

A CRITIQUE OF CALLAHAN'S UTILITARIAN APPROACH TO RESOURCE

ALLOCATION IN HEALTH CARE

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ABSTRACT: The rationale of this article is grounded in the liberal tradition. It places the individual at the center of concern, and attempts to fortify the individual's basic right to health care. Attention is focused on the writings of Daniel Callahan, arguing that his approach is too cold and detached, and that age should not serve as the decisive criterion. The criticism of his views on older patients and on patients in post-coma unawareness (PCU) stems from two different lines of reasoning: the medical and the moral-contractual. From the medical perspective, while age is an important variable in determining a patient's medical condition, there are other — no less important — factors that influence one's health. From the moral-contractual line of reasoning, liberal society should not desert its citizens at the time they need its help most. The age criterion is too simple, too general, too sweeping. It provides too convenient an answer to a tough and troubling question. Similarly, the argument with regard to PCU patients should be qualified, taking into account the age of the patient, the cause of the condition, and the length of time in state of unawareness.

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In most liberal societies, basic health is seen as one of the necessary conditions for the exercise of personal autonomy. It is generally acknowledged that individuals have a right to health care. The prevalent assumption is that this right generates an obligation or duty on the part of the state to ensure that adequate health care is made available and which further requires that equal access to available health-care is provided through public funds. The state has no obligation to provide a health-care system itself, but the state does have the obligation to ensure that such an adequate system is provided. Basic health care is now recognized as a “public good” rather than a “private good” that one is expected to buy for oneself.² The Constitution of the World Health Organization states: “The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.”³

The constraints on the financial resources allocated for care of the ill force us to consider, in an honest and serious manner, the tension between the ideal and the real. Currently, challenges to our health have medical solutions, albeit sometimes partial, that were unimaginable in the previous century. The new technology is very costly, and some

²MAX CHARLESWORTH, *BIOETHICS IN A LIBERAL SOCIETY* 108 (1993); *See also* Susan D. Goold, *Allocating Health Care: Cost-Utility Analysis, Informed Democratic Decision Making, or the Veil of Ignorance?* *J. HEALTH POLITICS, POLICY AND LAW*, Spr. 1996, at 69. For further discussion on the duties of the liberal state in maintaining the health of its citizens, *see* TROYEN A. BRENNAN, *JUST DOCTORING* (1991), especially chapters 3, 4, 8, and 9.

³Adopted by the International Health Conference held in New York from June 19 to July 22, 1946, and signed by the representatives of sixty-one States, *in* *THE UNITED NATIONS AND POPULATION: MAJOR RESOLUTIONS AND INSTRUMENTS* 204 (1974).

have claimed that saving lives is not a goal that should be achieved at any cost.⁴ Costs and benefits must be examined and priorities determined so as to invest resources only in “worthy cases.” The term “worthy cases” is often juxtaposed with the term “quality of life.”⁵ The claim is that expensive technology should be used to help patients who are likely to maintain a certain quality of life. When there is a low quality of life, it is preferable to exercise discretion as a society and to reserve our finite resources to treat patients who are more likely to lead autonomous lives.

The financial resources are obviously limited, and the national budget must be prioritized according to various needs: technology, security, education, culture, health, housing, food, transportation, science, the legal system, environmental protection, etc. The debate about how to allocate health care resources revolves around three basic concepts: duty, ability, and rights. The central questions are: Does a democratic society have a duty to provide optimal health care for each and every citizen? Can the state provide optional health care for each and every citizen? Do citizens have a right to demand such a commitment from their government?

In the liberal framework, the concept of ‘rights’ is understood in terms of a need that is perceived by those who demand it as legitimate and, therefore, the state has a real

⁴See DANIEL CALLAHAN, *THE TROUBLED DREAM OF LIFE* (1993), *WHAT KIND OF LIFE* (1990), and *SETTING LIMITS* (1987).

⁵For further reading on the quality of life concept in medical ethics, see G. A. Meeburg, *Quality of Life: A Concept Analysis*, 18 *J. NURSING* 32 (1993); Paula Boddington and Tesa Podpadec, *Measuring Quality of Life in Theory and in Practice: A Dialogue Between Philosophical and Psychological Approaches*, 6:3 *BIOETHICS* 201 (1992); HELGA KUHSE, *THE SANCTITY OF LIFE DOCTRINE IN MEDICINE: A CRITIQUE* (1987); E. W. KEYSERLINGK, *SANCTITY OF LIFE OR QUALITY OF LIFE* (Ottawa: A study written for the Law Reform Commission, Canada, 1980); and R. Cohen-Almagor & Merav Shmueli, *Can Life be Evaluated? The Jewish Halachic Approach vs. the Quality of Life Approach in Medical Ethics: A Critical View*, 21(2) *THEORETICAL MED. & BIOETHICS* 117 (Aug. 2000).

responsibility to provide health care for each and every citizen. “Rights” are primary moral entitlements for every human being.⁶ In this context one can differentiate between an individual’s rights with regard to the state or government, and an individual’s rights with regard to his or her fellow citizens. Rights, which are conceived to be legitimate, must be met by the state (*e.g.*, the right to life, to shelter, and to associate). They justify taking political actions to fulfil them. Rights regarding other individuals who act illegitimately justify the use of coercive measures against those individuals either by concerned citizens (right to self-defense or to protect one's property) or by the state.

