

Now, in fact this line of argument amounts to abandoning originalism—first because it picks and chooses among the historical views of the Framers, taking some seriously while rejecting others, but second because it seeks a general intention, an overarching idea that is largely independent of the historical minutiae. How do we determine the general intention of a provision? The best evidence, it seems, is in the language of the provision itself, understood in such a way as to yield a plausible general principle. We reconstruct the Framers' general intention, that is, by finding the most reasonable reading of their language we can; but at this point originalism has simply become non-originalism, and the debate is over. For now we see that even the originalist must interpret ambiguous constitutional language in such a way that it seems most reasonable.

Most reasonable to whom? Isn't this simply smuggling in the judge's own values? A first reply to this ultimate objection is that the alternative to the judge interpreting vague language according to his or her own standards of what is most reasonable is the judge interpreting vague language according to his or her own standards of what is *less* reasonable—and that seems merely perverse.

A more satisfactory reply is that it is indeed wrong for judges simply to cite some value as though it were an authority like a statute or prior case: that would be usurpation. Rather, a judge shows that a principle is reasonable by reasoning to it rather than from it—by argument rather than by fiat.

Can values be established by argument, by reason? Well, we do argue with others about questions of value, and sometimes we even persuade or are persuaded. That suggests that the answer is yes. Some, however, including Judge Bork, deny that values are susceptible to reasoned discourse. In his best-known work of constitutional theory, Bork wrote: "There is no principled way to decide that one man's gratification is more worthy than another's or that one form of gratification is more worthy than another. . . . [T]he judge has no basis other than his own values upon which to set aside the community judgment embodied in the statute. That, by definition, is an inadequate basis for judicial supremacy."

Can value-judgments be the conclusions of reasoned arguments, or are they simply expressions of "gratification," the brute fact that one thing pleases me and another does not? This is the oldest, and perhaps still most unsettled, question of moral philosophy. It is a surprising yet reassuring fact that the issue of judicial activism, on its surface an intensely practical matter of public concern, may ultimately turn on this subtle and disturbing question of moral theory. Surprising, because we do not often expect that theory will matter so much; reassuring, because it convinces us that even apart from its undeniably crucial political aspect, the public debate over judicial activism turns on a matter of perennial importance.

—David Luban

Excluding the Elderly: A Reply to Callahan

Setting Limits: Medical Goals in an Aging Society (New York: Simon and Schuster, 1987) is the latest word on how to treat the problem of geriatric care for growing ranks of older Americans. In this thought-provoking and ambitious book, Daniel Callahan defends a proposal to disenfranchise the elderly from government support for life-extending medical services once they have reached a natural life span. The proposal includes two key components: first, persons who have attained a natural life span are not entitled to receive government-financed life-extending medical treatment; second, once a natural life span is reached, government should only pay for medical care devoted exclusively to improving quality of life by relieving pain and suffering.

The springboard for Callahan's discussion is an indictment of contemporary culture, which he thinks fails to furnish a true picture of the meaning and

significance of old age and death. Some, the "modernizers of old age," believe that the physical processes of aging should be aggressively resisted and that the aged ought to remain actively involved in life and persistently struggle against decay and demise. This group is galvanized by the medical profession and the impressive biomedical technology it flaunts. A closely aligned group, the "anti-ageists," deplore the ageism of social policies that exclude the old. Demanding "age equity," they aim to remove the social and political obstacles to carrying out the modernizers' mission.

According to Callahan, both modernizers and anti-ageists are motivated by an idealized picture, which casts old age as "a kind of endless middle age." This suggests to Callahan that their goal is not modernizing old age but banishing it and in the process dismissing the important questions we as a society need to address: e.g., what is the significance of old age? what

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is the proper place of death in old age? Despite the efforts of the modernizers and anti-ageists, however, most cultures, including our own, manifest the belief that "death at the end of a long and full life is not an evil, that indeed there is something fitting and orderly about it." This points, Callahan thinks, to a "perennial human need to find a way of envisioning the fullness of a life and an acceptable conclusion to that life."

The first bold move Callahan makes in developing this cultural insight is to refurbish and refine the ideas of a natural life span and a tolerable death. On Callahan's definition, a tolerable death occurs at that stage in a life span when one has experienced the possibilities life affords (or more life will not enable one to do so), one has met or had ample time to meet moral obligations to dependent family members, and one's death will not involve great suffering or tempt others to despair and rage at the finitude of human existence. Correspondingly, a natural life span is a span of life in which life's possibilities have on the whole been achieved and after which death may be understood as a sad, but nonetheless relatively acceptable event. Callahan maintains that by the age of sixty-five most of us will have lived a natural life span and certainly we will have done so by our late seventies or early eighties.

