Stop, in the Name of Love!

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STOP, IN THE NAME OF LOVE! *

By GEORGE P. SMITH, II **

Although the traditional means for affording access to goods and services in a capitalistic economy is the free market system, Americans have been unwilling in the past - for the most part - to either condone or accept financial ability as the central means for distributing health care. Responding to this attitude or consensus, the United States Congress established both Medicare and Medicaid programs to deal with the commitment to provide health care services regardless of ability to pay.1 Recent surveys show, however, that while the American public is concerned about the idea or principle of providing not only health care for all who are in need, but catastrophic health care coverage for cancer and cardio-pulmonary problems and long-term care as well, "there is actually a significant limitation on their willingness to pay additional costs"2 outside of those provided for medical reimbursement coverage in their health insurance policies.

Even though the federal government does not control directly total health care delivery spending or, for that matter, hospital budgets it can and does exercise considerable influence through funding of a multitude of health care programs.3 In this essay, the extent to which cost containment adds to or detracts from the goal of meeting a uniform standard of quality health care delivery will be analyzed and a construct for principled decision making developed.

I. Congressional Actions of Rationing

In 1983, Congressional action was undertaken to meet the dramatic increase in Medicare program costs by changing the method of

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3. Silver, supra. 1 at 1007.
reimbursement for hospital charges under Medicare from a cost-based retrospective system to a prospective payment system (PPS). Under this new procedure, Medicare now pays hospitals a preset price for services to its beneficiaries that is calculated on the average costs of hospital care for those patients in diagnosis-related groups (DRGs). The central purpose and focus of PPS is to "define a single payment schedule in advance of treatment."

As a part of this new system, Congress also directed that for those hospitals seeking reimbursement under Medicare, contract with a peer review organization (PRO) was necessary. The central responsibility of the PROs is to assure that - consistent with professional standards as well as proven levels of efficiency and sound economics - medically necessary care is provided to Medicare beneficiaries. The PROs not only monitor Medicare admissions to hospitals, but review DRG designations and review the very costly cases for which more hospital care is required than that allowed in the basic Medicare contract.

Competitive relationships among hospitals have been heightened as a consequence of the PPS. While all hospitals now receive the same reimbursement for the same diagnosed illness regardless of the originating historic costs, national DRG rates promote a form of direct competition in that the hospital that can perform appendectomies more cheaply - for example - receives more profits from PPS on that particular procedure. "It can then use that profit to enhance its general competitive relationship to surrounding hospitals by subsidizing a losing service area, increasing its advertising budget, or providing better faculties for the medical staff."

A shorter hospital stay is the central goal of DRGs. Yet, a common perception is that the shorter stay means that patients are being discharged "sicker and quicker". While some patients return to homes where there is a supportive environment, many are impoverished and go to homes with no support systems for long term care.

Cost containment systems, such as DRGs, often inadvertently cast the caregivers in an adversary role against the patients for whom they ought to serve as advocates. Thus, the nurses and social workers are often obligated to promote the earliest possible patient discharge time, even when in their professional opinion, such action does not promote the patient's best interests.


6. Dougherty, supra.

7. Id.

8. Id. at 7.

9. Id.


11. Id.
Another New Initiative

The Physician Payment Review Commission established by Congress to tackle the problem of skyrocketing costs of Medicare, proposed recently a uniform fee structure for doctors treating patients in the program. Under the new proposal, Medicare would set basic national fees for each of 7,000 different services for which it pays. Thus, the basic fee for any given service would be the same everywhere - but local adjustments would be allowed to reflect regional differences in overhead and liability premiums. A very real danger that would exist if this policy were implemented would be that physicians faced with larger fees would simply increase the volume of services to patients. The Commission also recommended more research be undertaken to determine the best and most cost effective treatments for given illnesses.