More specifically, with regard to health, citizens have a “negative right” to not have their health impaired by the actions of the state. A democracy is expected to refrain as much as possible from taking actions that might endanger the health of its citizens. This does not mean that citizens in a democracy may demand that an army will not conscript them in a time of crisis but a democracy may be expected to take action to remove elements that are detrimental to our health. Hence, citizens have a right to demand that chemical, biological, and nuclear plants not be situated in populated areas. Citizens also have a right to demand that products that are harmful to our health be labeled properly as a precaution.⁷ The “positive right” to health care is concerned with

⁶For further discussion on the concept of rights, see RONALD DWORKIN, *TAKING RIGHTS SERIOUSLY* (1977); ROLAND J. PENNOCK & JOHN W. CHAPMAN, EDs., *HUMAN RIGHTS* (1981); L. W. SUMNER, *THE MORAL FOUNDATION OF RIGHTS* (1989); MICHAEL FREEDEN, *RIGHTS* (1991); HILLEL STEINER, *AN ESSAY ON RIGHTS* (1994); ALAN GEWIRTH, *THE COMMUNITY OF RIGHTS* (1996); ANNABEL S. BRETT, *LIBERTY, RIGHT AND NATURE* (1997); RICHARD DAGGER, *CIVIC VIRTUES* (1997); MATTHEW H. KRAMER, N. E. SIMMONDS & HILLEL STEINER, *A DEBATE OVER RIGHTS: PHILOSOPHICAL ENQUIRIES* (1998); SAMUEL WALKER, *THE RIGHTS REVOLUTION* (1998); MICHAEL J. PERRY, *THE IDEA OF HUMAN RIGHTS: FOUR INQUIRIES* (1998); and JOHN R. ROWAN, *CONFLICTS OF RIGHTS* (1999).

⁷See J. S. MILL, *UTILITARIANISM, LIBERTY, AND REPRESENTATIVE GOVERNMENT* (London: J. M. Dent. Everyman’s Ed. 1948).

providing proper treatment to overcome illnesses and other traumatic conditions that are endemic to our health. In this context, constraints that are forced upon citizens must be handled, such as scarcity and costs of resources.

Many researchers express concern regarding this ‘positive right,’ especially when medical expenses are increasing due to technological development. Those researchers claim that no society can afford to spend such large sums of money on health care. Some of the researchers raise concerns about our social responsibility *not* to cater to the needs of certain patients. These arguments are made most often with regard to patients whose quality of life is seen by these researchers as particularly low. Emphasis is placed on the high costs of care for these patients, the psychological and economic burdens on the patients’ families, and the financial constraints operating on hospitals.⁸ The focus of these researchers’ analysis shifts from the individual to society, as exemplified by John F. Kennedy’s famous remark: “Ask not what your country can do for you. Ask what you can do for your country.”

Every discussion on the allocation of resources is bound to reveal the tension between the macro and the micro, between the needs of society and the needs of the individual. The tension is inescapable, and the work of drawing the appropriate balance is delicate. Emphasizing the needs of society might inevitably result in ignoring the needs of some individuals. The questions obviously involve balancing and weighing various

⁸See Charles L. Sprung et al., *Is the Physician’s Duty to the Individual Patient or to Society?* 23 CRITICAL CARE MED. 618 (1995); Helga Kuhse, *Quality of Life and the Death of ‘Baby M,’* 6:3 BIOETHICS 233 (1992); E. Haavi Morreim, *The Impossibility and the Necessity of Quality of Life Research,* 6:3 BIOETHICS 218 (1992); Rebecca S. Dresser & John A. Robertson, *Quality of Life and Non-Treatment Decisions for Incompetent Patients: A Critique of the Orthodox Approach,* LAW, MED. & HEALTH CARE (Fall 1989), at 234.

considerations. In the liberal tradition, the starting point is the individual rather than the society. Liberals conceive shifting the emphasis from the individual to society as a very dangerous move.

Indeed, the sacrifice of the individual citizen for the good of the state is contrary to the spirit of liberalism. Liberal ideology places the individual at the center: all liberal reasoning derives from seeing the individual in the focus of analysis, and all its reasoning is aimed at the advancement and development of the individual which, in turn, results in the progress of society. This tradition evolves from the philosophical thought of John Locke (1632-1704), Thomas Paine (1737-1809), Alexis de Tocqueville (1805-1859), John Stuart Mill (1806-1873) and more contemporary, in our time, John Rawls and Ronald Dworkin. This longstanding liberal tradition places the individual, not the collective, in the center of analysis, viewing the state as a mere instrument to serve the interests of the individual. The liberal state is seen as a means of protecting society from external attacks, a framework regulating the implementation of the law for the prosperity of the citizens and a sophisticated tool to ensure individual rights.

