a limited supply of penicillin, etc.

This, then, is a halachic discussion which points to an order of precedence in the saving of lives (a man before a woman, a Priest before a Levite, etc.). However, it seems to me that the discussion, in spite of the *Tosafot*, does not necessarily refer to the rescue of endangered lives. The Mishna uses the word *lehachayot*. If the Mishna meant "to rescue from danger," we would have expected it to use the word *lehatsil*. In fact, the *Shach* (to Yoreh De-a 351.14) says that the word does mean *lehatsil* and interprets accordingly. But the Mishna uses this word in precisely the same way in which it is used in Psalm 33:19. The Psalm makes use of both words, *lehatsil* and *lehachayot*, each for a specific thought. It says "to rescue (*lehatsil*) thee from death, and to sustain thee (*lehachayot*) in famine." So our Mishna here uses the word *lehachayot* precisely in connection with providing clothing and ransoming from captivity. If our Mishna had actually meant "to rescue from death," then we would expect that the Codifiers, when giving the laws of rescue, would refer to this priority. But neither Maimonides, nor the *Tur*, nor the *Shulchan Aruch* mention any of these priorities in the laws of rescue (cf. *Yad*, Hilchot Rotseach I 14; *Tur* and *Shulchan Aruch*, Choshen Mishpat 42b).

Judging by the context of this Mishna and by the Biblical use of the word in the Psalm, *lehachayot* is not used here loosely as meaning the same as *lehatsil*, but precisely as meaning "to keep alive," in the sense of "to sustain or to support."

This is clearly the way in which the Codifiers understood the discussion. They do mention the list of personal priorities, but only in connection with charity. So Maimonides in *Yad* (Matnat Aniym VIII.15-17), the *Tur*, and *Shulchan Aruch* (Yoreh De-a 251).

Priorities in Medicine: Whom to Treat First

Abraham S. Abraham, M.D.

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The dilemma of whom to treat when there are insufficient resources for the treatment of all who are in need is not a new one. This dilemma also arises when treatment can be given to all, but decisions must be made on the basis of priority—even when the decision is not purely a medical one.

The Talmud (*Baba Metzia* 62a) sets forth a situation in which two people are on a journey and only one possesses a flask of water. If the circumstances are such that if both were to share the contents of the flask neither would survive—whereas if the water were consumed by one of the two, that person might reach safety—what are the travelers to do? Ben Petura opines that both should share the water, even if this meant that, as a consequence, both would die, because this would be preferable to one living at the expense of the other. Rabbi Akiva, on the other hand, on the basis of the verse “That thy brother may live with thee” (Leviticus 25:36), concludes that “your own life comes before that of another;” therefore the one who owns the flask of water may consume all of it in order to survive. In his commentary on this talmudic passage, Rabbi Isaiah Karelitz, known as Chazon Ish, says that if the flask belonged to a third person who did not need to drink, and there was only sufficient water for one of two others who would otherwise die of thirst, the owner may give the water to whichever one of the two he chooses.³⁶ This ruling is restricted to a situation in which the other two are of the same status (see the next paragraph); otherwise the water should be given in the order of priority specified in the ruling of the Mishnah (*Horayot* 3:7).

PRIORITIES IN JUDAISM

From this we learn that in a life-threatening situation, the order of priority that is, which of two persons to save is as follows: male before female (since men must observe a larger number of commandments³⁷); a Priest (*cohen*) before a Levite; a Levite before an Israelite; a sage or scholar (*talmid chacham*) before an ignoramus (*am ha'aretz*), and so on. In a medical situation, this order of priority holds only if the two persons present themselves to the physician at the same time; preference should then be assigned in accordance with the Mishnah.³⁸ However, if the patients involved are of the same status, the physician may choose whom first to treat. (See also the writings of Rabbi Yaakov Emden.³⁹)

Furthermore, this order of priority holds true only if both patients have equal status in terms of their potential for survival. However, if one patient would certainly die if left untreated and the other only questionably, then the physician should first treat the patient who would otherwise

³⁶ Commentary on *Baba Metzia* 62a.

³⁷ M. Maimonides, Commentary on the Mishnah, *Horayot* 3:7.

³⁸ J. Karo, *Shulchan Aruch*, *Yoreh De'ah* 251:9.

³⁹ Migdal Oz, *Even Bocher*, 1: 91-92.

certainly die. Similarly, if one person has no chance (or only a very small chance) of surviving if treated, and the other has a good chance of surviving if treated, the latter should be given priority.⁴⁰

Two questions must be asked. First, we know that the order of priority applies when both patients present at the same time to the physician who is in a position to treat only one of them. However, what would be the ruling if the two patients had arrived in the emergency room one *after* the other, but the physician had arrived later and found them both together? Does the rule of priority as stated in the Mishnah still hold, or should the physician first treat the patient who had arrived at the hospital first? In other words, should he proceed on the basis of “first come, first served?”

