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# BULLETIN

## OF THE PARK RIDGE CENTER

Volume 3, Number 5

September/October 1988

## Center to relocate in downtown Chicago

After three and a half years in its current location on the campus of Lutheran General Hospital, on December 5, 1988 the Park Ridge Center will move to offices at 676 N. St. Clair in Chicago.

The new offices are within five blocks of the American Medical Association, the American Hospital Association, the American Bar Association, and numerous other professional groups. Several hospitals and universities and the headquarters of both major Chicago daily newspapers are an easy walk from the Center's new location.

Center president Martin Marty cited several practical reasons for moving from suburban Park Ridge, chiefly the need for more space and a more central location. The Center has been continually expanding, with the staff size almost doubling since May. As it became apparent that the Center had outgrown its current quarters, the Center staff discussed relocation. "We found that some office space was available in the center of Chicago's bustling downtown, with prices per square foot being quite comparable to those of our current location," Marty said. He also noted that many of the Center's service, production, and communication functions can be more

efficiently carried out from the new location.

There were also more philosophical incentives to relocate, related to projected Center growth and future needs. "We see ourselves not only as a study center that generates its own topics but also as a service center that can help others find new dimensions to [questions]," Marty noted. "Many of the associations with which we'll be conversing have ethics panels which welcome discussion of the faith dimension, or, if they do not have ethics panels, they welcome ethics discussion." The Center can extend its indirect influence by linking up with the nearby national professional associations to reach their constituents across the country.

The proximity to more clinical settings was another draw, Marty said. "We have been very fortunate to have had our inception and early growth in so vital and supportive a clinical context as that provided at Lutheran General Hospital. And, while we'll miss the daily involvement made possible by our current clinic setting, we will continue to profit from an ongoing relationship with LGH while we expand the scope of our efforts. We look forward to

making many more clinical contacts through the large Northwestern hospital system—including the Rehabilitation Institute of Chicago—one block away from our new offices, as well as almost a dozen other hospitals within a several mile radius."

The Center also plans to take advantage of new academic contacts and

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676 N. St. Clair

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### AIDS virus can "hide"

Scientists have found traces of AIDS virus hidden in a certain type of body cell and thus able to escape detection through standard AIDS screening methods. Current tests look for antibodies rather than the virus itself, but the new discovery means that some of those declared uninfected by these tests may in fact harbor the AIDS virus.

Scientists had been puzzled by a process called seroreversion, in which patients who initially tested positive for AIDS antibodies gradually lost the antibodies. Seroreversion usually occurs in the final stages of the disease, when the body becomes too weak to produce the antibodies, but in one study about 4% of those who tested positive for antibodies displayed seroreversion when they had no symptoms of the disease.

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It was hoped that these subjects had somehow conquered the invading virus, but the new discovery suggests that the virus may merely be going into latency and temporarily not provoking an immune response rather than disappearing permanently. This means that the virus could be carried by some people who had been declared uninfected, and they could transmit the virus to others.

Scientists noted that the new discovery probably does not mean that there is increased risk to the general blood supply because most AIDS patients do develop detectable antibodies, most high-risk people do not give blood, and infected donors who are undetected by the standard AIDS tests often test positive for hepatitis. There is always a small risk to blood supplies, of course, from people who donate blood after they've been infected but before the body develops detectable antibodies.

### FDA makes more AIDS drugs available

Bowing in part to public pressure, the Food and Drug Administration has taken steps to make more drugs available to AIDS patients, even if those drugs have not completed the FDA approval process.

In July, Dr. Frank E. Young, commissioner of the FDA, announced that the agency was formalizing a procedure to permit Americans to privately import small quantities of unapproved drugs for personal use. The action was seen as a response to AIDS-patient advocacy groups, who have repeatedly criticized the government for foot-dragging in matters of AIDS drug approval. After making his announcement to the 10th National Lesbian and Gay Health Conference, at which he was often heckled and booed, Dr. Young told reporters, "There is such a degree of desperation, and people are going to die, that I'm not going to be the commissioner that robs them of hope."