The function of liberal democracy is to promote the prosperity of the individuals even when they are ill. Democracy has an obligation to preserve individuals' rights; namely, it recognizes that certain demands of its citizens are legitimate and should be satisfied within the framework of society. The right to life is recognized as a first priority. Some (most notably John Locke) call it a natural right, in the sense that it is the

consequence of nature, a right that precedes the state. Assuring health care to citizens is perceived as one of the basic duties of every democracy.⁹

One of the approaches dealing with the problem of allocation of scarce resources is the utilitarian, or the cost-benefit approach. Generally speaking, it seeks a policy that will bring the greatest number of advantages to the largest number of citizens. Recognizing that it is not possible to provide for the health needs of everyone, a decision is made in advance to exclude certain categories of people from receiving treatment. Treatment is equal for those who do not fall into the excluded category and for those who cannot afford more expensive medical insurance. The affluent people will find means to care for themselves and hence, this approach deals with most of society, not all of it.

The following discussion will criticize this version of the utilitarian approach. The writings of Daniel Callahan, one of the main representatives of the age-rationing approach, will be examined. He suggests that it is preferable to invest in the youth who have a better chance of recovery as well as a better chance to live longer and more quality-filled lives than older persons. Callahan sees old age as a valid criterion for limiting medical care. It will be argued that Callahan's approach is too cold and detached. Ultimately, age should not serve as the decisive criterion. Criticism of this criterion is based on two different lines of reasoning: the medical and the moral contractual. From the medical perspective, while age is an important variable in determining a patient's medical condition, there are other - no less important - factors that influence one's health. Young people who suffered a grave emotional trauma or barely survived a road accident

⁹See the writings of Locke, URL:<<http://weber.ucsd.edu/~dmckiern/locke.htm>>.

might find themselves in a much worse physical condition than an eighty year-old person who leads a healthy and active life. Age is an arbitrary concept, existing regardless of the conduct and condition of any individual. It is too simple, too general, too sweeping, providing too convenient an answer to a tough and troubling question.

From the moral-contractual perspective, democracy should not neglect its elderly citizens, at the time of their greatest need. There is an unwritten contract between the state and its citizens that should be maintained and preserved. As the state expects its citizens to contribute to its maintenance so the citizens expect their state to assist in their own maintenance. The contract is mutual, not one sided. If one resorts to the Rawlsian terminology, no person would like to think that, behind the veil of ignorance, his or her physician would decide whether it is worthwhile to sustain life on the sole criterion of age.¹⁰

Determining Boundaries for Medical Treatment:

The Place of Old Age in Society

Daniel Callahan examines the place of old age in our lives. He predicts that the shortage of resources and the growing expenses of modern medical treatment will force us to determine a limit for being deserving of and obtaining access to medical treatments. Callahan opposes the idea that life must be prolonged as much as possible. He suggests accepting old age as a part of life and not as an obstacle or a medical challenge to be overcome. In his opinion, limits must be placed on governmental expenditures on

¹⁰For further deliberation on the contractarian approach, see JOHN RAWLS, A THEORY OF JUSTICE (1971), and POLITICAL LIBERALISM (1993).

healthcare. He addressed his book *Setting Limits* to people of his own age group and invited them to ponder his ideas on allocation of scarce resources in healthcare, aiming to change their thinking and expectations about old age and death.¹¹ Callahan suggests the concept of a “full biographical life span,” meaning the point at which it can be said that a person has lived a complete, fulfilling, whole life. He does not determine a specific age but suggests a range — late seventies, early eighties, which in his opinion is equivalent to a natural, complete life cycle.¹² Callahan claims that today medical technology can extend life beyond the point that he believes is sensible and worthwhile. He deliberates what can be done to avoid such a result.¹³

Callahan does not clearly locate the point after which life stops being worthwhile, nor does he say how that point can be determined, nor by whom. However, according to his perspective, not all life is worthwhile. Callahan thinks that there exists an objective scale of worthwhile life, and that it is possible to determine when other people’s lives cease to be worthwhile. Callahan makes gross generalizations about scales which, in his opinion, should convince any logical individual of their veracity. For Callahan, age is such an objective scale.

Callahan’s statements must be placed within a given historical context. The average life expectancy in western countries is not static. People live many more years today than in the past. The health system is improving, the ability to cope with many

¹¹CALLAHAN, *SETTING LIMITS*, *supra* note 4, at 10.

¹²CALLAHAN, *WHAT KIND OF LIFE*, *supra* note 4, at 152.

¹³CALLAHAN, *THE TROUBLED DREAM OF LIFE*, *supra* note 4, at 37.

formerly incurable illnesses has increased. Awareness of hygiene and cleanliness is much higher than it was a century ago. Let us examine, for example, the effect that the introduction of western medicine had on the occupied territories after the 1967 Six Day War. In 1967, the average life expectancy for inhabitants of the territories was 48 years. By the 1980s, the average life expectancy had risen to 62 years, and the figure is still rising.¹⁴ There are various places world wide that demonstrate similar results due to increased awareness of cleanliness and hygiene and the introduction of modern western medicine. In Canada, the life expectancy of women rose from 70.9 years in 1951 to 81 in 1991. In the same period, men's life expectancy rose from 66.4 to 74.6 years.¹⁵