The problem of prioritization applies not *only* to patients in mortal danger, but also to situations in which two patients who are not seriously ill present simultaneously to the physician. Therefore, the foregoing question might be rephrased as follows: If a physician walks into his office and is confronted with a full waiting room, is it “first come, first served” (either on the basis of who arrived first or who had the first appointment), or is it the Priest before the Israelite, even though the Israelite has been waiting an hour and the Priest only five minutes? The same halachah (Jewish legal ruling) applies not only to the physician vis-à-vis patients, but also to the giving of charity or other acts of kindness⁴¹ or to the bank teller and the bank’s clients or the shop attendant and the customers.⁴²

Now the second question: Does anyone in practice observe the order of priority stated in the Mishnah? Does the physician do so with his patients? Does the rabbi so behave if he comes home to find people waiting to tell him their problems? The answer, obviously, is no! But why not? What justifies behavior contrary to the ruling of the Mishnah and the Code of Jewish law (*Shulchan Aruch*)?

This second question is asked by Rabbi Abraham Gumbiner,⁴³ in relation to the Priest’s right to priority: Why is it that we do not find that he is given priority in the foregoing circumstances? Gumbiner’s answer is that it is probably because of the questionability of the present-day Priest’s being an indubitable and direct descendant of Aaron the High Priest.⁴⁴ This answer is also given by Rabbi Yaakov Emden.⁴⁵

A parallel may be noted in the prioritization of men versus women. One possibility for consideration is based on the line of reasoning set forth by the Magen Avraham: The man has priority over the woman because he is commanded to observe, and we assume that he indeed *performs*, more commandments (*mitzvot*) than a woman. However, do we truly know which of the two patients *actually observes* more commandments? The Talmud (*Taanit* 23a) relates that when Abba Chilkiah and his wife prayed for rain, his wife’s prayers were answered because she, being at home, had given already prepared food to the beggar at the door. Abba Chilkiah, on the other hand,

⁴⁰ Y. Te’umim, *Pri Megadim*, commentary on *Orah Chayim* 328, section *Mishbetzot Zehav* 1; E. Y. Waldenberg, *Responsa Tzitz Eliezer*, vol. 9, no. 17:10:05 and no. 28:3; M. Feinstein, *Responsa Igrot Moshe, Choshen Mishpat*, part 2, no. 73:2.

⁴¹ A. S. Abraham, *Nishmat Avraham, Yoreh De’ah* 252:2, cited in the name of Rabbi Shlomo Zalman Auerbach.

⁴² I. Lipschutz, commentary *Tiferet Yisrael* on *Horayot* 3:7, note 33.

⁴³ Commentary *Magen Avraham* on J. Karo’s *Shulchan Aruch, Orah Chayim* 201:4.

⁴⁴ *Nishmat Avraham, Orah Chayim* 128:10, at the end.

⁴⁵ *Op. cit.*, part 1:89.

had given money, with which the beggar then had to buy food. Similarly, the Talmud (*Ketubot* 67b) relates how Mar Ukva was saved from danger by the greater merits of his wife.

With regard to a sage vis-à-vis an ignoramus, we are told (*Baba Bathra* 10b) that in the world to come, the teacher may find himself in a status lower than that of a former pupil.⁴⁶ In addition, some rabbinic authorities hold that nowadays no one complies with the definition of “sage” (*talmid chacham*) as required by the Talmud,⁴⁷ and that it could therefore be argued that today only a person who is outstanding in learning or piety should be given priority.

FIRST COME-FIRST SERVED PRINCIPLE

With regard to our first question, the *Shulchan Aruch* (*Choshen Mishpat* 15:1) states that if two cases are awaiting judgment, the *beth din* (court of law) should consider them in the order of their presentation, unless one involved a “sage.” This ruling implies that even if the two cases were already waiting when the *beth din* convened, the rules of priority would apply. However, Rabbi Yosha’ Valk Cohen,⁴⁸ known as the Sema, limits this ruling to a situation in which the parties appear *after* the *beth din* had already convened; only then does the “first come-first served” rule apply. However, those already waiting *before* the convening of the *beth din* are subject to the standard rules of prioritization even if one arrived before the other, and the *beth din* may choose to deal first with whichever case it wishes (unless one involves a sage).

Rabbi Waldenberg⁴⁹ has stated that this ruling of *Shulchan Aruch* is not generally accepted and that many authorities, foremost among them Rashi, Maimonides (Rambam) and Tosafot, decided that, on the contrary, the sage’s priority applies only if he arrived together with the ignoramus. Therefore, the answer to the foregoing question depends upon a combination of two propositions: (1) Whether the Mishnah applies only to the situation in which the two patients (the sage and the ignoramus) presented simultaneously to the physician, or whether the Mishnah is relevant if the parties arrived at different times and the physician arrived to find them both waiting; and (2) whether anyone in modern times can rightly be called a sage. A combination of these two doubts (*safek sefekah*) explains why the priorities set forth in the Mishnah are no longer adhered to today. Rabbi Waldenberg, however, is of the opinion that a recognized “sage” or person of outstanding piety should be given priority even if that person arrives after the physician has already started consultation hours.