Today, the accepted norm in meeting health care costs is to invoke and implement the "Robin Hood Ethic" that forces the "rich" (or those covered by private insurance policies) to give to the "poor" (or the under and uninsured). Accordingly, the common practice designed to finance care for the nation's some 37 million uninsured - who generally come to the hospital through the emergency room facilities - is for the physicians and hospitals to inflate the bills they send to privately insured patients. All too often, another alternative to meeting soaring hospital costs is patient dumping.

Patient Dumping

Although there are many forms of patient dumping, the most common one is found in the hospital emergency room - where the patient is transferred from the emergency facility in one hospital to that in another. The transfers are effected - essentially - for simply economic reasons: because the at-risk or afflicted patient lacks insurance and, thus, is unable to pay for the health care services rendered to him.

In an attempt to deal with the widespread problems of patient dumping, a 1987 amendment to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) establishes criteria for safe transfers between hospitals of critically ill or injured patients as well as women in active labour. Thus, all hospitals certified to participate in the Medicare Program, (that means virtually all hospitals) must:

1. Provide a medical screening examination to determine if an emergency medical condition exists in the patient;  
2. Provide stabilizing treatment to any individual with an emergency medical condition or women in active labour prior to transfer.  
3. If the hospital cannot stabilize the patient, he or she may be transferred to another hospital:  
   a. if the responsible physician certified in writing that the benefit of transfer outweighs the risk;  
   b. if the receiving hospital has space and personnel to treat the patient and has agreed to accept the patient;  
   c. if the transferring hospital sends medical records along with the patient; and  
   d. if the transfer is made in appropriate transplantation equipment with life support if necessary.  
4. If a hospital knowingly and willfully, or negligently violates any of the above, it can be terminated or suspended; and  
5. If a physician or hospital knowingly violates the law, a civil monetary penalty of up to $50,000 can be imposed on each or either of them for each violation of this law.15

While this legislation deals effectively with patient dumping, restraining the marketplace costs of simply growing old is extremely difficult.

Costs of Aging  
The Health Insurance Association of America estimates that by 1990, about 7.7 million Americans will need some form of long term care. Almost a third of all males over 65 will spend some time in a nursing home, as will 54 per cent of women. The average stay for elderly patients in nursing homes is 2.5 years. The average cost of skilled care is $25,000 and custodial care costs $11,000 or more. In the Washington, D.C. area, nursing home care costs average $42,000.00. Already, the collective annual bill for nursing homes now exceeds $35 billion.16

It has been estimated that by the year 2000, the cost of the nation's budget for health will be almost $2 trillion - an amount calculated to be four per cent of the gross national product.17

Present further estimates show that 80 per cent of all health care resources are tied to expenditures for chronic disease. For those individuals aged 56 to 74, over 45 per cent of them have some type of chronic disease; and this percentage is doubled to 80 per cent for those individuals over 75.18

18. Silver, supra n. 1 at 996.
AIDS as a Complication
A New York City Mayoral Task Force reported recently that the city hospitals are so crowded by AIDS patients that there is "a dire possibility" that they soon will be unable to care for seriously ill people. Already, many City hospitals are operating at 95 per cent of capacity. Presently, 1,700 AIDS patients occupy about 6 per cent of the city's medical beds. A growing portion of AIDS patients are poor, black or Hispanic or intravenous drug users. It is predicted that the growing influx of AIDS cases will add $1 billion to $2 billion annually to the city's $20 billion health care bill by 1992.

Costs of Medical Technology
Additional health costs are realized as a consequence of new advances in medical technology. While some of these new technologies do reduce the costs of patient care, they are nonetheless considered responsible for anywhere between 25 and 75 per cent of the increases in hospital costs.

Two billion dollars is spent for expenditures yearly on coronary artery bypass graft surgeries - with the average patient cost being anywhere from $10,000 to $20,000. The total costs for kidney dialysis is said to exceed $1.5 billion - with the annual per patient cost being approximately $30,000.00. And, the cost of neonatal intensive care has a yearly cost in the billions.