Had Callahan written his book in the 1950s, he might have set the critical age at sixty. Perhaps in the twenty-first century, the life expectancy will be higher, and then Callahan's assumption will seem outdated. The age criterion, therefore, cannot be applied without regard to technology and without regard to the question of whether we can afford the expensive technology. It is impossible to assert categorically that upon reaching a fixed age people would think that they had completed their life span. Furthermore, as technology progresses, the purchase price of advanced medical equipment falls. In the twenty-first century it may be possible to provide treatment, which is today considered costly and sophisticated, to a larger number of people at a lower cost. In other words, Callahan's claims are dependent on time and place. Even according to his own reasoning, we should not accept his assumptions as axioms that are always valid, or as arguments

¹⁴JUDEA, SAMARIA AND THE GAZA DISTRICT SINCE 1967 (Jerusalem: Israel Information Center, 1986).

that should be applicable even in the next decade. His views developed in a certain historical context, and at best they might be correct for the period in which they were written.

Callahan further claims that we need to set priorities in light of certain financial limitations. Society must determine its most urgent needs and set boundaries on the economic possibilities that progress has made possible. If, for example, a society decided it could not afford artificial hearts for patients over the age of ninety, the decision is an outcome of priorities stating that the health system's primary purpose is to enable the young to grow old.¹⁶ Another example provided by Callahan is that of bypass operations for patients aged eighty and over. In his opinion, such an operation poses a new problem, both ethically and financially. Callahan asks: even if we agree that each person should have access to a decent level of health care, does this mean that the government must provide at tax payer's expense every technological development that science may bring, at any cost? Callahan's answers this question, which to him seems purely rhetorical, negatively.¹⁷

Callahan does *not* merely say that if we have two patients in exactly the same medical condition, one is eighty years-old, the other is thirty years-old, and only one scarce resource (say, a bed in ICU), then we should give priority to the young over the old. This is a plausible suggestion. If other things being equal, we should give precedence

¹⁵David C. Naylor, Catherine Fooks & J. Ivan Williams, *Canadian Medicare: Prognosis Guarded*, CANADIAN MED. ASS'N J. (Aug. 1, 1995), at 285, 286.

¹⁶CALLAHAN, THE TROUBLED DREAM OF LIFE, *supra* note 4, at 214.

¹⁷*Id.* at 213. Discussion with Dan Callahan, the Hastings Center (Mar. 18, 1999).

to the person who has longer prospect of living. Callahan's line of reasoning is far more general, arbitrary and sweeping, speaking of age as a crude single criterion upon which we decide on priorities in allocation of resources in health care, no matter what are the medical conditions of the patients in concern. There are eighty-year-old patients whose physical and mental functioning is excellent and a bypass operation could give them new life. Their body only needs a valve replacement to renew their vigor. On the other hand, there are forty-year-olds whose physical condition is so run down that neither a bypass operation nor a heart transplant would be sufficient to restore their health. The age criterion alone should not be the main consideration in the decision whether to transplant or repair a heart. The criteria of the patients' condition, the chances for the operation's success, and the chance to live as normal a life as possible after the treatment are more important.

A series of studies regarding intensive-care patients shows that the severity of the illness, not the patient's age, is the main criterion for predicting the chances of recovery. Other studies that analyze age as a factor in forecasting chances of recovery or death found that the predictive power of this variable was minimal.¹⁸ I agree that in cases where age is the single differentiating factor, unique or costly treatment should be provided to the patient with the longer life expectancy. The problem is that Callahan does

¹⁸Cf. Lakshmipathi Chelluri, Ake Grenvik & Myrna Silverman, *Intensive Care for Critically Ill Elderly: Mortality, Costs, and Quality of Life*, 155 ARCHIVES INT'L MED. 1013, 1014-16 (1995).

not make any reference to such issues: for him the age criterion seems to play the role of trump card.¹⁹

Moreover, reading Callahan's writings evokes the feeling that technological progress, as such, troubles him. In *What Kind of Life*, Callahan claims that there is a major contradiction between the desire of the public to keep prices under control and the desire to improve their access to technologically advanced treatments. There are contradictions in our knowledge and behavior. We cannot have things both ways: progressing in medicine and at the same time restraining our budget. According to Callahan, advanced technologies should have a low priority in the comprehensive medical insurance plan in a reality where resources are scarce. Callahan rebukes those who believe in a right to die with dignity when he points out that people speak of the right to die with dignity, while simultaneously enlarging budgets that seek cures for death-causing ailments.²⁰

Callahan believes that ideas concerning prolongation of life, stopping the process of aging, and conquering death are neither possible nor defensible. These are false causes, which divert medicine from its true purpose of defeating illness, rehabilitating, and improving human health. We ought to recognize our limitations: instead of attempting to stop the aging process and thinking that old age can be changed into a permanent midlife

¹⁹The Swedish Support and Services Act that went into effect on January 1, 1994, is equally problematic. It is an entitling Act, implying positive discrimination in favor of persons with severe functional impairments. Its aim is to facilitate full participation in the life of the community of certain functionally impaired categories and, accordingly, equality. It does not apply, however, to persons over the age of 65. *Final Report from the Swedish Parliamentary Priorities Commission, in 5 PRIORITIES IN HEALTH CARE 16* (Stockholm: Swedish Government Official Reports, 1995).