The question of what significance “waiting in line” has in Halachah in terms of giving preference to the first in line (even when those in line are all of equal status) is also not clear. Rabbi Waldenberg writes that this is only a custom hallowed by public consent, and that it therefore cannot override Halachah as enunciated in the Mishnah. Rabbi Yitzchak Zilberstein⁵⁰ quotes Rabbi Menachem Meiri,⁵¹ who suggests that “first come, first served” is not merely custom,

⁴⁶ Commentary of Tosafot on *Baba Bathra* 10b, s.v. *elyonim*.

⁴⁷ M. Isseries, glossary known as *Ramah* on J. Karo's *Shulchan Aruch*, *Yoreh De'ah* 243:2 and 243:7; A. Z. Eisenstadt, commentary *Pitchei Teshuvah*, *ibid.*, 243:2:2; M. L. Avraham, commentary *Yad Avraham*, *ibid.*; *Mishnah Berurah* 547:12.

⁴⁸ *Ibid.* 15:1:1.

⁴⁹ Personal communication.

⁵⁰ *Halachah Urefuah*, vol. 3, ed. M. Hershler (Jerusalem, 1983), pp. 91-101. Commentary Meiri (Bet Habechirah) on Sanhedritl 32b.

⁵¹ Commentary Meiri (Bet Habechirah) on Sanhedrin 32b.

but is supported by the verse "Justice, justice shalt thou pursue" (Deuteronomy 16:20); therefore, such priority should prevail as long as it does not contradict the Halachah of the Mishnah.

Finally, Rabbi Moshe Feinstein⁵² writes that although priorities should be assigned only according to the criteria cited in the Mishnah, it would be difficult to apply them in practice without great deliberation.

CONCLUSIONS

All the conclusions reached thus far apply only to the situation in which the physician has not actually started to treat the patient. If treatment is already underway, such treatment may not be interrupted in favor of another patient. This rule applies to treatment by the physician personally as well as to the use of equipment for treatment, such as an intensive care unit bed or a respirator. In such a situation, regardless of the medical or other status of the two patients, nothing is permitted that may result in the sacrifice of the patient who is already being treated, in favor of the other. Thus, if interrupting treatment would mean the earlier death of an elderly, chronically ill patient who would be expected to die even in spite of continuing treatment, interruption of treatment is still forbidden, even in order to save the viable life of another person who is young and intrinsically healthy. As Rabbi Shlomo Zalman Auerbach says:⁵³ One may not sacrifice a life for a life, even to save oneself, or even to save the life of a person of outstanding learning and piety and who serves the world at large, by means which hasten the death of a person who may be very aged, mentally incapacitated, and a burden to others.

⁵² *Responsa Iggrot Moshe, Choshen Mishpat*, part 2, 74:1.

⁵³ Cited in *Nishmat Avraham, Yoreh De'ah* 252:2.

Section IV Additional Resources

- 1. Rationing Health Care**
Melinda Beck
Newsweek, June 27, 1994

- 2. A Sick Boy Says “Enough!”**
Christine Gorman
Time, June 27, 1994

- 3. Was Angela’s life worth the \$1.3 million price tag?**
Ellen Goodman
Philadelphia Inquirer

- 4. A Closing Thought: Living Each Day**
Rabbi Abraham Twerski
Mesorah, Brooklyn, p. 115.

RATIONING HEALTH CARE

Despite all their talk of reform, politicians don't want to admit that the era of unlimited medicine is over. The notion is political poison.

WHEN THE LAKEBERG Siamese twins were born last summer sharing a single heart and liver, they posed a challenge to American medical prowess. Experts said there was a less than 1 percent chance that even one twin would survive a tricky separation surgery. Surgeons at Children's Hospital in Philadelphia operated anyway, sacrificing Amy to save her sister, and for a time, it looked like Angela had beaten the odds. But when she died two weeks ago, she left behind a stack of disputed medical bills and an even greater ethical challenge. Was \$1.3 million too much to spend on a single life when so many other Americans need basic medical care? Should the nation have let both twins die instead?

Those are the kinds of agonizing questions that should be guiding the debate over health-care reform. Most lawmakers in Washington agree on the twin goals of reform: cutting costs and extending care to the uninsured. Yet no one is willing to admit that it will take rationing to make that possible. Politicians are reluctant to concede that the era of unlimited medical care is over; the notion is political poison. Many Americans in managed-care plans have already seen the future, and they hate being told they can't choose their own doctor, get a second opinion for a child's ear infection or have the latest high-tech diagnostic test for a nagging headache. As Dr. Joseph Simone, physician in chief at Memorial Sloan-Kettering Cancer Center in New York, puts it, "Rationing is the third rail in Washington—you touch it and you die."