A kidney transplant can cost from $25,000 and a heart transplant approximately $75,000 - with the life time use of immunosuppressive drugs to prevent rejection of the transplanted organ averaging from $6,000 to $12,000 a year.

The British Response
The system of national health insurance in Great Britain is an interesting study of how a system of budgetary constraints applies to shape the availability of medical care. Under this system, all hospital expenditures are limited by a budget set by the national government. The individual hospitals receive funds through regional (and strict) disbursements. Budgetary limits, of necessity, introduce restraints on the availability of personnel and equipment - even though hospital administrators

20. Id. See also Abramowitz, Violence Straining D.C. Health Network, Wash. Post, Feb. 19, 1989, at 1, col. 2. Unpaid care is driving up costs for all patients. The typical gunshot victim's stay in the Washington Hospital Center is for an average of 11 days with a hospital bill totalling about $2,225.00 per day. More than half of such patients lack any kind of health insurance and the hospital usually recovers only about one-tenth of the charges - and then only from government sources. Id.
22. Id.
23. Id. See generally, Bailey, Rationing and America's Health Policy, 9 J. Health Politics Pol'y & L. 489 (1984).
24. Silver, supra n. 1 at 1005.
theoretically have discretion in allocating resources. Physicians in Great Britain are thus in turn forced to operate within those constraints selecting some patients for treatment, while rejecting others.

A private medical care system is intertwined with the national health service and is not supported directly by the government. Patients are allowed to enter this private system at various points, with a few choosing to sign up initially with a private general practitioner. More often, patients elect to see a consultant privately either directly or after an initial referral by their national health service general practitioner. These private patients are given much greater access to health care resources simply because of their ability to pay extra for these services.

In the United States, direct federal governmental control of total spending on hospital budgets is not seen. The federal government nonetheless exercises great influence in health care maintenance by deciding those treatments for which reimbursement will be allowed and, at what level. The extent of government influence, however, extends well beyond its own programs. Thus, should a hospital be given assurance that it will be reimbursed by Medicare for providing expensive technology (as with cardio-vascular surgeries and nuclear medicine), it will be more likely than not to undertake the capital investment necessary to provide for that very technology.

The effect of cost containment on the allocation of scarce medical resources is seen dramatically in the case of kidney dialysis. In Britain, dialysis competes with other types of health care for government financing, while in the United States, Medicare reimburses the cost of treatment for everyone, and this includes coronary by pass surgeries. While there are no specific regulations restricting these latter surgical interventions - as well as various transplants - common medical sense would preclude coronary rehabilitation for Medicare patients of advanced age. Among the criteria used in Britain to select those suitable for dialysis are age, mental illness, and the presence of other medical diseases or physical handicaps. Because of the selection criteria and the competition for scarce hospital funding sources, the end result is that many patients denied treatment in England would in fact be treated in the United States.

Toward an Equitable Health Care Delivery System
For the past several decades, it has become more and more apparent that

27. Id. at 22.
28. Silver, supra n. 1 at 1007, 1008.
31. Silver, supra n. 1 at 1006.
32. Id. at 1005.
the two primary concerns of the health care delivery system in the United States have been the need to provide a minimal level of care and equity of access for all citizens - and especially the underinsured - and, at the same time, keep in check the staggering escalation of costs associated with health care delivery. 33 A significant range of factors influences any allocative process in medicine. Foremost among these factors "are perceptions of the characteristics of a non-allocation decision that imposes harm, or a risk of harm". 34 This harm or risk of harm may in turn be perceived as imposed by choice or by chance, directly or indirectly, through an act or an omission, by an overt or latent decision-making process and/or by identified or unidentified allocators on identified or unidentified allocatees. 35

"The more that a harm or a risk of harm is, or appears to be, imposed by choice, directly, by an act, through overt decision-making, by an identified allocator, or an identified allocatee, the more likely is the decision to be considered unacceptable". 36 Conversely, it is postured that,

"The more that a harm or risk of harm is imposed either in reality or apparently by chance, indirectly, through an omission, through latent decision-making, by an unidentified allocator at the time the risk is created, the more likely is the decision to be considered tolerable and acceptable". 37

II.

