



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).

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