Dueling partisans in the reform debate have invoked the R word—but only to further their own agendas. Last week Hillary Clinton reminded Chamber of Commerce

members from North Carolina that "we ration already... by who can afford what." She also insisted that there is no need to discuss rationing until "we get everyone covered and then we need to squeeze the system and become more efficient." This week the Health Insurers Association of America plans to unveil a new ad campaign in which "Harry" and "Louise" will fret that reform will lead to rationing of a different sort. But such rhetoric is just more evidence of denial. Regardless of what plan passes Congress, rationing is inevitable, and the real debate should be over how to do it logically and fairly.

Unfortunately, most Americans still regard fairness as doing it all. In a new NEWSWEEK Poll, 76 percent of Americans said they were unwilling to accept less choice of doctor or hospitals—even if it helped bring down health-care costs and make universal coverage possible. Considerably more than half of those polled want to preserve high-tech diagnostic tests like MRIs and CAT scans, use of specialists, experimental medicine and care for the very old—and for tiny preemies. Forty-nine percent even favor continuing expensive long-odds operations like separating the Lakeberg twins. Yet Americans do recognize that hard choices are ahead: 74 percent said they think reform will lead to rationing.

Rationing, in its purest sense, means allocating scarce resources, as sugar was doled out during World War II. To date, only Oregon has done that with health care. In a series of 50 town meetings, state residents debated what kinds of medical care were more critical than others: a computer ranked a priority list and the legislature funded only those the state could afford. Treating severe head injuries, appendicitis and tuberculosis ranked high on the list; bone spurs, lower back pain and advanced AIDS cases were eliminated altogether, partly because there are no effective cures. But Oregon's program applies only to Medicaid recipients. Trying to devise such a list for all Americans would be politically impossible. Instead, most reformers think they can avoid such overt rationing and save billions by cutting "waste and inefficiency."

But that won't be as easy as it sounds. The definition of "unnecessary care" varies wildly, depending on whether you are a profit-minded HMO administrator or a frightened patient. Take in vitro fertilization. Many reformers and insurance companies see it as a frill, since each attempt costs roughly \$7,000 and only one in five, on average, results in a live baby. But thousands of infertile Americans have come to see IVF as a right, simply because the technology exists. Bonny Gilbert of Brookline, Mass., owes her 2-year-old daughter, Channa, to three IVF attempts, \$21,000 in medical bills and Massachusetts' law that requires insurers to pay for unlimited IVF. Now she's rushing to try to conceive again in

case IVF is rationed out under health reform. "Suddenly, I'm being seen as this selfish person who's eating up the health-care dollars of this country," Gilbert says. But she argues that having blocked fallopian tubes is the same as any other medical problem, and that IVF is no more elective than arthroscopic knee surgery that allows skiers to return to the slopes.

Even doctors admit there is fat to be cut out of the system. Many concede that they sometimes order tests and treatments simply to cater to patients' whims—or to ward off malpractice claims. "People feel that if they go to the doctor and don't walk out with five tests and a pre-

BY MELINDA BECK

scription, they haven't had a good visit," says Dr. Christine Cassel, a professor of medicine and public policy at the University of Chicago. Landmark studies by the Rand Corp. in the early 1980s estimated that as many as a third of all medical treatments were unnecessary. Ever since, researchers have been working to develop "outcomes research" and "practice guidelines" to determine what really works in medicine and what could be eliminated.

Already, practice guidelines are being used to cut out some routine procedures. Starting this winter, emergency-room doctors in Maine plan to stop X-raying routine ankle and rib injuries—and to tell patients to come back later if they still hurt. Designers of the system con-

cede that it may not sit well with some patients. "In the McDonald's society, people want to know now whether an X-ray shows a broken bone," says Dr. Pamela Bensen, an E-room physician in Lewiston. But she calculates that if each of the nation's 7,000 emergency rooms refrained from X-raying just two ankles a day, the nation would save \$511 million annually.

The entire premise of managed competition is that HMOs and other health plans can make such cuts without harming "the quality of care." The trouble is that many medical specialties are still a long way from agreeing on what is necessary and what isn't—or even on what "quality" means. It is also unrealistic to expect patients to be "informed consumers" of health care. Middle-aged men are pummeled with reports that prostate cancer will strike one in eight and claim 35,000 lives this year. But specialists argue about whether radiation, surgery or doing nothing at all is the best course of treatment. Mammography is equally controversial: the American Cancer Society has long recommended routine breast screenings every one to two years for women older than 40. Yet the National Cancer Institute recently stopped advocating mammograms for women under 50—even though 20 percent of all cases are diagnosed in women in their 40s.