In August the FDA relaxed its usual regulations, making available a drug

used to treat the form of pneumonia that is the leading cause of death among AIDS patients. The drug, trimetrexate, has been used experimentally to treat the *Pneumocystis carinii* strain of pneumonia, but only on patients for whom the two approved drugs had dangerous side effects. Under its new policy, the FDA will allow trimetrexate to be used on patients for whom the other two drugs were simply ineffective. AIDS-patient advocacy groups and several members of Congress had protested the FDA's restrictions on trimetrexate, contending that the agency was "overly restrictive in interpreting its own regulations."

As of August, 56% of the total number of persons with AIDS in the U.S. had died from the virus, according to the Centers for Disease Control.

### U.S. verifies safety of new prenatal test

The federal government has completed a study of 3,000 pregnant women and concluded that chorionic villus sampling (CVS) is not significantly less safe than amniocentesis, the traditional method of fetal testing.

CVS involves removal of a small amount of tissue surrounding the fetus, while amniocentesis consists of extracting some amniotic fluid. CVS can be performed 9-12 weeks into the pregnancy, while amniocentesis is usually performed at 16 weeks. The difference is important because if fetal defects are found and the mother wants an abortion, it is safer in the first trimester than in the second. Both types of test accurately detect the presence of Down's syndrome, the most common inherited cause of mental retardation.

Until this study, doctors were reluctant to perform CVS testing for fear of causing miscarriages. The miscarriage rate for CVS patients in the study was 2% and for amniocentesis patients, 1.3%. CVS testing is currently done in about 20 medical centers in the U.S. However, amniocentesis, which is more effective in spotting spina bifida, will continue to be used for mothers



who have had a previous spina bifida pregnancy as well as for women in the later stages of pregnancy.

Ultrasound, a method of fetal testing that uses sound waves bounced off the fetus to produce a picture on a video screen, can determine gender or detect physical abnormalities such as a swollen brain, but is not as precise as CVS or amniocentesis.

Even less invasive testing methods may be on the horizon. Researchers at several medical centers hope eventually to test fetuses using only a mother's blood sample. Fetal cells often appear in the blood of pregnant women, but scientists aren't certain whether they are always present and, if so, how to locate them.

### Egyptians use in vitro procedure to circumvent Islamic law

The Associated Press reports that several "test-tube baby" clinics have sprung up in Egypt to cater to infertile couples who feel that Islamic law pertaining to adopted children is too restrictive.

Islam, as generally interpreted in Egypt, prevents adopted children from inheriting any property unless they are specifically named in their parents' will, and even then the share is limited to no more than a third of the property. Furthermore, the adopted child cannot take the adoptive parents' surname unless the identity of the biological parents is unknown, prompting couples to try in vitro fertilization to preserve family lineage.

Ironically, Egypt has a severe overpopulation problem, with 4% of the land (the Nile Valley) producing food for 55 million people. The government spends about \$60 million a year to limit population growth, but because of in vitro fertilization's high cost and limited success rate, no restrictions have been placed on the procedure. "Every wife wants to become a mother and 50 or 100 more babies a year won't affect the population," explained the minister of health. It is assumed that only married couples can use in vitro fertilization.

### Regulations of U.S. in vitro industry proposed

Concerned that many infertile couples are being exploited by deceptive advertising claims, experts in the fertility industry are calling for increased regulation of "test-tube baby" clinics, which perform in vitro fertilizations. An editorial signed by 11 prominent physicians in a recent issue of the journal *Fertility and Sterility* warned others in the field against exploiting infertile couples; the biggest debate now is whether the industry can regulate itself or whether the government should step in.

There are estimated to be about 200 "infertility clinics" nationwide, but experts attribute about half of the 3,000 test-tube pregnancies in the U.S. to only three of those clinics. In fact, the American Fertility Society calculates that half of the American clinics have never used the procedure successfully.

Timing, the age of the mother, and the skill of those performing the fertilization affect the success rate, which overall is estimated to be around 9-12 pregnancies per 100 attempts. Even for the best candidates, experts say, the success rate rarely exceeds 25% on the first try and 50% after three tries. (Each attempt costs about \$5,000; the federal Office of Technology Assessment estimates the annual in vitro market at \$30-\$40 million.)

Although several medical associations have established guidelines for the industry, compliance is optional and clinics are not required to report their success rates. "What you have is a million couples desperate for a baby, and the evidence is that the fertility clinics are promising results they can't achieve," said Congressman Ron Wyden (D. Ore.), who is proposing federal regulation of the industry.

