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ALLOCATING HEALTH CARE RESOURCES TO THE ELDERLY

George P. Smith, II*

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I. LIMITATIONS ON ELDERLY ACCESS TO MEDICAL CARE

Introduction

Health is not an absolute condition, but is assessed by reference to age and other factors. Therefore, a relative scale is necessary to determine whether an elderly person's right to health care is being satisfied.¹ Today, older Americans are increasingly affected by the growing need to regulate health care delivery. Since 1900, those over the age of 85 years have become twenty-one times as numerous in society, with an eightfold increase in the number of people over the age of 65.² Given the need to curb rising health care costs — particularly the expenses related to caring for older individuals — and improve access to health care, society has effectuated two methods of governing the distribution of limited health care resources: allocation and rationing.³

Health Care Allocation and Rationing

The allocation of health care resources involves a societal determination of what resources should be devoted to a particular program.⁴ The allocation process is typically performed on a *macro* level, with allocation decisions often only affecting statistical lives (*i.e.*, the statistical determination of various life and death rates arrived at based on the evaluation and computation of numerous factors).⁵ In contrast to the identifiable lives often affected by health care rationing, statistical lives affected by allocation decisions are much more readily sacrificed.⁶

A common means of deciding on health care allocation is through political processes. Government decisions pertaining to health care spending and regulation typically involve allocation determinations. For example, the Medicare and Medicaid programs in America allocate resources to numerous purposes.⁷ Hospitals, too, regularly make allocation decisions in determining the quantity and type of resources to have available.⁸ Their actions, in turn, impact directly upon physicians who subsequently also become health care allocators.

Whether a duty arises to the elderly citizens affected by such allocation decisions is the subject of much debate. The government does arguably have a duty, based on a collective social obligation, to help people live out a natural life span.⁹ Yet, without a limit on investments into health care for the elderly, younger generations will suffer based on an inadequacy of available health care resources.¹⁰ Others argue that individuals should support health care plans allocating fewer resources to health care in old age in exchange for more comprehensive health care earlier on in life.¹¹

In broad terms, rationing commonly refers to the equitable division of scarce items by limiting the amount individuals are entitled to.¹² Rationing of medical care is more narrowly defined as the deliberate denial of treatment to some individuals who might benefit from it.¹³ The pervasiveness of rationing throughout the health care industry no longer represents the deliberate, equitable sharing of a scarce commodity. Rather, rationing has come to represent discrimination in access to health care services on the basis of socioeconomic status.

Justifying Age-Based Health Care Rationing

Proponents of rationing contend that anything short of rationing will not prevent a looming economic catastrophe in America's health care system. Specifically, the proponents argue that rationing is the only way of managing unbridled patient demand, an aging population and the open flood gates of medical technological developments.¹⁴ They argue that an explicit system of rationing health care services must be implemented to avert a national disaster.¹⁵ This argument, however, is founded on more than mere economic considerations.

Older persons seem particularly susceptible to rationing efforts. Commentators have argued that an integral part of a rationing system is to ration care among the elderly, thereby restricting expensive, high technology, life-sustaining care for those who have reached a certain age.¹⁶ Implicit in this argument is the principle that elderly health care represents an investment of scarce resources with limited returns.¹⁷ In addition, this argument reflects an intuitive conclusion that an older person has less chance of achieving a successful clinical outcome.¹⁸ The assumption is therefore made that vast resources are spent on care for dying elderly; an assumption bolstered by empirical evidence.¹⁹ In further support of age-based rationing, proponents have proffered a wide gamut of benefits, including productivity, equality, natural life span, intergenerational justice and medical benefits.²⁰

Withholding of costly medical treatment to the elderly has been justified on the basis of waning productivity in the later years of life. It is an argument centering on an investment return theory, suggesting that the dollars spent on elderly health care may best benefit society when invested in patients with greater 'potential.'²¹ Coupled with the greater investment return argument is the suggestion that individuals should have the right to live until the same age as others. As such, health care services for the elderly should be curtailed in order to allow for such an outcome. By limiting health care for the elderly, services can be provided to allow all, to the extent possible, to reach a certain age.²²

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Justifying age-based health care rationing has also been done on the basis of intergenerational justice and a 'natural lifespan' view. The theory articulated is that health care costs for the elderly invariably deprive younger generations of access to adequate health care and thereby limit their exposure to other life experiences. Under this theory, the elderly should recognize that their own welfare is the result of other generations' hard work and should therefore deem their health care needs as inferior to those of the younger generation.²³