MANY REFORMERS ALSO WANT TO cut down on the burgeoning number of MRIs, now used to diagnose everything from cancer to knee-cartilage tears. Each costs about \$1,000, and many confirm only what doctors already suspect. But at other times an MRI does uncover a major problem. Last year Sen. Arlen Specter's doctors dismissed his complaints of pains in his face and tightness in his collars—at one point there was a diagnosis of "too tight a shirt collar," said his son. But Specter demanded an MRI anyway. It revealed a brain tumor, which, though benign, could have hampered his speech and body movements. Specter favors managed care, but he wants it to be flexible enough so that people can pay for more care on their own: "86.1 percent of Americans have the best care in the world. I don't think we should change that basic system."

Even experts involved in "outcomes research" say it will take years and massive investments in clinical trials before we can know what is safe to eliminate for thousands of diseases. In the meantime, many fear that under managed competition, competing health plans will cut care based on cost alone. "The tendency will be to save money rather than prolong life," writes John Goodman of the National Center for Policy Analysis in a new study warning that managed competition could hurt the sickest Americans. Even Robert Blendon, professor of health policy at Harvard and a strong advocate of reform, concedes: "If plans start making decisions about who lives and dies, people will be outraged."

The fact is that HMOs and insurance companies already make such decisions when they deny coverage for "experimental therapies"—and patients are taking their outrage to court (page 36). Insurers insist that they aren't being callously profit-minded—their main concern is whether the procedure has proven effective. But just as with unnecessary care, experts can't agree on what "experimental" is. And doctors argue that in life-threatening illnesses where there are no proven cures, denying an experimental therapy is tantamount to issuing a death sentence.

Viola Docyk's doctors told her that a controversial autologous bone-marrow transplant was her only hope for survival after her breast cancer metastasized to her hip and shoulder last year. With it, they said, the 47-year-old Long Island, N.Y., mother's chances were one in four. But it took four months for Docyk's insurance company to even answer her requests, then it denied the \$125,000 procedure, claiming it was experimental. "My life wasn't worth the money," fumes Docyk. "My husband has been paying his insurance for years, and they were denying me coverage when we needed it most." Docyk threatened a lawsuit and finally got her bone-marrow transplant in April—but only af-

ter she had lost precious time and her insurer had paid \$60,000 for two more rounds of conventional chemotherapy. The insurers "weren't saving any money, truly," says her doctor, Nicolae Ciobanu. "But with reform coming, insurance companies are getting much bolder about denying."

The battles over experimental care aren't limited to cancer therapies. Many cutting-edge treatments for Parkinson's disease, Lyme disease and dozens of other ailments have yet to be proven effective. With AIDS "almost everything is experimental," says David Barr of the Gay Men's Health Crisis in New York. Under Clinton's reform plan, a proposed National Health Board would determine when treatments are no longer "experimental." (Most rival reform plans aren't nearly that specific.) But many doctors bristle at the notion of bureaucrats making such calls. "I can't imagine how a government that can't decide what to pay for a toilet seat is going to get this right on a national level," says Roger Parker, senior vice president of Memorial Sloan-Kettering, which is suing Empire Blue Cross for \$12 million

over payment denied for 58 cancer patients. "We're going to keep blundering along, lawsuit by lawsuit," predicts University of Pennsylvania bioethicist Arthur Caplan. Some ethicists even joke that health reform may turn out to be a federal jobs program for attorneys.

Ironically, while HMOs and insurers routinely refuse to pay for new therapies that could save lives, most refuse to even consider "pulling the plug" on patients who are arguably already dead. Some 35,000 U.S. adults and children are living in a persistent vegetative state. A few have languished for decades, with bills running into the millions. But families, doctors and hospital ethics boards hate to consider cost when deciding those troubling end-of-life cases. Courts also frustrate efforts to terminate care. Doctors say the infant known as "Baby K" will never hear, see, feel or be conscious. Yet a federal appeals court recently ruled that Fairfax Hospital in Virginia must continue aggressive efforts to

problems. To date, her mother's HMO, Kaiser-Permanente, has paid nearly \$250,000 in medical bills without question. Dr. Nicholas Rogentine, who helps rule on bioethics for Kaiser, concedes that "society has a right to ask, in such cases, if money is being spent wisely." But he insists that society must make such ethical decisions, that the onus can't be on insurers.

If society were to rise to that challenge and try to set limits, where would we begin? Some ethicists argue that we should set an upper age limit—say, 75 or 80—on aggressive medical care. More than one quarter of all Medicare payments go to patients in their last year of life; in other words, it didn't buy them much more time. But those who claim that enormous savings can be had by denying care to the elderly are mistaken. Dr. Ezekial Emanuel, a Harvard ethicist and oncologist, points out that some 70 percent of dying patients already voluntarily forgo some treatments, and that if every American died at home or in a hospice, the nation would save only 3.3 percent of its health-care costs—or roughly \$100 a person.

