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Reining in America's Insatiable Appetite for Hi-Tech Care

Taming the Beloved Beast: How Medical Technology Costs Are Destroying Our Health Care System

By Daniel Callahan

Princeton University Press, \$29.95, 267 pages, ISBN 9780691142364

By **STEPHEN SAPP**

In his 2009 book, *Taming the Beloved Beast: How Medical Technology Costs Are Destroying Our Health Care System*, Daniel Callahan updates and amplifies the position he has taken consistently since his 1987 book, *Setting Limits: Medical Goals in an Aging Society*, which is famous (or infamous!) for its proposal that after a person has lived a “natural life span,” publicly provided healthcare should be severely restricted.

A philosopher by training, Callahan was cofounder of the highly respected Hastings Center bioethics think tank and is currently the Center's senior researcher and president emeritus. An elected member of the Institute of Medicine, he has long been regarded as a leading authority on bioethics, particularly with regard to aging and allocation of limited resources.

REINING IN THE BEAST

Callahan focuses here on the detrimental effect on spiraling healthcare costs of our insatiable appetite for “advances” in medical technology (he includes pharmaceuticals, medical devices, and biotechnology in this category). He argues that overall healthcare costs cannot be controlled unless we rein in this “beloved beast” (his analogy of a favorite but ill-behaved family dog that wreaks havoc in the household but that no one would even consider putting to sleep) to control technology, however, this requires not organizational “tweaks” around the edges but rather painful changes in fundamental values by which Americans have long lived and which constitute some central elements of American “identity.”

Although any number of statements could express the book's basic philosophical premise, this one captures Callahan's underlying philosophy well: “What might be of immense value to us as individuals may not be compatible with an equitable health care system, aiming for a common good, not just the private good.” In the rest of the book, Callahan systematically lays out his case in support of this thesis, beginning with an excellent overview of our unaffordable current system, moving on to document the central role that medical technology plays and presenting ideas about what it will take to “get serious” about cost control.

Next, he argues strongly and convincingly that competition is a “solution” that is bound to fail and then illustrates how the problem of limiting technology is complicated by the intimate relationship (or “cohabitation”) of industry and medicine. Two subsequent chapters critique the concept of “medical necessity” and offer a redefinition, in which he divides the lifespan into stages and suggests how much and what kinds of healthcare should be available in each.

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A final chapter presents his call to Americans to accept the pain and take the steps necessary to bring about meaningful reform, along one of his two outlined paths of “optimal” and “conciliatory.” At appropriate points throughout he offers telling international comparisons, especially contrasting the tax-based systems of Great Britain and Canada with the various social health insurance approaches of countries on the Continent (the latter of which he finds preferable as models for reforming American healthcare).

A CONTROVERSIAL CASE

Chapter 6, “Medical Necessity: An All-But-Useless Concept,” is especially thought-provoking and challenging. Callahan presents his case for the “finite model of health care” (contrasted with our dominant “infinite” model), which he sees as essential to save the healthcare system. His model rests on the assumption that “we are biologically finite creatures, born to live but eventually to die, and whose lives as a whole should be valued more for what is done with them than for how long they last.”

Interestingly, although Callahan is a philosopher and not a theologian, his position accords perfectly with the religious view that may be the only teaching shared by all the world’s major religions, namely, that humans are finite, mortal creatures that will die. He also reintroduces his earlier concept of a “natural life span” (here renamed “a full life”) as more reflective of what he means by the idea. Consistent with the book’s stated goal, he argues that our individual definitions of what constitutes a full life cannot be the norm for setting national policy.

With abundant notes citing wide-ranging sources and a helpful index, this book will be a valuable resource in undergraduate and graduate classrooms in many disciplines: It should be required reading for anyone who cares about the future of healthcare in the United States, especially for those who work in aging.

The book’s real value is not that Callahan’s specific suggestions provide the answer but that “we need an open discussion of what counts as good or bad choices, wise or imprudent ones, and our social obligations to our community as we make them.” *Taming the Beloved Beast* is a significant contribution to that discussion. ♦

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The following is excerpted from the book entitled *Taming the Beloved Beast: How Medical Technology Costs Are Destroying Our Health Care System*, by Daniel Callahan, published by Princeton University Press. Copyright ©2009 by Princeton University Press. Printed by permission.

DEFINING A FINITE MODEL OF HEALTH CARE

The other stratum, and the one I take to be primary, consists of a view of human nature and life and of the place that the quest for health should have in it. The most prevalent view is one I have called the “infinity model” of health care. By that I mean an open-ended view of medical progress and technological innovation, one that has no finite goals, no inherent limits to aspirations for better health, and no shared notion of the meaning of such common terms as “good health,” the “quality of life,” and “medical necessity.”

In one sense, that lack of shared meaning bespeaks a culture of medical relativism and political pluralism; those are the values that individualistic, free societies generate, although more intensively in America than in other developed countries. Even more, it reflects a utopian vision of science and its possibilities. There is no disease that cannot be cured, no length of life that cannot be aspired to, no human enhancement that is beyond the realm of scientific possibility, and no biologically based mental or physical suffering that cannot be overcome. One consequence of this view is not simply its emotional power in pushing us continually forward—for who wants to get sick, to suffer, to die?—but no less the grip this aspirational model has on our conscience: it would be profoundly wrong, many argue, not to pursue the unlimited possibilities to improve health, combat aging, and to carry out a war against death.

Yet that infinity model is increasingly unaffordable—nearing the limits of economic plausibility—and with a destructive distortion of our other important national needs. To make the doctor's office and health care the center of American life would not be a good outcome. The assorted managerial efforts to control costs, pointed out in previous chapters, are not working in the United States and are barely working even in those countries that use the strongest available means. Those realities should alert us to the inherent difficulties of trying to finance an infinity model of health care with finite funds.

We need a new and different model, one that is limited in aspiration and thus economically more plausible but at the same time still responsive to our need for good health. Here are my ingredients for such a model. At its core is an acceptance of the reality of death and aging, which we can aim to ameliorate, not conquer. I start with the assumption, earlier uncontroversial but now more contentious, that we are biologically finite creatures, born to live but eventually to die, and whose lives as a whole should be valued more for what is done with them than for how long they last.

The aim of health care should be, within a finite life span, to help us to have a good chance to progress from being young to being old—but not to go from being old to being indefinitely older; to relieve us of our most burdensome physical and mental suffering—but not always fully or perfectly; to rehabilitate us as best it can if we are disabled—but to understand that some of us will live our lives with chronic illnesses and disabilities; and to help us achieve as pain-free and peaceful death as is possible—but knowing that goal will not always be possible. Medicine ought not to seek an indefinite extension of life, or aim to enhance our nature beyond the ordinary standards of good health, or search out medical ways of excessively fighting our decline and frailties, many of which are now and always will be unavoidable. Just as death ought not to be taken as the ultimate enemy of human life, health should not be taken as the ultimate good.