Callahan next advances an argument that government should desist from financing life-extending medical services for elderly persons who have achieved

a natural life span. The argument begins by defining the relationship between a natural life span and a tolerable death: if a person has lived a natural life span then that person's death would be tolerable. If a person's death would be tolerable, this suggests that letting death occur—e.g., by denying Medicare support for life-extending medical treatment—is tolerable, too. Since persons attain a natural life span somewhere between their mid-sixties and early eighties, it is tolerable for government to refuse to pay for life-extending medical treatment for the elderly: old people are not entitled to receive reimbursement from government for any medical intervention, technology, procedure, or medication whose ordinary effect is to forestall the moment of death. A denial of Medicare coverage will be acceptable once "a full-scale change in habits, thinking and attitudes" takes place—i.e., once a social consensus about natural life span and tolerable death is brought to the fore. A consensus like this would have obvious advantages in the current context of an aging society and an economic downturn. It is important to note, however, that Callahan's argument presupposes that even if the current context were different and resources were abundant, it would still be unwise for us to provide the elderly with life-extending medical care beyond the point of a natural life span.

As it stands, Callahan's argument for age rationing does not rule out the possibility of allowing people to use their own resources to purchase life-extending

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medical treatment. His position is rather that old people are not *entitled* to life-extending medical care, not that it is wrong for them to get such care. The point here is that government can legitimately refrain from financing such treatment. In other words, Medicare and Medicaid policies that exclude the elderly from life-extending medical care are morally tolerable.

There are a number of reasons for doubting the

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soundness of this argument. These reasons concern the practical implications of the approach. In all fairness to Callahan, it should be pointed out that he regards the practical details and implications of his proposal to be read in the "tentative vein in which written," to be "taken seriously not literally." Still, it is precisely here that the cogency of his principles can be evaluated. It is here that they must bear fruit.

Let us imagine, then, that a cultural agreement of the sort Callahan envisions has been realized. Suppose Sue is a widow who enjoys good physical health and is mentally alert. She takes tremendous pleasure in a painting hobby, in visits from great-grandchildren, and in watching afternoon television shows. Suppose further that Sue is eighty-two and that she depends upon Medicare and Medicaid to cover her health expenses. On Callahan's proposal for age rationing, if Sue suffers a cardiac arrest, then the fact that she has had a long life history should militate against government financing of rescue measures designed to extend her life—e.g., cardiac pulmonary resuscitation, coronary bypass surgery to replace clogged arteries, or various medications.

It is useful to imagine as vividly as possible what implementing Callahan's proposal would involve. Suppose Sue's attack begins while she is at home. Sue calls an ambulance because she thinks her chest pains may be warning signs of a heart attack. After arriving at a hospital emergency room, Sue completes forms asking about her medical history, her age, and her insurance carrier. Shortly afterwards, she experiences shortness of breath and sharp pains in her chest; she murmurs, "Don't let me die!" and then passes out. The attending physician immediately picks up her chart, sees that she is eighty-two and dependent on Medicare, and decides to conform with hospital policy prohibiting life-extending treatment for indigent patients who are no longer eligible for Medicare reimbursement—having lived beyond, say, age seventy-five.

Is the reasoning supporting this policy sound? I do

not think it is. Sue is entitled to receive government-financed life-extending medical care despite her age. A number of considerations inform this judgment: (1) Sue's life is good, (2) people inevitably disagree about when an individual should be allowed to die or be kept alive, and (3) Sue prefers to live. Moreover, (4) the means to keep Sue alive are ready at hand and are neither extravagant nor especially costly nor in short supply. Let us review each of these considerations in turn.

(1) A first objection to Callahan's proposal is that whenever the lives of elderly persons are enjoyable this is a reason to make life-extending treatment available to them. If someone has lived a natural life span then that person's death *may* be tolerable, but it is not *necessarily* tolerable. Whether a person's death is tolerable also depends upon what quality of life that person can expect in the future. Even though Sue has reached a natural life span, allowing her death by refusing to pay for the treatment she needs is intolerable, in part because Sue is not decrepit or mentally incompetent. Her life has not lost its dignity or pleasure. Arguably, it is permissible for government to refrain from Medicare support for life-extending treatment when quality of life falls below a certain minimal level. However, a large portion of the elderly population enjoys relatively good health and a fairly high quality of life. A government policy of denying these people Medicare support for life-extending medical treatment is wrong-headed. After all, suppose some genetic engineering technology were discovered that enabled us to increase the average life span from the mid 70s to mid 90s and also enabled us to live as sprightly in our 90s as we now do in our 70s. If that technology were cheap and abundant, why should the fact that its ordinary effect is to extend life count against Medicare support for it?