Some ethicists also suggest ending heroic efforts to save premature babies weighing less than 500 grams (about 1.3 pounds). Such infants rarely survive, and a third of those who do are permanently disabled, even after spending months in neonatal ICUs at costs as high as \$2,000 a day. But for every statistic, there are heart-tugging exceptions. "I don't get this cutoff thing," says Mary Cataldo, whose daughter Rebecca was born at 490 grams after just 24 weeks in her mother's womb. Rebecca spent 3½ months on a respirator. She needed laser surgery on her eyes, which were still fused shut at birth, but she had none of the digestive, heart or brain problems that preemies often do. Today, she is a cherubic 4-year-old with no sign of developmental problems. "How small is too small, and should you mount a full-court press for every baby?" asks Dr. John Driscoll of the neonatal ICU at New York's Columbia-Presbyterian Medical Center. "Based on the data in hand, maybe we can't afford to do that. . . . But I don't think Americans are ready to be told, 'Sorry, Nobody will pay for your baby. It's too costly.'"

OTHER SUGGESTED RATIONING STANDARDS pose even trickier questions. Should smokers pay for their lung cancer—and alcoholics finance their liver problems? There is a growing consensus that raising cigarette taxes is a good way of making people more accountable for their own health problems. But how far can we push the principle? What about crack addicts and AIDS victims who don't practice safe sex, diabetics who don't watch their sugar consumption—or a president who loves french fries? Should more health-conscious Americans subsidize their medical care?

As difficult as such questions are today, they will be even harder in the future. The U.S. population is aging, and technology is constantly posing new ways to fight disease. Some innovations offer only marginal advances. But others hold enormous promise—what if gene therapy could correct the DNA of cells destined to cause cancer, Alzheimer's and other diseases? Ethicist Daniel Callahan, director of the Hastings Center, argues that this would only bring higher costs, since people would eventually die of other causes later. "Do we want to keep paying for endless progress?" he asks. "We should give much higher priority to making people comfortable than to things that save lives and cure people."

That notion runs at odds with the American spirit—and all our medical progress to date. But in a world of scarce resources, we must make fundamental decisions about what kind of medicine we want—how much "basic" care we will provide every citizen, how much we will devote to research and how much, if any, will be left over for long-odds cases like the Lakebergs. Those will be painful choices, but if we continue to hide from them, we will never make them wisely.

With DERRA ROSENBERG in Boston, SUSAN MILLER in New York, KAREN SPRINGEN in Chicago, ANDREW MURR in Los Angeles and MARY HAGER in Washington

■ ETHICS

A Sick Boy Says "Enough!"

In another case involving a child's right to die or be treated, a transplant patient refuses further help

By CHRISTINE GORMAN

IT IS AN ALMOST UNIVERSAL TRUTH THAT children who have been sick most of their lives possess a wisdom and maturity beyond their years. Benito Agrelo, 15, possesses both—and plenty of spunk to boot. When social workers arrived with five police cars and two ambulances at his Coral Springs, Florida, home, they planned to force the boy, who is dying of liver failure, to go to the hospital. But Benny, who has already undergone two liver transplants, told them he wanted to be left alone to live out whatever remained of his life in peace. The 5-ft., 2-in. teenager, who weighs just 79 lbs., kicked and screamed and even managed to knock out a windowpane with his elbow before being tied to a stretcher and loaded into an ambulance. At the hospital he refused to have a biopsy or blood tests and spurned the antirejection drugs he was offered. Finally, after four days, a judge ruled that Benny could go home, where he can sleep late if he wants to, play Nintendo with some of the neighborhood children or read a good book.

At first glance, Benny's story seems to be yet another case of a patient asserting his right to die when medicine can only prolong suffering. The twist is that Benny is still, in the eyes of the law, a child who cannot make such weighty decisions on his own. If he were in his 70s, the decision would seem like a victory: a dignified death with the consolation of a rich life fondly remembered. Benny, however, seems not only too young to die but also too young to want to.

The boy's mother has made her peace with his decision, and the Florida judge also deemed him suitably mature to make the choice. But Benny's doctors would like to buy him some more time. Perhaps, they argue, they could figure a way to vary the amount of the antirejection drugs he is taking so the side effects are not quite so miserable. There is also the possibility of yet another transplant. The chances he could

survive a year after a third operation, however, are generally considered to be less than 50%. "We proposed trying to rescue his liver," says Dr. Andreas Tzakis, head of liver transplantation at the University of Miami. "He refused." One thing is sure: as Benny loses weight, and his skin turns ever deeper shades of yellow, his chances dim with each passing day.