Arguments Against Age-Based Rationing

The argument is often made that health care services should not be rationed at all, particularly not on the basis of age. Proposals in support of age based rationing do not generally advocate the withholding of all medical treatment from older persons. Rather, such proposals suggest that expensive, aggressive care should be withheld from elderly patients.²⁴ According to one study, withholding all care for high-cost Medicare decedents would have resulted in a 2.8 billion dollar saving in 1987.²⁵ While withholding high cost health care from older patients who were seriously ill may save some money, this savings must be balanced against the cost of ending many lives.

The consistently reappearing theme in all of the analyses of age based rationing centers on defining the value of an elder person's life. Some make the argument that excluding older persons from expensive medical treatment may allow society to realize a greater return for those invested dollars. Moreover, commentators argue that limitations on health care to the elderly will allow for greater equality in the number of life years attained. Imputed from this position is a demeaning, monetary value affixed to a human life. Regulating access to medical care based on age runs against the egalitarian nature of society and the principle that all human life is sacred and equally deserving of protection.²⁶

Another widely discussed justification for rationing life-sustaining health care for the elderly is the natural lifespan principle.²⁷ This proposal attaches a normative average to valuating a person's natural lifespan (calculated to be roughly around the late seventies or early eighties) after which a person should receive only supportive and palliative care.²⁸ The goal of establishing an acceptable age after which health care should be rationed is an attempt at applying a homogeneous criterion to a very heterogeneous society. The contributions to society made by elder citizens varies widely and makes very difficult any attempt of valuing a human life strictly on age and natural lifespan. In addition, although it is suggested that the elderly should give priority to the health care needs of a younger generation, intergenerational equality is a two way street. Although the work and contributions of the younger generation provide for much of the older generation's welfare, it must

not be forgotten that the sacrifices of the elderly created many of the resources, opportunities and services that younger generations now enjoy.²⁹

II. THE EQUALITY OF AGE-BASED HEALTH CARE ALLOCATION AND

RATIONING

The theory of equal medical treatment supports implicitly the proposition that persons with similar health conditions receive roughly the same health care. Given the reality of scarce medical resources, however, society is faced with the obligation of allocating the resources as equitably and efficiently as possible. Thus, the debate is no longer whether health care should be rationed; rather, how to ration it equitably.

The presumption that old age hinders the possibility of favorable medical outcomes may be accurate statistically but remains a highly undependable clinical outcome predictor. What must be considered is that older people are generally, as a population, physiologically and psychologically very different. As such, curtailing treatments pursuant to an arbitrary, age-based policy will not result in the most efficient use of medical resources and fails to recognize individual human potential.³⁰

The Equal Opportunity Argument

Empirical studies make immediately apparent that, given the rate at which the number of elderly and their needs are increasing, no society has available all the resources necessary to completely fulfill these needs. With age based rationing, however, the aim of equal access to health care is ostensibly achieved in that, with the passage of time, individuals inevitably move through the various stages of life. Furthermore, the opportunity to live out one's life is understood to include such aspects as work, love, procreation and raising a family and enjoying life with others. Assessing the aged members of society, most have experienced these opportunities of life. As such, age based rationing does in essence provide elder citizens with the same opportunities afforded to younger citizens.³¹

One such age based health rationing plan sets forth the goal of guaranteeing a minimally decent level of health care for all while limiting the private demands of ailing elders. Specifically, the plan proposes to cut off all but the most basic medical care at the age of eighty. This policy would be instituted through the Medicare/Medicaid system and would refuse consistently to fund intensive treatment beyond the established age limit.³² It is argued that such a plan is both decent and manageable and that only through such an active plan can society avoid a genuinely serious crisis in health care costs.