²⁰CALLAHAN, WHAT KIND OF LIFE, *supra* note 4, at 78-79.

stage, we must recognize that old age is an inevitable stage in life. Callahan claims that even if we had unlimited resources at our disposal, it would still be wiser to set boundaries.²¹ Because old age and death are inevitable, there should not be an unlimited demand to fight them and to harness national resources for this mission.

Callahan adopts a collective posture, whereby an older person's place in society is a group issue, not a personal one.²² He justifies his position by asserting that "policy must do that."²³ Individualism should make way for the social, group idea, along with the recognition that we live in a reality of limited resources. The concept of autonomy, which lies at the heart of liberal ideology, does not receive due reference in Callahan's books. Moreover, the matter of reward is totally neglected. Callahan refrains from pondering the moral question of neglecting those who have contributed to society for many years. His calculation is utilitarian. His goal is to maximize the benefits, by reallocating resources to the younger populations. My deontological criticism of Callahan's view focuses on his referring to sacrificing the older population as a means to achieving greater social happiness and prosperity, rather than as an end in itself. He is prepared to sacrifice the older population for the younger. This approach of cost efficiency largely excludes moral considerations. It is an efficient method insofar as it

²¹CALLAHAN, SETTING LIMITS, *supra* note 4, at 116.

²²*Id.* at 32.

²³In his comments on a draft of this article.

reduces funds spent on medical care, but it is not a just method. Older people need and deserve more care, not abandonment.²⁴

In a recent discussion with Callahan about this article, he explained that his train of thought is totally different from the thinking in this article. Callahan does not see his policy as one that sacrifices the older population or abandoning them. For him, older persons in his term “won the game” by reaching an old age. The young have an obligation to allow the old a decent life; but at the same time, the old have an obligation not to pose excessive obligations on the healthcare system. Callahan draws an analogy between elderly people and marathon runners. Older people have finished the marathon and, in this respect, they are far better off in comparison with those who had to retire from the marathon at an early stage. We should allocate our resources in a way that would enable other people to start the race. According to Callahan, the fact of chief importance is that the 80 year-old reached this ripe old age. Other people should be helped to reach the same age.²⁵ The crude result of Callahan’s policy is sacrificing some individuals for the common good, in accordance with the single criterion of age. In his view, people must accept some form of rationing, and once people accept this rationing some people will not get what they need.²⁶

²⁴For further criticism, see Shimon Glick, *Rationing and Priority Setting: Discussion*, in PETER ALLEBECK & BENGT JANSSON, EDS., *ETHICS IN MEDICINE* 77-87 (1990); and R. W. Hunt, *A Critique of Using Age to Ration Health Care*, 19 *J. MED. ETHICS* 19 (1993).

²⁵Discussion with Dan Callahan, the Hastings Center (Mar. 18, 1999).

²⁶Interestingly, while discussing this article, Callahan described himself as a communitarian when explaining the ideology underpinning his arguments. I said that his position sounded more like utilitarianism. Callahan was not happy with the description but after some thought he conceded that it was

In other words: patients should be considered as individuals, regardless of their age. It is unjust to sacrifice individuals in the name of a predicted general benefit simply because they are old. Individuals must be considered as an end in and of themselves and should be accorded equal care to satisfy their needs and interests. Age should not serve as the sole utilitarian index when society makes decisions about life and death.²⁷ Other important considerations exist, such as the patient's quality of life, his or her wishes, efficiency of care for the patient, his or her chances of recovery, and perhaps economic considerations such as the cost of treatment. Using age as the main variable of reference in medical decisions constitutes a utilitarian policy that ultimately is amoral.²⁸

The problem with Callahan's position is that we, as people, are not merely logical and calculating creatures. People are also beings who act on sensations, instincts, and feelings, which do not always agree with cold rationalism. Often people knowingly act on the basis of irrational arguments. Many people take the liberty to express emotional experience socially, knowing that these emotional experiences contradict logical thought, and still these people prefer to give themselves that freedom. People enter into holy

unavoidable to be utilitarian if you involve yourself in policy matters. Discussion with Dan Callahan, the Hastings Center (Mar. 18, 1999).

²⁷I do not claim that utilitarianism in itself is immoral. In certain circumstances utilitarianism could have moral consequences. In this particular matter I think that utilitarian results might be immoral. For further discussion, *see* NORMAN DANIELS, *JUST HEALTH CARE* (1988); and SHELLY KAGAN, *THE LIMITS OF MORALITY* (1989).