Born with a malfunctioning liver, Ben-



PRIORITIES: A jaundiced Benny suffers from potentially fatal liver failure, but after quitting his medication he enjoyed "the best months of my life"

ny underwent his first transplant at age 8. For five years, he took a drug called cyclosporin that prevented his body from rejecting the alien organ. When that medicine no longer worked, his doctors at Children's Hospital in Pittsburgh performed a second transplant in 1992 and started him on what was then an experimental treatment called FK506. Given his long experience, he was probably better prepared than most people for the pain and discomfort antirejection drugs can sometimes cause. He had already outlived most of the children he had met in the hospital while awaiting the initial transplant.

Eventually the side effects, which are poorly understood, proved too much. An avid reader, Benny found he could not scan a book for more than five minutes without

a blinding headache. The pain in his joints often kept him from playing with friends. Last year, after thinking about it all summer, he decided to cut back on his dosage. His mother and the rest of his family protested, but by October Benny had stopped taking any medicine at all. And for half a year he lived what he has called "the best months of my life."

Nevertheless, in the view of transplant experts, Benny had made a mistake. In some cases transplant patients can be weaned from their antirejection drugs, but it must be done under close medical supervision so doctors can intervene at the earliest sign of trouble. If Benny had bided his time, say doctors, he might have had a happier relationship with the transplanted organ. "The longer you have an organ, particularly the liver, the more it becomes a part of you, and you a part of it," says Dr.

Andrew Klein, a liver-transplant specialist at Johns Hopkins Medical School. Transplant surgeons admit they are among the most aggressive at trying to keep death at bay. "Considering the severe shortage of donor organs, I think there is a moral obligation to take care of the organ you receive as best you can," says Klein. He allows, though, that preserving an organ should not take precedence over preserving some semblance of pleasure in life.

One suspects that in Benny's case, patient and doctors failed to understand one another's priorities. Perhaps the boy felt his pain was not being taken seriously enough. Perhaps the medical team misread the young man's growing determination to choose his own fate. "Often when problems like

this arise, there's a miasma of suspicion about families and how trustworthy they are," says James Nelson, a medical ethicist at the Hastings Center in New York. Someone from the Pittsburgh team decided to call the child-abuse hot line in Florida to try to force Benny to renew treatment, and the result was the awkward standoff. "That's the most distressing part to us," says Tzakis. "We all have the feeling that Benny has slipped out from under us."

Tzakis has not given up hope that Benny may still change his mind. Several transplant recipients have volunteered to talk to the boy. But after a week spent dealing with lawyers and turning away phone calls from Nightline, PEOPLE and other national media, Benny seemed weary. "Just tell them," he said, "I want to be left alone." ■

Was Angela's life worth the \$1.3 million price tag?

Ellen Goodman

Philadelphia Inquirer

Was Angela's life worth the \$1.3 million price tag?

By ELLEN GOODMAN

On Monday, Angela Lakeberg was buried in a grave next to her sister Amy. The pair had been born 11 months ago in what was romantically and medically described as an embrace. Now they were laid to rest side by side.

By some random and rare accident of nature, they came into the world joined at the heart. By the most sophisticated medical technology available, they went out of the world in two coffins.

Ten months ago, when these so-called Siamese twins were brought to the Philadelphia operating room where one would die in an attempt to save the other, the headlines screamed the moral question: Angela or Amy? But only a story here and there noted the end of Angela and Amy.

It is tempting to try to wrest some good from this tragedy, to grasp the straw of a happy ending. It's tempting to try to find comfort in the notion that the doctors did "everything they could." They did that.

But in any public eulogy for these girls it is fair to ask when and whether doctors should do "everything they could." In the midst of a debate over health care and costs, it's fair to ask about ethical choices and their prices.

When Reitha and Kenneth Lakeberg were told that she was carrying conjoined twins, abortion was offered as a merciful choice. When the twins were born at Loyola University Hospital in Chicago, the doctors decided, after much soul-searching, not to operate.

After all, one child would die on the operating table — killed by surgery. Perhaps we shouldn't question the judgment of the surgeons today. It's easy, after the fact, after the death, to second-guess the mixture of hope and heroics that went into the decision to go for it.

In the way of American medicine, it was the doctors and the parents alone who were given the right to choose for Angela and Amy — and for the rest of us. They made the decision to spare no effort. And to spare no expense.

Money is the uncomfortable bottom line of this ethical life story. It cost more than \$1.3 million to keep the red-haired, blue-eyed Angela alive in an intensive care unit, fed by tubes, mostly attached to a respirator, for 10 months.

The bill itself is being wrangled over by three states, two hospitals, one Medicaid program. But it will come back to the public in one form or another.

We are properly reticent, understandably reluctant to put a price tag on a life. If Angela had lived, would she be worth it? Is it only because she died that the money was "wasted"? But along the treacherous path to health-care reform we're going to have to factor in costs with caring.

While the second of the Lakeberg twins was buried, Congress was in the middle of grappling with health care, trying to figure out the minimum to which every American is

*Money is the
uncomfortable bottom
line of this ethical
life story.*

entitled. But we also have to ask: What is the maximum?