Elderly Discrimination

Promoting age-based rationing is detrimental to the elderly in that it devalues the status of older people and caters to the values of a youth-oriented culture in which negative stereotyping based on age is prevalent. Age based rationing carries the danger of signaling to society that the old are not as respected as the young. In addition, denial of life-extending treatment to the elderly may foster the growing trend of unequal respect towards the elderly.³³

Unequal access to basic goods and services promotes inequality and is demeaning to those who are excluded. Medical treatment, however, is not a good resource that can be conserved in the same manner that other goods or resources can. It is morally unacceptable to ration beneficial health care except in the most extreme of situations. Thus, medical treatment cannot ethically be denied from any predetermined segment of the population based on age. Such a denial could, in essence, be denying patients life itself. The factor determining the propriety of medical treatment should therefore be the patient's condition, and not an artificial criterion such as age or status.³⁴

III. PATIENT DUMPING

Although patients in 'right to refuse medical treatment' cases have trouble terminating their medical care, many persons have difficulty *obtaining* medical care in the first place because they are refused admission to hospitals. This problem is termed 'patient dumping'.³⁵

Also known as 'demarketing of services' or 'management of patient mix',³⁶ patient dumping refers to the hospital practice of transferring or refusing to treat persons who are indigent, uninsured, or otherwise undesirable to admit.³⁷ Patient dumping has origins in the common law no-duty rule.³⁸ This rule provides that hospitals have no duty to admit and treat all patients who seek care and, in some cases, have no duty even to specify reasons for rejecting patients.³⁹ Hospitals often 'dump' patients who arrive at hospital wards either without any health insurance or with only Medicaid insurance—a program which physicians know provides low reimbursement payments.

The economic pressures placed upon hospitals over the past decade increased the frequency of patient dumping in cases falling under the no-duty rule.⁴⁰ This rule and the ability of hospitals to refuse medical treatment have been limited by the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986⁴¹ and the Emergency Medical Treatment and Active Labor Act (EMTALA)⁴²—an amendment to COBRA.

In the final analysis, it will be seen that the elderly will be secure from the indignity of patient dumping only when society and the health care industry acknowledge their inherent value as an important segment of contemporary American life.

Ethical Obligations to Treat the Elderly

In a society where the elderly are more susceptible to illness and disability than any other age group,⁴³ they 'ought to command special attention in matters pertaining to health care.'⁴⁴ Clearly, access to hospitals and health care resources is an important concern to them.⁴⁵ Many in fact have Medicare, or private insurance, or both; but many others have neither. As with society as a whole, the elderly population is composed of persons having various income levels, interests, and needs.⁴⁶ Even if society's ethical consensus advocated unlimited access to health care, health care providers would still be unlikely to provide health care to persons unable to pay for it.⁴⁷ Patient dumping and access to health care remain prominent issues for the elderly because elderly persons are not typically economically productive.⁴⁸ Indeed, the population of elderly is impoverished disproportionately and disadvantaged economically.⁴⁹

Some physicians and patients have adopted a consumerist image of the physician as an independent contractor who sells his knowledge and skill to patients who demand care.⁵⁰ This contractual model of medical care⁵¹ overlooks the moral and ethical considerations inherent within an emergency patient-physician situation and belittles the idea that a doctor should make 'a correct technological (medical) choice consonant with a patient's needs and desires.'⁵² In addition, for-profit hospitals face an inelastic demand for services, which contributes ultimately to their being unresponsive to altruistic social winds.⁵³

Americans should be offended particularly by hospitals' dumping elderly patients because the elderly are characterized as recruited to poverty after relatively decent working lives.⁵⁴ An elderly person's 'social worth' and corresponding health care resource allocation should not be determined by his ability to be a rational consumer⁵⁵ who has saved money to purchase healthful retirement years. Instead, health care should be allocated by considering the fairness to the persons who need care the most—specifically, the sick and indigent elderly.

When society allows health care providers to operate and profit in any community, an ethic of fairness—which respects the wisdom,⁵⁶ self respect,⁵⁷ and achievement of the elderly—should be in place and, indeed, controlling.⁵⁸ Respect for the dignity and autonomy of elderly patients, as well as the underlying motive to help them, must replace the all consuming profit

motive held by both hospitals and physicians as the lodestar for American health care delivery. In order to reach this goal, society should restrict medical licenses to health care providers who will care for the indigent elderly as a condition for doing business with the rest of society. Only then might the incidence of dumping elderly patients be diminished significantly.