Increased pressure for regulation—or at least for publication of success rates—is also coming from the insurance industry, which regards the procedure as experimental and is unlikely to treat it otherwise until clinics have outside auditors verify success rates. However, cautions Dr. Howard

Jones (who performed the first successful in vitro fertilization in the U.S. in 1980) simple success percentages could also be deceptive because they wouldn't disclose how often fertility drugs were involved. Moreover, clinics might not accept less promising candidates if the industry overemphasized success percentages.

### Bernardin calls for consensus on euthanasia

In a May 26 speech at the University of Chicago's Center for Clinical Medical Ethics, Joseph Cardinal Bernardin of Chicago called for "a national consensus opposing euthanasia or assisted suicide" but said that allowance should be made for withdrawal of useless and excessively costly or painful measures from certain patients.

Bernardin said he opposes legalizing direct measures to end the lives of the terminally ill, and urged opponents of euthanasia to concentrate on "positive responses" to the problem, such as better care outside of hospitals and more attention to alleviating pain. He also advised opponents of euthanasia to address larger cultural issues such as the society's emphasis on youth, uncertainty about resource priorities, and the breakdown of community support for many individuals.

Bernardin discussed his consistent ethic of life in a *Second Opinion* interview published in volume 8 (July 1988).

### AMA urges physicians to warn potential AIDS victims

In a sharp break with its tradition of physician-patient confidentiality, the American Medical Association voted to urge physicians to directly alert sex partners of AIDS carriers when there was no other way to notify them. Although the approved resolution called for doctors to first try to convince the AIDS patients to notify partners, and then to call upon public health authorities to do so, the fact that a direct

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breach of privacy was encouraged as a final resort surprised many.

"This will undermine to its root the physician-patient relationship and undermine the effort to control the epidemic," said the executive director of a gay rights defense fund in New York. "If patients feel doctors are going to rat on them, they're not going to go to their doctors." The new president of the AMA, however, speaking at the group's annual meeting in Chicago, said that the seriousness of the AIDS epidemic warranted an exception to the Hippocratic oath, in which physicians swear to secrecy. "We are saying for the first time that, because of the danger to the public health and the danger to partners who may be contaminated with this lethal disease, the physician may be required to violate patient confidentiality," asserted Dr. James E. Davis. "The physician has a responsibility to inform the spouse or known partners. This is more than an option. This is a professional responsibility."

Legal experts suggested that the language of the AMA resolution, which made notification more of a requirement than a suggestion, would increase physicians' liability in cases where they did not notify third parties. This, in turn, might lead physicians to "overnotify" for fear of being sued, several gay rights groups asserted. There have been no definitive court decisions on the matter, although in California a former companion to Rock Hudson is suing the actor's doctor for not informing him that Hudson had AIDS.

## AMA: Are MRIs worth the money?

While magnetic resonance imaging produces clearer pictures than most other body imaging systems (including computer axial tomography, "CAT scans"), a recent article in the *Journal of the American Medical Association* suggests that the actual medical benefits may be less significant than commonly believed.

Magnetic resonance subjects patients to high magnetic fields then monitors the reaction of selected atomic nuclei to specific radio waves.

A University of Rochester study of several dozen reports from the first four years the magnetic resonance imaging was available found frequent praise for the quality of the pictures but little critical evaluation.

In an interview with the *Chicago Tribune* Dr. Lawton Cooper, director of the study, suggested that doctors rush to acquire new technology without assessing its true benefits, if any. "If they like the pretty pictures, they say they need it, just like someone who likes the way a new car looks," Cooper said. "It's easy to be seduced by pretty pictures."

A *JAMA* editorial accompanying the research findings stated that in light of the \$2-million-plus cost of an MRI, there were "serious doubts about whether limited resources are being wisely used, at least from the perspective of improved clarity of diagnosis or patient outcome."

The past president of the American College of Radiology defended the growth in MRI use, noting that the Cooper study included no MRI evaluations conducted after 1984: "He looked at the studies done when this technology was in its infancy, (when) we were just learning how to use these machines."

## U.S. ends funding for artificial hearts

Noting that none of the five human recipients of artificial hearts is still living, the director of the National Heart, Lung, and Blood Institute announced in May that the federal government would no longer subsidize the development of artificial human hearts. "The human body just couldn't seem to tolerate it," Aloysius P. Lenfant explained.