The Ethics of Gatekeeping

Since the founding of America, notions of individual rights, autonomy and self-determination have been gained in prominence. In the medical relationship, they have lagged behind. Indeed, only within the last several decades have these notions become strong enough to bring a direct challenge to the traditional principle of paternalism that has dominated the relationships between physicians and patient since the time of Hippocrates. 38 As always, the primary danger of paternalism is its irresponsible use. 39
Today, more and more, society is calling upon physicians to assume the role of a "gatekeeper" or guardian of its limited health care resources. And, of course, in such a capacity, the danger of unreasonable use and conflict of interest is ever present to one degree or other. This is especially the case when it is realized that it is the physician who makes the decisions regarding 75 per cent of all health care delivery expenditures.

The De Facto Gatekeeper
As a de facto "gatekeeper", the unavoidable conflict the physician encounters is over his duty to ensure that monies expended for health maintenance or restoration are used in an effective and beneficial manner. The economic constraint, imposed by the health care maintenance system or, more specifically, the hospital where the physician has staff privileges, is pitted against the physician's hippocratic obligation to act in the best interests of his patient in order to assure that the patient receives proper medical or surgical treatment without unreasonable economic restrictions.

In a very real sense, then, the physician becomes a de facto gatekeeper or micro economist because he is the first individual consulted by an ailing member of society and he in turn determines what - if any - economic resources within the health care maintenance structure will be allocated to correct the ailment. While some of these allocative measures are indeed effective, as for example treatments for pneumonia, they may not be beneficial in all situations "if they prolong unnecessarily the act of dying and thus impose the burden of futility and expenses without benefit for the patient." Similarly, as with diagnostic procedures, the physician is under a moral mandate to use only those laboratory tests, x-rays and imaging procedures, that "contribute materially to the certitude of the diagnosis or the nature of the clinical decision". Tests that are only of marginal value or done for teaching purposes - assuming the patient is in a teaching hospital - are not to be regarded as justifiable.

Ideally, when ethically performed, the de facto gatekeeper's responsibilities present no real conflict with the patient's good; for not only are economics and ethics in congruence, but also are individual and social good as well as the doctor's and the patient's interests.

The Negative Gatekeeper
The negative gatekeeper is seen when the physician is placed "under

41. Id.
42. Id. at 26.
43. Id.
44. Id.
45. Id. at 27.
constraints of self-interest to restrict the use of medical services of all kinds but particularly those that are most expensive. Here, a number of measures are utilized that interject significant economic determinants into the clinical decisions the physician makes and thereby impose a limitation on his standard of discretionary decision making.

The Diagnostic Related Groups (DRG) program and other cost containment programs, motivate the health provider to limit access to care by appealing to a level of self-interest. Thus, under such programs, if total costs of hospitalization or procedures exceed a contracted amount, the provider bears the loss. If, contrariwise, the costs are less, then a profit is accorded the provider.

The Positive Gatekeeper
With the positive gatekeeper, which is a role less structured than the other two, (and, indeed, is somewhat of an ambiguous misnomer) the physician "is constrained to increase rather than decrease access to services." Accordingly, enhancing profits is the primary goal instead of containing costs. The latest and most expensive diagnostic or therapeutic services are available to those who can afford to pay for them; with services being provided based on a pure market demand rather than medical need. Thus, the "gatekeeper's" role here in this model is akin to that of a director of marketing services who allows entry into the particular health market based simply on the consumer-patient's financial where-with-all.