IV. WHO SHOULD DECIDE?

The ultimate decision on the merits of age based rationing and the provision of life extending care is linked directly to society's perception of health care for the elderly and society's medical capabilities. This decision making process inevitably introduces value considerations into policy formulations, specifically into the policy surrounding the allocation of expensive health care resources for the elderly. Allowing values to be a factor may hinder ultimately the resource allocation planning process. Nevertheless, safeguarding the personal values of older Americans may require such a compromise.⁵⁹

Formulating a national policy on health care requirements of the aging presents inevitable value conflicts. There exists a common perception that the transfer of social resources essentially polarizes the younger and older generations.⁶⁰ Nevertheless, such an intergenerational clashing of values must not be viewed as an obstacle. Rather, the rational resolution of competing health care policy considerations demands that conflicting values be scrutinized and through some factor interlinked with one another. It must be remembered that values generally serve as self-justifying ordering and selecting principles unless they are evaluated critically and impartially. Thus, regardless of how objective an approach society takes towards constructing an equitable national policy on health care allocation to the elderly, the competing value concerns must be addressed in an orderly, critical and reasonable way. The tool for allowing society to undertake such a critical evaluation is ethics.⁶¹

Ethics is an unparalleled regulator of value selection and must therefore be factored into the formulation of a national elderly health care policy. The American Medical Association's Principle of Ethics, for instance, states clearly that notwithstanding the societal interest in containing health care costs, 'concern for the care the patient receives will be the physician's first consideration.'⁶² The weighing of the ethical aspects of medical decision making for the elderly would indicate how aggressive treatments or intervention should be in prolonging a life otherwise viewed as having limited potential.⁶³

Conclusions

Ultimately, in order to confront the issue of health care rationing for the elderly, society must integrate effectively the disciplines of moral and ethical reasoning with the quantitative formulations of needs and resources. Such

an effort, supported by an abundance of public debate and discussion, will result in an equitable policy on elderly health care rationing with long-term viability. Until such a point, however, the greatest danger to avoid is the perpetuation of 'nondecisions' regarding health care treatment for the elderly that are being made daily. Such 'decisions' all too frequently result in the nontreatment of elderly patients and institutional residents because of an inability to assess effectively the equitable and efficient allocation of the scarce health care resources.⁶⁴

If the proposition that the 'simple and compact' rules of the common law are a more effective mechanism for providing health care than legislative and judicial actions is true,⁶⁵ an acknowledgment must be made of the lynchpin of the common law itself: namely, the normative standard of reasonableness. And, with this standard's implementation comes the utilization of a rather deceptive balancing test—a test which seeks to measure the gravity of the harm of a decision against the social utility (or values) of maintaining the *status quo*.⁶⁶

Placed within the context of distributing health care resources, this common law balancing approach forces an evaluation of the competing individual interests or social values. Thus, the value and cost to society of expending health care resources—for example—to maintain an individual with a futile medical prognosis—is balanced against the economic utility of providing care to one whose health care can either be rehabilitated or restored.⁶⁷

Age should never be recognized as the determinative factor in the balancing test for health care services. Rather, a patient's condition, informed or negotiated consent to treatment, together with the primary physicians professional judgment as to the need for the commencement or cessation of medical services should be controlling. While varying from situation to situation what is the most efficacious and humane treatment and in a patient's best interests is always, of necessity, a medical judgment.⁶⁸

The real moral question raised from this contemporary debate is not whether too much treatment or too little is offered. Rather, 'it is how to optimize the appropriateness of the treatment'; and therein lies the moral obligation of health care as well.⁶⁹ However difficult or tragic the allocation decision is to make, taking no action is perhaps the most pernicious conduct of all. Society must realize that aging is not a disease, but an inherent part of human life.

Absent a verifiable mechanism for allocating health care resources to the elderly, rationing may well be effected over succeeding years by an insidious allocation process removed from the public view altogether. More and more, because of governmental pressures on the medical profession to control costs

and to eliminate waste and inefficiency, patient care becomes secondary to distributive justice with a physician's responsibility to advance a patient-centered ethic thus being compromised by competing responsibilities to preserve societal resources.⁷⁰ In the final analysis, practicing distributive justice at the bedside—without any clear social and ethical contours in place—can very well become an arbitrary process dependent largely on the value system of the medical gatekeepers. In a deliberative democracy, this cannot be allowed to happen.

ENDNOTES

Some of the ideas in this essay are derived from my book, *Legal and Healthcare Ethics for the Elderly* (1996) and adapted from my essay, 'Our Hearts Were Once Young and Gay: Health Care Rationing and the Elderly', (1996) 8 *U Fla JL and PubPolicy* 1.