²⁸In 1994, during my first visit to the Hastings Center, I had some additional conversations with Callahan. In one of them I asked him whether he would have chosen the same assertive opinion if he had been dealing with his own parents. His reply was that it did not matter what the thoughts of Dan Callahan the person were, only the thoughts of Dan Callahan the citizen. The state cannot fulfil the wants of all. Its reasoning must be rational, not emotional, and therefore we require a calculated examination of the priorities in medicine. In 1999, Callahan reiterated the same line of reasoning while conceding that "I am not young any more." Callahan, however, has private insurance and hence will not suffer the consequences of his suggested policy.

matrimony because they are in love, sometimes despite recognizing that they have very little in common.²⁹ People wish to help their fellow humans not for utilitarian reasons but because they want to treat people as valuable ends, in and of themselves as human beings who are worthy of respect and deserving of human concern. John Stuart Mill's well-known example of a man who wishes to cross a bridge without knowing that it is unsafe is pertinent. Mill states:

If either a public officer or anyone else saw a person attempting to cross a bridge which had been ascertained to be unsafe, and there were no time to warn him of his danger, they might seize him and turn him back, without any real infringement of his liberty; for liberty consists of doing what one desires, and he does not desire to fall into the river.³⁰

The idea here is that when all people treat their fellow human beings with respect and concern, all of society is better off. But under no circumstances should society be put before the individual, nor, in the name of an amorphous body called 'society,' basic rights of any particular sector be denied. Callahan's way of thinking might be appropriate in a world based on narrow financial considerations, utilitarian considerations, and rational computerised brains. However, this way of thinking seems too cold, detached and impersonal.

²⁹*Cf.* R. COHEN-ALMAGOR, *THE BOUNDARIES OF LIBERTY AND TOLERANCE*, ch. 1 (1994).

Morals, emotions as well as pure reasoning may lead society to think that society must care for the older people of today. One should consider their contribution to society in the past and remember that today's midlife generation is tomorrow's elderly community. To suggest that the state should help only those who can still help the state amounts to gross utilitarianism. According to Callahan, as long as the citizen can contribute, participate in social activities, pay taxes, serve in the army when summoned and fulfil civic responsibilities, the state must provide him or her with medical aid. But when citizens reach old age their costs grow, and since in the pre-technological era they would have died anyway, Callahan asks us to think in a way that is devoid of context. He asks us to make-believe that we do not have the medical means to save older people — so society should let them die. Precisely when older people need help most, the state's decision-makers are supposed to give up on them and apologetically deny them access to costly treatments that could preserve their lives. In contrast to Callahan's view, the liberal state must not desert its citizens at the time and place where they need help more than ever. This follows the tradition of liberal thought, which should serve as a guide. The liberal state is founded on the principles of respect for others and not harming others. These principles must not be deserted when dealing with older persons.³¹

³⁰J. S. MILL, UTILITARIANISM, LIBERTY, AND REPRESENTATIVE GOVERNMENT, *supra* note 7, at 151-52.

³¹This is especially true in the state of Israel, where the citizens carry an unusually heavy burden. Besides the burden of taxes, which is one of the heaviest among democracies, Israel is under constant security pressures. Since the establishment of the state, Israel has been through six wars, a Palestinian uprising that lasted more than five years (1987-1993), the Gulf War (1991), and a Palestinian guerilla warfare that is now lasting for over a year (2000-2001) and still we see no end to it. The majority of the adult citizens were obliged at one stage or another to risk their lives for the state. Israeli leaders repeatedly stress their commitment to the state's soldiers, emphasizing that the state stands behind its soldiers for better and for worse. Soldiers are not deserted if their health has been damaged during service. While it is

Thinking in utilitarian terms, there are important tasks to which the state allocates considerable resources yet no one challenges the priority that the state has assigned to each task. The state of Israel allocates considerable resources to the cause of bringing home its prisoners of war. It is difficult to measure and calculate the efforts dedicated to the location of the navigator Ron Arad who disappeared during the Lebanon War (1982-1985). Still, justly, no one has stood up and said that it would be better to put an end to the efforts and to consider more worthy causes for those resources. Liberal countries devote considerable resources to ensure a fair trial for those suspected of felonies, and no one questions the set of priorities applied in this case. I have not heard of a Callahan utilitarian equivalent in the area of law, wondering about decisions made by a jury and claiming that the maintenance of juries is too costly for the taxpayer. The cost per year of the Simpson trial alone was estimated at \$9 million.³² Even so, no voices were heard claiming that it would be better to find a different trial method for financial considerations. The liberal state takes these stands because the right to a fair trial is seen as a basic one that must be preserved despite the cost.³³ At the root of this policy are the principles of not harming others and respecting others. The liberal state concerns itself with issues such as caring for POWs and maintaining a fair judicial system because any

clear that soldiers must not be deserted in the present, would it be acceptable to abandon those who served their country as fighters, loyal law-abiding citizens who paid taxes throughout their lives, but who now wish the country to help them at their moment of need?

³²*Simpson trial cost more than \$9 million, county report says*, L.A. TIMES, Dec. 2, 1995, Metro, Part B, at 2.

³³Capitalists would say that the judicial system must be controlled by the state, while the health system could be held in private hands. I, on the other hand, do not see a replacement for the involvement of the state in medical affairs when individuals cannot pay for costly treatments. Furthermore, most people cannot pay for expensive transplant operations with personal funds, but only via private medical insurance.

other form of behavior would mean neglecting these principles. The state's obligation to ensure citizens' right to live in dignity is no less important than its commitment to its POWs and the promise of the right to a fair trial. Rights do not expire when citizens reach a certain age.