Ethics and Morality
A primary moral issue that permeates the whole of gatekeeping is the degree to which profit motive or self interest intrudes into and dilutes "the trust the patient places in the physician as his primary agent, minister and advocate." This doctor-patient relationship may be likened to a fiduciary relationship where the doctor must act always to advance his patient's best medical interests. Yet, as has been seen, various gatekeeping roles or junctions - if not defined and applied uniformly within health care maintenance facilities or hospitals in a given geographic area - will give rise to unfair or discriminatory competition among hospitals and among the patients they attend. Thus, a public hospital in a large metropolitan area may cast itself in the role of a negative gatekeeper and, as such, adopt stringent cost containment policies for its patients and impose those policies on all of its staff physicians. Accordingly, although a staff physician at such a hospital may well wish to select a morality of care and treatment

46. Id.
47. Id.
48. Id.
49. Id. at 29.
51. Id.
for his patient, he may be precluded from this because of strict negative
gatekeeping policies that restrict his utilization of certain hospital
resources. The ethical dilemma for the physician in this case is obvious.

It is suggested that all ethical problems associated with gatekeeping can
be avoided if institutions were to establish decision-making structures
based on a hierarchy of services tied to benefit, effectiveness and need and
a rationing principle determined by public policy enunciated and
communicated to all seeking care. If rational medicine - which consists
of "diagnostic elegance and therapeutic parsimony" - were practised
universally and optimally, some 15 to 20 billion dollars would be generated
in savings as a consequence of the elimination of unnecessary tests.

III.

Principles of Allocation

More and more, then, the central question of from whom will people seek
care in decentralized health systems becomes tied to the simple reality of
their financial backgrounds and their medical salvageability as a
consequence of their treatment using scarce medical resources. Modern
principles of triage and cost-benefit analysis dictate, in reality, the extent
to which a definitive response can be given to the question of how
contemporary and decentralized health systems respond to the needs of an
equally contemporary society.

The classical definition of triage may be acknowledged as being:

"The medical screening of patients to determine their priority for
treatment; the separation of a large priority for treatment; the
separation of a large number of casualties, in military or civilian

52. Id. at 39, 40. The five levels of care in the hierarchy would be: service for preventive
measures for disease such as small pox and polio; then could follow beneficial
treatments for life threatening disease such as emergency trauma care and renal
dialysis; the third category would be treatment for less acute but serious diseases
such as coronary by pass surgery for intractable angina pectoris; the fourth category
would be expensive treatments with marginal benefits such as certain types of
carotid endarterectomy; and finally would come effective treatment for both non-
disabling and non-threatening disorders, such as purely cosmetic surgery. Id.

Engelhardt delimits four levels of health care choices - higher level
macroallocational and lower level macroallocational as well as higher level
microallocational and lower level microallocational - with each level interacting
systematically by bringing with it its own particular moral problems and,
simultaneously, influencing the other levels of choice by thus shaping the character
of the very dilemmas it creates. H. Engelhardt, Jr., The Foundation of Bioethics 344-
348 (1986).

53. Supra n. 40 at 39.

54. Id.

55. See Donley, A Social Mandate for Nursing: Prescription for the Future, 1 J.


disaster medical care, into three groups: those who cannot be expected to survive even with treatment, those who can recover without treatment, and the priority groups of those who need treatment in order to survive.\textsuperscript{58}

Even before \textit{triage} found significant application to military or civilian catastrophes, its root meaning in French - "sorting, picking, grading or selecting according to quality" - was subsequently first applied in the English language to the process of separating wool according to quality and even later, to the separation of coffee beans into three categories: "best quality", "middling" and "triage coffee", with the last consisting of beans which had been broken and were, thus, the lowest in grade.\textsuperscript{59} Over the course of time, the use of \textit{triage} has been expanded to other situations where it has become, in actuality, a metaphor for social, economic and even political decisions.\textsuperscript{60}