1. See Bernard M Dickens, 'Medico-Legal Issues Concerning the Elderly—An Overview' in John M Eekelaar & David Pearls (eds.), *An Aging World* (1989), 487.
2. Nancy C Jecker, 'Age-Based Rationing and Women' (1991) 266 *JAMA* 3012.
3. David C Hadon & Robert H Brook, 'The Health Care Resource Allocation Debate: Defining Our Terms' (1991) 266 *JAMA* 3328.
See generally, Marilyn Chase, 'Too Often, the Elderly Don't Get the Drugs Or Care They Need' *Wall Street Journal*, (24 Sept. 1999), B1.
4. Barry R Furrow, Thomas L Greanery, Sandra H Johnson, Timothy S Jost & Robert L Schwartz (eds.), *Health Law: Cases, Materials & Problems* (1997), 18-27, chs 11, 12.
5. *Ibid.*
6. *Id.*, 53, 54.
See generally Paul T Menzel, *Strong Medicine: The Ethical Rationing of Health Care* (1990).
7. *Ibid.* See also Edmund D Pellegrino, 'The Commodification of Medical Consequences of a Paradigm Shift from a Professional to a Market Ethic?' (1999) 24 *J of Med and Philosophy* 243.
See generally Thomas H Stanton 'Fraud-And-Abuse Enforcement in Medicine: Finding Middle Ground' (2001) 20 *Health Affairs* 28.
8. See generally Joanna Coast, Jenny Donovan & Stephen Frankel (eds), *Priority Setting: Health Care Debate* (1996). See also Mary R Anderlik, *The Ethics of Managed Care* (2001).
9. Daniel Callahan, *Setting Limits* (1987), 137.
10. Above n2.
11. *Id.*
12. See *Webster's New World Dictionary* (3d ed 1991) 1115; Mark R. Wicclair, *Ethics and the Elderly* (1993), 80.
13. See George P Smith, II, *Legal and Healthcare Ethics for The Elderly* (1996), ch 4.
14. See Andrew H Smith & John Rother, 'Older Americans and The Rationing of Health Care' (1992) 140 *U Pa LR* 1847, 1848; Daniel Callahan, *What Kind of Life?* (1990), 20-26.
For a comparative analysis with the British system, see Christian Witting, 'National Health Service Rationing: Implications for The Standard of Care in Negligence' (2001) 21 *Ox J Legal Studies* 443.
15. *Ibid.* See Peter A Ubel, *Pricing Life: Why It's Time for Health Care Rationing* (2000).
16. Smith & Rother above n14, 1849.
17. *Ibid.*
18. Jessica D Silver, 'From Baby Doe to Grandpa Doe: The Impact of the Federal Age Discrimination Act on the Hidden Rationing of Medical Care' (1988) 37 *Cath U LR* 993.
19. Smith & Rother above n14, 1848-50.
20. *Ibid.*
21. See John F Kilner, *Who Lives? Who Dies?: Ethical Criteria in Patient Selection* (1990), 79-80.
22. *Id.*, 83-84.
23. See Daniel Callahan, 'Health Care Struggle Between Young and Old' *Society*, (Oct 1991) 29, 30-31; Vernon L Greene, 'Human Capitalism and Intergenerational Justice' *The Gerontologist* (1989) 721.
24. Smith & Rother above n14, 1850.
25. See Dennis W Jahnigen & Robert H Binstock, 'Economic and Clinical Realities: Health Care for Elderly People' in Robert H Binstock & Stephen G Binstock (eds), *Too Old for Health Care? Controversies in Medicine, Law, Economics, and Ethics* (1991) 13, 17-22. See also Stanton above n7.
26. Kilner above n21, 90.
27. See George P Smith, II, *The New Biology: Law, Ethics and Biotechnology* (1989), ch 3.
28. Above n9, 20.