Patients in Post-Coma Unawareness (PCU)

Reading Callahan's writings, one cannot avoid suspecting that he selects the older community as a means of saving resources because of their weak position in society. Older people no longer contribute to society, are not efficient, are often neglected, and sometimes constitute a burden on their families. It is easy to justify budget cuts pertaining to this segment of society. This same train of cold and assertive thought guides Callahan's consideration of PCU (termed unethically "persistent vegetative state"³⁴ (PVS)) patients. In the context of his discussion of the term "futile treatment," Callahan writes that the phrase should be explained in two ways: nothing positive will result from the treatment, and because of limited resources, the treatment is economically unjustifiable. Therefore, continues Callahan, we must reach a general social agreement concerning PCU patients and the right of doctors to deny treatment for such patients.³⁵ A social agreement should also be reached on the kinds of medical treatment that are to be considered useless for patients who are going to die of chronic disease or slow

It is possible that in a short time, however, we will hear voices in the capitalist world calling for the privatization of the court system as well, out of materialistic-utilitarian considerations.

³⁴I explained why I think the term PVS is unethical in *Language and Reality at the End of Life*, 28 J. LAW, MED. & ETHICS 267 (2000).

degeneration. Cranford and Smith would likely agree with Callahan.³⁶

One of the most difficult populations to deal with in medicine is that of unconscious, brain-damaged patients. In this state of prolonged unawareness patients are in need of committed, ongoing care that is very costly. PCU patients show no signs of communication with their environment. They are able to maintain this state for months and even years. With reference to these patients, Callahan focuses on the consideration of costs, and for this he is willing to sacrifice the liberal principles of not harming others and respecting others. Callahan has not paid enough attention to the social ramifications (beyond the financial ones) of his sweeping suggestions. His ideas suggest one end for all patients in a state of unconsciousness, no matter how long they have been in this state or what their chances are for some improvement in their condition. Some of these patients, who have a chance of returning to some form of life, would lose that chance altogether.³⁷ These patients, who need more devoted care than patients in other categories, would be deserted completely if society followed Callahan's reasoning, because in his opinion treating them is useless. Callahan believes this even though in quite a few cases there is a chance for rehabilitation. As I have shown elsewhere, the relevant criteria to evaluate the medical condition of PCU patients are the age of the patient, the cause of his or her condition, and the length of the period of unawareness. As a policy, I urged hospitals not to cease treatment of post-traumatic PCU patients younger than 50 years-old within a

³⁵*Cf.* CALLAHAN, THE TROUBLED DREAM OF LIFE, *supra* note 4, at 216.

³⁶Ronald E. Cranford & David Randolph Smith, *Consciousness: The Most Critical Moral (Constitutional) Standard for Human Personhood*, 13 AM. J. L. & MED. 233, 233-34 (1987).

period of less than two years. The two-year waiting period should be regarded as the minimum period of evaluation before forgoing hopes for patients' rehabilitation and return to some form of cognition. I provided data and human stories from the Israeli experience to substantiate this argument.³⁸

As stated, without qualification, Callahan's attitude condemns all PCU patients to death, no matter at what stage of unawareness. Thousands of lives will be terminated every year if we adopt Callahan's argument because we could not afford to maintain them.³⁹ A considerable number of this weak, tragic population of patients might have a chance of regaining consciousness and returning to normal living. For many of them, the statement that "no benefit whatever can be achieved from treatment" is simply false. No communal obligation exists in Callahan's society. No sense of sharing and of giving to those who require need most. They are deserted because their treatment seems 'futile' to Callahan. Maybe not all of these forms of life will be appreciated by Callahan, but some

³⁷Cf. *A Letter from Dr. Keith Andrews, House of Lords, Select Committee on Medical Ethics, session 1993-1994, Vol. III, Minutes of Oral Evidence*, London: HMSO, 1994, at 221-24.

³⁸R. Cohen-Almagor, *Some Observations on Post-Coma Unawareness Patients and on Other Forms of Unconscious Patients: Policy Proposals*, 16 *MED. & LAW* 451 (1997). For further discussion on PCU patients, see Sheila A. M. McLean, *Legal and Ethical Aspects of the Vegetative State*, 52 *J. CLINICAL PATHOLOGY* ____ (1999); Paolo Cattorini & Massimo Reichlin, *Persistent Vegetative State — A Presumption to Treat*, 18 *THEORETICAL MED.* ____ (1997); Keith Andrews, *Vegetative State — Background and Ethics*, 90 *J. ROYAL SOC'Y MED.* ____ (1997); HARVEY S. LEVIN & ARTHUR L. BENTON, EDS., *CATASTROPHIC BRAIN INJURY* (1996); S. L. Wilson et al., *Constructing Arousal Profiles for Vegetative State Patients — a Preliminary Report*, 10 *BRAIN INJURY* ____ (1996); Chris Borthwick, *The Permanent Vegetative State: Ethical Crux, Medical Fiction?* 12 *ISSUES IN LAW & MED.* 167 (1996); BRITISH MEDICAL ASSOCIATION, *GUIDELINES ON TREATMENT DECISIONS FOR PATIENTS IN PERSISTENT VEGETATIVE STATE* (1996); Concezione Tommasino, *Coma and Vegetative State Are Not Interchangeable Terms*, 83 *ANESTHESIOLOGY* ____ (1995); Z. Groswasser & L. Sazbon, *Outcome in 134 Patients with Prolonged Posttraumatic Unawareness*, 72 *J. NEUROSURGERY* ____ (1990).