The government will continue to finance heart assist mechanisms, such as ventricular pumps, but will not pay for devices intended to supplant the entire function of a living heart. The

decision to end funding was seen as a serious blow to the dream of creating a fully functional human heart, but privately funded efforts to develop artificial hearts will not be affected by the government decision. One such private effort, by the Humana Corporation, resulted in the first artificial implant, performed in 1982 on Barney Clark. He lived three months. A detailed account of the development of the artificial heart can be found in volume 8 of *Second Opinion* (July 1988).

## New York City approves "free needles for addicts" program

On August 11 the New York City Health Commission announced that in late October it would begin distribution of free hypodermic needles to users of illicit drugs in an attempt to slow the spread of AIDS. Several other countries have adopted similar programs, but the policy is controversial and no such distribution had yet taken place in the U.S.

Use of dirty needles is the leading mode of AIDS infection in New York City; because most drug abusers are heterosexual men, their sex partners—and often, their unborn babies—also become infected. One in every 77 babies born in New York City in the first half of 1988 tested positive for AIDS antibodies. Citywide, blood tests indicate that about half of New York's 200,000 drug abusers are already infected with the AIDS virus.

During the trial period of the distribution program, needles will be given to 200 addicts on the waiting lists of drug treatment centers. Another 200 similar addicts will be monitored as a control group but not given free needles. If the results are encouraging, the program will be expanded.

Announcement of the program sparked bitter controversy in the city's drug enforcement and minority communities, where opinion is sharply divided over whether the plan will reduce the spread of AIDS or increase the use of drugs. Noting that drug abuse is highest in black and Hispanic areas, the city's special narcotics prosecutor,



who is black, told the *New York Times* that the policy has racist implications because free needles will promote drug abuse in the minority population—"this is an apartheid policy."

In an effort to curb drug abuse, New York law mandates that hypodermic needles be sold by prescription only. As a result, needles that cost less than a quarter by prescription are sold illegally for \$5 apiece. To avoid the risk involved in buying the needles illegally addicts share needles.

### Five-organ transplant recipient dies

Three-year-old Tabatha Foster died on May 10, more than six months after she underwent a transplant of a new liver, small intestine, pancreas, and parts of a colon and stomach. She was the world's longest survivor of a five-organ transplant.

Born with an intestinal deformity, Tabatha had 95% of her small intestine removed when she was three days old. Over the next two years, her necessary liquid diet damaged her liver, and in October 1987, doctors decided it would be easier to replace all five organs rather than just the liver and small intestine.

The 15-hour experimental operation and subsequent treatment were conducted at Children's Hospital in Pittsburgh under Dr. Thomas Starzl. "This is not the loss meaninglessly of a life," said Starzl, a pioneer in organ transplantation research. "Along with Tabatha's death came the accrual of something really worthwhile."

### Presidential AIDS commission releases report

Calling discrimination "the foremost obstacle to progress" in combatting AIDS, retired admiral James Watkins issued a 300-page report of the eight-month-old presidential AIDS commission.

The report contained 579 recommendations, some of which are counter to previous Reagan policies—including new federal antidiscrimination laws and new confidentiality statutes with

regard to AIDS testing and reporting. Watkins echoed a National Academy of Sciences report issued a week earlier when he stated, "The system has failed. It is not working well, and we had better get with it." His personal criticisms were deleted from the final report.

### Circumcision endorsed by pediatric group

A task force appointed by the American Academy of Pediatrics is finding evidence that challenges the AAP's 1975 announcement that there is "no good medical reason for routine circumcision."

A study of 220,000 infants, published in the journal *Pediatrics*, showed that urinary tract infections occur in fewer than 1% of circumcised infants, compared with 10% among uncircumcised babies. Cancer rates may also be affected: only about 10 of the 50,000 men diagnosed with penile cancer since 1930 were circumcised. And a Canadian research team found in a study in Africa that uncircumcised men were 7.6 times more likely to contract AIDS than were circumcised men, although that finding is rejected by experts at the Centers for Disease Control in Atlanta.

Opponents of circumcision charge that the operation causes unnecessary pain and anguish while providing no discernible health benefits. In part due to trends toward more natural methods of childbirth, the proportion of American boys who are circumcised has dropped slightly in recent years to around 60%. Worldwide, about 20% of all baby boys are circumcised, while in Great Britain the figure is less than 1%.