29. Greene above n23, 723-724.
30. Above n13, chs 1, 4.
31. Above n2, 3013.
32. Sheryl A Russ, 'Care of The Older Person: The Ethical Challenge of American Medicine' (1988) 4 *Issues L and Med* 87 ast 88-89.
33. Above n13.
34. Above n32, 89; Smith & Rother above n14, 1856-57. See David C Thomasma, 'The Ethical Challenge of Providing Healthcare for The Elderly' (1995) 4 *Camb Q Healthcare Ethics* 148.
35. See George P Smith, II, 'Patient Dumping: Implications for The Elderly', (1998) 6 *Elder LJ* 165; Daniel N Rosenstein, 'Emergency Stabilization for a Wounded COBRA', (1993) 9 *Issues L and Med* 255.
36. Rosenstein, id., 256.
37. Ibid.
38. Karen J Treiger, 'Preventing Patient Dumping: Sharpening COBRA's Fangs' (1986) 61 *New York U LR* 1186, 1191.
39. Ibid. See George P Smith, II, 'The Elderly and Patient Dumping' (1999) 73 *Fla BarJ* 85.
40. See *Hines v. Adair County Pub. Hosp.*, 827 F. Supp. 426, 428 (W.D. Ky. 1993).
41. 42 U.S.C. §1395dd (1994).
42. 42 U.S.C. §1395dd (1994).
On December 7, 1998, the Department of Health and Human Services Office of Inspector General proposed a patient anti-dumping 'guidance'—designed as such as or clarification of the responsibility of managed care hospitals to provide patients with emergency medical treatment 63 Fed. Reg. 64,556.
43. See Arthur Caplan, 'Ethical Issues and the Care of the Elderly' in Robert Kane (ed), *Improving The Health of Older People: A World View* (1990), 675.
44. Id, 679.
45. George P Smith, II, 'Our Hearts Were Once Young and Gay: Rationing and the Elderly' (1996) 8 *Fla JL and Pub Policy* 1.
46. Above n13, ch 1.
47. See generally Catherine K Cassell, 'Health Care for the Elderly: Meeting the Challenges' in Marshall B Kopp (ed), *Legal and Ethical Aspects of Health Care for The Elderly* (1985), 3, 5.
48. Above n43, 668-73.
49. Id., 675.
50. See generally, Edmund D Pellegrino, 'Rationing Health Care: The Ethics of Medical Gatekeeping' (1986) 2 *JContemp Health L and Policy* 23, 28.
51. See Bruce Jennings 'Ethical Challenges of Chronic Illness' (1988) 18 *Hastings Cntr Rep* 51, 58.
52. See Daniel A Moros, 'Chronic Illness and the Physician-Patient Relationship: A Response to the Hasting's Center's Ethical Challenges of Chronic Illness' (1991) 16 *J Med and Phil* 161, 170.
53. See generally, Dave Lindroff, *Marketplace Medicine: The Rise of The For-Profit Hospital Chains* (1992), chs 1, 2, 5 & 8. See also Jennifer L Williamson, 'The Siren Song of the Elderly: Florida's Nursing Home and The Dark Side of Chapter 400' (1999) 25 *Am JL and Med* 423.
54. See Ronald Bayer & Daniel Callahan, 'Medical Reform: Social and Ethical Perspectives' (1986) 10 *J Health Politics, Policy and L* 533, 536.
55. Above n43, 668.
56. See John Rawls, *A Theory of Justice* (1971), 440.
57. Above n13, ch 1.
58. Id., chs 2,12.
59. See generally Alfred Conard, 'Elder Choice' (1993) 19 *Am JL and Med* 233.
60. B J Soldo, 'Epilogue: Confronting the Age of Aging in Ethics of Health Policy for Elderly' (1985) 19 *Socio-Econ Plan Sci* 289, 290.
61. Ibid.
62. Am Medical Ass'n, *Code of Medical Ethics: Current Opinions of The Council on Ethical and Judicial Affairs* § 2.09 (1992).
63. Terrie T Wetle, 'Ethical Aspects of Decision Making for and With the Elderly' in Marshall B Kopp (ed), *Legal and Ethical Aspects of Health Care for the Elderly* 258, 266 (1985).
64. Above n60, 293.
65. Richard A Epstein, *Our Inalienable Right to Health Care* (1997), 23.

66. George P Smith, II, 'Setting Limits: Medical Technology and The Law' (2001) 23 *Sydney LR* 1, 13.

67. Ibid. See George P Smith, II, 'Utility and The Principle of Medical Futility: Safeguarding Autonomy and The Prohibitions Against Cruel and Unusual Punishment' (1996) 12 *J Contemp Health L and Policy* 1.

68. Above n66, 13.

69. Pope John XXIII Medical-Moral Research & Education Center, *Scarce Medical Resources and Justice* (1987), 112.

70. See William S Andereck, 'Money, Medicine, and Morals' in David C Thomasma & Judith L Kissell (eds.), *The Health Care Professional as Friend and Healer: Building on The Work of Edmund D Pellegrino* (2000), 236.