(2) Nor does it seem possible to regain the cultural consensus regarding ideal old age and death that Callahan invokes. One reason for doubting that such

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a cultural agreement can be reached is that what makes death and old age good or tolerable may be inherently individual. The philosopher and geriatrician Christine Casell cautions against forming generalizations about what people want from geriatric medicine: "One person wants comfort and help in confronting pain and frailty and another is more interested in pride and independence than in treatment for swollen ankles."



Likewise, for some elderly dying, "the fight to continue living has intrinsic meaning in itself and should continue as long as there is breath; these people believe doctors should be helpers in that fight"; but others want no part of ambulances, doctors, or hospitals. Even if conceptions of old age and death are not inherently individual, surely there is an enormous diversity of conceptions in contemporary American culture.

(3) Putting aside the question of whether it is *possible* to achieve a cultural consensus, we should also ask whether it is *desirable* to found public policy on such a consensus. This goes to what is most troubling about the advice Callahan proffers. What is most troubling is not the recommendation to *forge* a consensus, but instead the recommendation to *enforce* a consensus. It is a bad idea to design a restrictive Medicare policy and thereby deny individuals latitude in making their own health-care decisions. In the case of Sue, death is intolerable most of all because Sue wants to live. Even if Sue's preference to extend her life is at odds with a cultural consensus on the significance of old age and death, it would be wrong to deny her the right to be wrong. Even if indefinitely extending the lives of old people is unwise, still less wise is the suggestion to coercively cut them off from life-extending care. There is hubris in the belief that as a society we know more about how to treat old people than they know themselves. The alternative is to think that wherever possible, we should let individuals make their own health-care decisions.

(4) In closing I want to stress the importance we give and should give to factors such as the availability, extravagance, cost, and abundance of life-extending medical resources in our debates about how best to allocate them. To do this, it is useful to consider one further example. Suppose Sabina is diagnosed with some fatal disease at age seventy-three, for which there is an inexpensive and easily available cure. It would be perverse to say to her: we will not pay for treatment to extend your life because you have already lived a natural life span. But we will pay whatever it costs to alleviate the suffering you will experience as disease spreads throughout your body. Yet Callahan's proposal appears to bring this result, because it recommends that beyond a natural life span we finance only health care that is devoted exclusively to relief of pain and suffering.

What makes such a policy perverse is not that Sabina is entitled to receive from government whatever she needs to sustain her life. It is rather that government has a duty to underwrite a decent minimum of health care, and what counts as a decent minimum must be relative to information about the cost and supply of medical goods. The imagination strains at picturing a Medicare or Medicaid system that would cover expensive and rare pain-cure pills and computer-assisted rehabilitative treatment but not cheap drugs or routine surgeries, if these latter are primarily life-extending. The cost and supply of medical goods determine, in part, the kinds of care we can and should offer people.

Because we frame discussions in this way, we understand that in an aging society there simply may not be enough medical care or enough public funds to purchase medical care for everyone who needs it. We already accept the task to design and live with a fair method for distributing scarce medical resources.

But a situation in which we are *forced* to deny people the means to extend their lives because the means are costly and in short supply is very different from a situation where we *choose* to deny people these means because we decide that their requests for more life are unwise. The latter choice is not one we should make lightly or at all. As individuals who age and die, we should each try to envision what old age and death will be like for *us* and to form ideas about how we would like our old age and death to be. This process can be

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facilitated by a public *debate*; it would be hampered by a public *consensus*. It can also be fostered and encouraged by a health-care system that empowers people to carry out their plans for old age and restricts them only to the extent justice demands.

These objections notwithstanding, *Setting Limits* is an important and impressive achievement. It is a deliberately confrontational book, a book which challenges its readers to question long-held assumptions about old age and health care.

—Nancy S. Jecker

Christine Casell is quoted from her article, "The Meaning of Health Care in Old Age" in Thomas Cole and Sally Gadow, eds., *What Does It Mean to Grow Old?* (Durham, N.C.: Duke University Press, 1986).