\textit{Utilitarian v. Egalitarian}

Since the law provides at present no uniformly agreed upon principles which may be applied in order to regulate the allocation of scarce medical resources, current medical practice draws upon a structure of decision-making evolved as such from a number of philosophical and ethical constructs.\textsuperscript{61} There are five utilitarian alternatives of application which are operative in the hierarchy of \textit{triage}: medical success; immediate usefulness; conservation; parental role and general social values.\textsuperscript{62} Translated as such into decisional operatives, what emerges is a recognition that priority of selection for use of a scarce medical resource should be accorded to those for whom treatment has the highest probability of medical success, would be most useful under the immediate circumstances, to those candidates for use who require proportionally smaller amounts of the particular resource, those having the largest responsibilities to dependents or to those believed to have the greatest actual or potential general social worth.\textsuperscript{63} The utilitarian goal is - simply stated - to achieve the highest possible amount of some good or resource.\textsuperscript{64} Thus, utilitarian principles are also commonly referred to as "good maximizing strategies".\textsuperscript{65}

Egalitarian alternatives - contrariwise - seek either basic maintenance or a restoration of equality for persons in need of a particular scarce resource.\textsuperscript{66} There are five basic alternatives utilized here: 1) saving no one

\textsuperscript{58} Stedman's Medical Dictionary 1476 (4th unabr. ed. 1976).
\textsuperscript{62} Winslow, supra n. 60 at 106.
\textsuperscript{63} Id. at 63-86.
\textsuperscript{64} Id. at 87.
\textsuperscript{65} Id.
\textsuperscript{66} Supra n. 62.
- thus priority is given to no one because, simply, none should be saved if not all can be saved; 2) medical neediness, under which priority is accorded to those determined to be the medically neediest; 3) general neediness, which allows priority to be given to the most helpless or generally neediest; 4) queuing, where priority is given to those individuals who arrive first and - finally - 5) random selection, where priority of selection is given to those selected by pure chance.67

To the utilitarian, maximizing utility, and hence what is diffusely referred to as the "general welfare", are both the primary ground and subject of all judgments.68 That which is required in order to maximize utility overall may, thus, infringe upon an individual's own entitlements or rights to particular goods.69 Accordingly, moral rights are either rejected generally or recognized as certainly not absolute.70

To those health care decision makers more disposed to maximize efficient economic resource allocations to individual patients who have the highest possible probability of medical success in their use of the scarce medical resources, utilitarian alternatives would be preferred. But, for health administrators steeped in and guided by principles of civil liberty, equality of distribution in health care service and resources is preferred.

In the final analysis, which position taken and its subsequent effectiveness and implementation depends - to a very large extent - on the health care policy of each hospital and of the doctors who have staff privileges at them. In America, a unified policy would be very difficult to enforce - again, because as previously observed, no law provides for uniformity in allocating scarce medical resources.

### Seeking a Construct for Decision-making

The basic challenge of modern medicine should be, simply, to seek, promote and maintain a level of real,71 and when the case may dictate, potential achievement for its user-patients which allows for full and purposeful living.72 Thus, the underlying principle of application, with obvious utilitarian underpinnings, should always be to seek to minimize suffering overall and maximize the qualitative potential for fulfilling human relationships, thereby promoting a purposeful life for at-risk individuals.73 The extent to which this principle, inquiry or test should be applied depends solely upon the facts of each situation as it arises to present a problem. To have an unyielding a priori standard of mandated

70. Id. at 668.
71. G. Smith, Genetics, Ethics and The Law 2, 8 (1981).
72. Id.
care for all seriously handicapped newborns, whose chances for qualitative life of any significant duration are severely limited, for example, would be unjust not only for the infants, themselves, and be promotive of undue suffering to it, but equally would be unjust and harsh for parents and present an unreasonably heavy economic burden to society for its maintenance and allocation of scarce and expensive medical support resources and mechanisms. It is unfair to expect any health care system to expend excessive and unreasonable sums of money and health resources on fertile cases where there is no honest chance for recovery and rehabilitation. Efforts must always be made to ensure, however, that if a class is structured and labelled, "disabled", it is drawn as narrowly as possible and as strictly defined as possible; for by seeking such a narrow classification, the policy of treatment or that of mere palliative care will be confined to specifically designated individuals within a given class and, thus, not distributed at will and without direction.