What are the costs, the benefits, the odds of success for a 70-year-old man who wants a liver transplant, for a 45-year-old breast cancer patient who wants a bone marrow transplant? For conjoined twins joined at the heart?

In fact, the tale of Angela and Amy should have been one of the easier of the hard choices coming down this road. The moral discomfort that entailed sacrificing one twin to the other was towering, the odds of success were dismally low.

For once, the cry for mercy and the call for cost containment were in harmony. And yet, these twins were brought to the cutting edge. If we cannot make the relatively easy choices, how will we make the hard ones? How will we pay for them?

I am afraid that my eulogy for these girls is not very comforting. If we learned something important, it won't be found in the medical texts. It's another lesson in how hard it is to say enough is enough. Only now may two girls who shared one heart rest in peace.

Ellen Goodman is a syndicated columnist.

A Closing Thought: Living Each Day

Rabbi Abraham Twerski

Mesorah, Brooklyn, p. 115.

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From the Sages

A doctor who treats for nothing is worth nothing (Bava Kama 85a).

The Talmud teaches that “there is no free lunch.” Anything of value comes with a price tag, and if something is given away free, we should suspect that it may be worthless.

People are reluctant to accept some things as true. Today, a millennium and a half after the Talmud was written down, we still yearn to get things for free, and if not completely free, then at the least possible cost.

Nothing is wrong with bargain hunting. At the end of a season, some leftover merchandise of good quality may be put on sale, or discontinued models may be available at a fraction of their original price. Still, we must be cautious that we do not extend this penchant for bargains to areas where it can be destructive, such as relationships or other things of spiritual value.

Valuable relationships can be costly. If we are not willing to sacrifice our comfort for a relationship, but look only for friends or spouses that will demand nothing of us, the Talmud teaches that this relationship will be worth exactly what we invest in it: nothing. Likewise, if we seek spiritual goals that will come easily to us without any effort or deprivation on our part, we will achieve goals that are worth nothing.

The Talmud uses the example of free medical care to teach us that for things that are truly important, such as our health, we must be willing to bear the cost. We should apply this lesson to other items of value.

Section V Programmatic Suggestions

1. Suggestions for Implementing an Ethics Curriculum

Setting Limits

Personal Autonomy

Value of Life

Priorities

2. Some Additional Resources to Consider

Suggestions for Implementing an Ethics Curriculum

Setting Limits

Note Rabbi Mendel's article in which he says "we are forced to confront the moral issues involved with placing limits on health care in the context of a society that has traditionally thought and acted in terms that are limitless and boundless."

Note Dr. Callahan from *The Troubled Dream of Life* and the idea that limits needs to be defined in the way we view care and life, age and ability of society to respond.

This gets into the pieces on age-based rationing and us into a question of who shall decide.

Take the High Holyday Prayer: *UnetanaH Tokef* and develop a discussion/panel/socio-drama on "Who shall decide?" Should discussions on limits be decided by legislators? By doctors and lawyers (see Lieberman's paper)? By a group or committee?

Does "justice" (*tz'dakah*) mean the greatest good for the greatest number?

- Does it, in Jewish terms, really mandate that if we are just then we have a sacred responsibility to provide equal access to health care for all, and that society has the obligation to fund that? To what extent?
- Does society have the right/obligation to provide that care for those who misuse the system or abuse their own health?

What should be considered as *necessary* treatment?

- Is treating the stranger extraordinary, but you necessary?
- How do we teach limits in our society of excess? Should we?
- What's wrong with Benny (the Florida teenager who refused treatment) deciding that he wished to live out his life on his own terms? (N.B. Benny died in August, 1994.)

Personal Autonomy

What happens when *my* needs conflict with *society*? Does society have a right to subvert my needs? What are needs and how may we have to define and re-define them (see Rabbi Edelheit's article)?

Value of Life

We accept that our Jewish view of life is paramount. Yet, given some of the discussion in the articles and papers, do we see life as an infinite value, to be preserved at all costs? Or can we, due to technology, re-evaluate and put forth a more *limited* belief?

- Does this reflect how we view God?
- What is the definition of death (vs. brain death) in the context of Judaism?

How much *is* a life worth? See the article on the Lakeberg twins.

- Should the twins have been kept *alive* conjoined? Is *life itself* more important than quality of life?
- How could one twin have been sacrificed to save the other? Whose blood was *redder*? Refer to Freehof and Abraham articles.
- Who *really* pays for extraordinary interventions?

Priorities

Compare the article by Dr. Abraham and the Responsa from Dr. Freehof regarding the issue of "priorities" in treatment.

Additional Resources in Ethics and Allocation

"What do we Owe the Elderly? Allocating Social and Health Care Resources." Special supplement. *Hastings Center Report*, Vol. 24, No. 2, March-April, 1994.

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If I Were A Rich Man Could I Buy A Pancreas? Arthur Caplan. Indiana University Press, 1992.

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