³⁹Estimates about the number of patients in PCU in the United States alone range from 10,000 to 25,000. See Adam Zeman, *Persistent Vegetative State*, 350 *LANCET* 797 (1997); See also T. C. Britton,

of those patients may prefer to continue living. Callahan wants to cut their thread of life because it is too expensive. Again, prescribing a detailed criteria and qualified arguments in dealing with these patients is sacrificed for the sake of making a clear, simple, simplified policy. However, when dealing with life and death issues, what is required is careful analysis and not sweeping generalizations that would condemn weak segments of society to crude reality of unfair and unjust treatment, or to lack of treatment altogether.

Conclusion

This essay does not claim that the state should assume the task of supporting all life as such. Patients suffering from irreversible brain-stem injury need not be sustained. Patients who specifically ask to die because of the critical disease that has deprived them of their desire to live should not be kept alive against their will.⁴⁰ It is appropriate to recognize the autonomy of patients to determine their destiny, and the state should not implement inclusive paternalism against the better judgment of the patients. Nor should the state invest scarce resources in supporting life in cases where medical experience shows slight chances of improvement, and the disease is defined as irreversible and incurable. For example, it is pointless to invest in costly chemotherapy for a cancer patient in the last stages of the illness, when it is known that such patients do not gain from these treatments nor does their condition improve. There is not much sense to treat the gangrene in the leg or to perform an amputation on a cancer patient if the patient is

Persistent Vegetative State, 350 LANCET 1324 (1997); Jack Colover, *Persistent Vegetative State*, 350 LANCET 1324 (1997).

likely to die from the cancer in a few days. It is also futile to provide a radical treatment whose side-effects outweigh the good emerging from the treatment. If the side effects are too severe, the patient is better off without this treatment altogether. Furthermore, it might be senseless to treat a disease when the patient is suffering from another life-threatening disease.⁴¹

Recently, members of the Council on Ethical and Judicial Affairs sensibly recommended a fair process approach for determining and subsequently withholding or withdrawing, what is felt to be futile care. The fair process approach insists on giving priority to patient or proxy assessments of worthwhile outcome, accommodating community and institutional standards, and the perspectives offered by the quantitative, functional, and interest approaches that involved parties may bring.⁴²

An important pertinent question concerns the role of physician, whether or not a physician has an obligation to be loyal to a single patient, even if this loyalty results in the allocation of large resources; or should a physician be aware that he or she acts in a social framework, that he or she must be loyal to society at large, and therefore must

⁴⁰See R. Cohen-Almagor, *Reflections on the Intriguing Issue of the Right to Die in Dignity*, 29 ISRAEL L. REV. 677 (1995).

⁴¹For discussion on the concept of futile treatment, see SUSAN B. RUBIN, *WHEN DOCTORS SAY NO: THE BATTLEGROUND OF MEDICAL FUTILITY* (1998); Lance K. Stell, *Real Futility: Historical Beginnings and Continuing Debate About Futile Treatment*, 56 N.C. MED. J. ____ (1995); LAWRENCE J. SCHNEIDERMAN & NANCY S. JECKER, *WRONG MEDICINE* (1995); Lawrence J. Schneiderman & Nancy S. Jecker, *Is the Treatment Beneficial, Experimental, or Futile?* CAMBRIDGE Q. HEALTHCARE ETHICS, Spr. 1996, at ____; Glenn G. Griener, *The Physician's Authority to Withhold Futile Treatment*, 20 J. MED. & PHIL. ____ (1995); John D. Lantos, *Futility Assessments and the Doctor-Patient Relationship*, ____ J. AM. GERIATRICS SOC., Aug. 1994, at ____; Robert D. Truog, Allan S. Brett & Joel Frader, *The Problem with Futility*, 326 NEW ENG. J. MED. ____ (1992).

⁴²Council on Ethical and Judicial Affairs, American Medical Association, *Medical Futility in End-of-Life Care*, 281 JAMA 938 (1999).

function in accordance with more general considerations that limit his or her responsibility to the patients. Between personal accountability and inclusive social accountability there is constant tension. In agreement with Steinberg,⁴³ I think that the physician carries the duty of properly considering the diagnostic tests, of responsibly and wisely choosing the treatment methods, and of acting in the best interest of the patient.⁴⁴ The classic codes of medicine, beginning with the Hippocratic Oath, place the patient at the center and demand the best for him or her. With this in mind, it is possible to foster the good of the patient on the basis of the medical norms that are accepted by all of society. The ideal situation would be for the clinical agent to represent the patient in good faith, without dealing with problems of allocation of resources, and the general policy makers should decide the possible frameworks for care on the basis of what society considers acceptable.

⁴³*Cf.* Avraham Steinberg, *Limited Resources in Medicine — Moral Principles*, 112 MED. 512, 515 (Hebrew 1987).

⁴⁴*Cf. id.*