Birth Weights
Birth weights are a common criterion for allowing physicians to determine whether intensive or aggressive treatment should be undertaken for newborns. In the United States, one report has disclosed that infants in the 501-750 gram range (1 lb. 1 1/2 oz. to 1 lb. 10 1/4 oz.) are often times treated aggressively. Those in the 751-1,000 gram range (1 lb. 10 1/4 oz. to 2 lb. 3 oz.) are commonly treated in an aggressive manner, while those infants weighing more than 1,000 grams (2 lb. 3 oz.) at birth are routinely treated aggressively.75

In contrast, intensive care in Britain and Sweden is generally reserved for infants over 750 grams. Conversely, when an infant weighs less than 750 grams, it is seldom subject to aggressive care.76 Infants with a very low birth weight are susceptible to brain injuries, which in turn may result in associated handicaps such as mental retardation and cerebral palsy, and


76. Id.
sustained treatment may be obtained at considerable financial expense.77

Age
It has been argued eloquently that age should be used as a standard to set limits on health care "entitlements" for the elderly under designated public programs.78 Interestingly, under the Federal Age Discrimination Act of 1975,79 age is already used as a rationing standard for evaluating the medical suitability for heart transplantation.80

Other Criteria
At various times it has been suggested that the capacity for consciousness,81 social interaction, human relationships (and especially love)82 and rational thought are the four most important considerations in determining who was to be placed in a "non-salvageable" classification.83 The importance of each capacity in the hierarchy of the classification depends, very obviously, upon one's particular social, ethical, religious and philosophical perspective.


See also, Bowen, Sec. of Health & Human Services v. Am. Hosp. Assoc., 476 U.S. 610 (1986) where it was held that federal regulations promulgated under Section 504 of the 1973 Federal Rehabilitation Act and designed to prevent hospital discrimination in the care of handicapped newborns were invalid.

Birth handicaps are often a significant subset of any decisional construct. On April 20, 1989, the Court of Appeal in England held that a five week premature infant born on December 23, 1988, blind, deaf and hydrocephalic could be allowed - with its parent's consent and approval of the attending physicians - a course of "treatment" designed to allow it to be as comfortable as possible but not seek to prolong its life, this course of action being in the "paramount interests" of the defective baby girl. See In re C (a Minor), reported by Nicholson-Lord, Child Can be Allowed to Die, The (London) Times, April 21, 1989, at 1, col. 3. The decision is reproduced at 31 of this edition.

80. Id.

81. Fletcher, Indicators of Humanhood: A Tentative Profile of Man, Hastings Center Rpt. 1 (Nov. 1972). Yet, one ethicist has stated that, "the warmth of human interaction, the love of one person for another, the emotional bonding that links people in moral communities does not require a capacity for consciousness". R. Veatch, A Theory of Medical Ethics 244 (1981).

82. D. Callahan, Setting Limits (1987).

Balancing Costs and Benefits
The conundrum of seeking to maintain purposeful living yet at the same time protecting the recognition of life's sanctity in and of itself - without concern for any lack of quality - finds reality and force when dealing with the plight of genetically defective newborns. This conundrum is also to be recognized as presenting a quality of goals. One goal is and must be balanced against another in attempting to reach a level of distributive justice in the hard decision required here. Each case problem, of necessity, is fact sensitive. Accordingly the situation ethic must be predominant over a harsh, unyielding a priori standard. The effort to establish a unified policy, then, must give way to a fluid and flexible approach to decision making; an approach that inherently balances the costs over the benefits of a particular medical action. Viewed from another perspective, this balancing test underscores recognition of the fact that human life is, in actuality, but a resource - as are natural, physical and environmental resources. Thus, the primary goal for the conservation of every resource is the maximization of its full use or potential - be it viewed as economic, social, cultural or political. Waste must be avoided. Considered as such, then, in seeking to maximize the good of this precious resource of life, the right of personal autonomy and spiritual awareness are but vectors of force which must be additionally factored into any balancing equation. State interest is yet another positive force and also a constraint on autonomous or, in this area, parental-familial medical decision-making.84

An African Paradigm
The Akamba people of Kenya, Africa, approach the problem of allocating scarce medical resources in a most interesting manner. For example, where only one person can be saved, the Akamba would favour an older person over a younger person - this being in direct contrast with the posture taken in the United States where the young are prized more highly than the old because of their economic productivity - or at least their perceived productivity. The Akamba insist that life is much more than "atomistic sums of individual economic contributors".85 Rather, it is viewed as "a social fabric of interpersonal relations".86 Thus, under their philosophy, the more advanced age a person reaches, the more strongly related that person becomes to the lives of others and the greater wisdom he shares with the community. This relationship is thus viewed as a significant social resource.87

Similarly, a man without children would be saved over one with five. Again, in the United States, an opposite position would be taken - with the view that for the sake of the children their father should be treated

84. Supra n. 70.
86. Id.
87. Id.
medically and saved. The Akamba maintain "that the man without children faces annihilation and must be allowed to live so that he can ‘raise up a name’ for himself by having children."

And, finally, the Akamba prioritize half-treatments to each of two dying patients rather than allow one to receive full treatment, even when the record of experience indicates that a half-treatment is insufficient to save either at-risk individual. This they do under their theory of substantive equality. In the United States, procedural equality (or, what is commonly acknowledged as equal access) would dictate a course of action where only one person would be saved - all according to a first come, first served principle.

A Distributional Standard
Distributing scarce medical resources involves obvious problems of distributive justice. Although acknowledged as existing, they are quite difficult to resolve in a pragmatic manner. Consequently, owing to this often insurmountable difficulty, the question of how the distribution will be made is reduced to the issue of who will make the first order decision. If triage decisions are questioned or even discounted as being merely loose, subjective evaluations of patient's salvageability instead of being recognized as decisions based upon acknowledged and proven medical standards and classifications of useful capacity for survival, a substitute construct must be put in place for evaluation and for use.

Today, there is a recognition that an admirable goal of a national health policy is quality health care at an affordable cost. Cost containment thus has become a major force of wide significance and application in all levels of health-care decision-making. There is little disputation of the fact that resources are scarce relative to wants and that they have alternative uses; and furthermore that differences in individual wants mean an assignment of different values to these wants. The basic dilemma, then, is where to determine a line of compromise between competing interests.

Conclusions
Life - viewed as a human resource - should be developed and preserved along those lines which allow for the achievement of its fullest potential for total economic realization, social or philosophical maximization or basic productivity. Indeed, human life - at whatever stage of development or decline - is both a precious and sacred resource. Its "initial advancement or abrupt curtailment should be guided always by a spirit of

88. Id.
89. Id.
90. Id.
91. Supra n. 63 at 146.
humanism. Viewed thus, attainment of the quality of purposeful, humane living becomes a coordinate or complement to total economic utility.\textsuperscript{93} Or, stated otherwise, decisions regarding the allocation of health care services should be reached by balancing the gravity of the economic harm that will accrue in a particular case of use or maintenance against the utility of the social good that will occur if that resource is not used.

\textsuperscript{93} \textit{Supra} note 91. See generally, Jarrett, Moral Reasoning and Legal Change: Observations on The Termination of Medical Treatment and The Development of Law, 19 \textit{Rutgers L. J.} 949 (1988).