### Euthanasia initiative fails

Advocates of a proposed California law to allow terminally ill patients to ask their doctors to kill them were unable to place the initiative on the November ballot when they failed to obtain the necessary 400,000 signatures by the May 6 deadline.

The California Catholic Conference had been a major opponent of the initiative, which was sponsored by the Hemlock Society. The state's Catholic bishops charged that "those who would exploit the suffering and depression of (AIDS patients) to serve a political campaign for euthanasia cannot be described as advocates for human rights." The California Catholic Conference hired a full-time staff person to oppose future euthanasia initiatives.

### AIDS conference discusses vaccine

Many of the 3,100 researchers who presented papers at the Fourth International Conference on AIDS in Stockholm addressed measures taken or planned with the goal of finding a vaccine to prevent AIDS.

But the overall effect of the new research was to expose some basic research gaps, wrote science reporter Richard Harris in the June 25 issue of *Science News*.

"Although HIV was isolated five years ago, only now are scientists conducting the classic vaccine experiments: killing the virus, then injecting it into chimpanzees to see if the killed virus acts as a vaccine," Harris wrote.

Harris reported that "half a dozen" genetically engineered AIDS vaccines have already been announced, two of which have provoked an immune response in humans. "But it will take studies with hundreds, perhaps thousands, of volunteers followed over many years to determine whether these vaccines are effective," Harris concluded.

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# Daniel Callahan's public problem

by James P. Wind,  
Director of Research  
and Publications,  
the Park Ridge Center

One of the most talked about books over the past year has been Daniel Callahan's *Setting Limits: Medical Goals in an Aging Society*. The book's message is straightforward enough. We are an aging society. As medicine becomes more successful at extending life the balance is tipping between older and younger generations. Paradoxically, the triumphs of high tech medicine often result in more human suffering. Chronic illness becomes more common as we become better able to keep people alive after major health crises. The proportion of resources devoted to the health care needs of people in the last years of life threatens to mortgage the future of baby boomers and their children. For all of these reasons, Callahan argues, we cannot afford to keep going in the direction that medicine and society have taken.

Callahan's proposed solution for this grim scenario is that we (society and physicians together) change the goals of medicine. Instead of being preoccupied with life extension at almost any cost, modern medicine should seek to help all citizens achieve a natural life span. Instead of engaging death in relentless battle whenever it occurs, medicine should distinguish between premature and natural deaths. Rather than attempting to banish old age, medicine should seek to help people maintain that level of health sufficient to a meaningful experience of life's last—and perhaps most significant—stage. These goals require society and medicine to agree on what constitutes a natural life span. To avoid rigid biological determinism Callahan fudges a bit with the actual border—"late 70s, early 80s"—to natural life. A fuller life rather than a longer life is his goal. He is concerned that an individual have had the opportunity to do meaningful work, share human love, participate in the full range of family life, live in community, pursue moral ideals, and experience beauty, knowledge, and travel.

By and large the reviewers and pundits who have responded to Callahan's book have understood this message. Some have lauded him for helping us face our national and individual limits. Others have quibbled with the statistics he marshalls in support of his argument. Still others strenuously challenge his assumptions, claiming that our resource problem is not as grim

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as Callahan thinks or that accepting a natural life span is tantamount to a premature throwing in of the towel in the ultimate match between Eros and Thanatos.

As important as the fine points of Callahan's argument—or those of his critics—are, I do not want to rehash them here. Instead I want to call attention to a more important problem pointed out in Callahan's book: our national public meaning crisis. If we take seriously the author's social location (director of the Hastings Center) and his experience (as one of the most active participants in our nation's public policy debates over health issues), Callahan's diagnosis of this deep culture-wide problem should give us pause. Yet, this part of his argument has received much less attention than have his specific proposals. If he is right about our national malady, then we have a much more serious situation on our hands than we thought, one affecting our public policies on aging, but also spilling over into many other areas of modern life.

Consider these lines from *Setting Limits*.

We lack, as a people, any common coherent vision of the wellsprings of moral obligation toward the elderly in general and our elderly parents in particular. We do not have a shared understanding of the

moral significance of pain and suffering, or any clear notion of how we ought to support one another's private griefs and burdens. We do not provide strong encouragement for those personal virtues which enable people to endure in the face of adversity. All these communal deficits can come to a high intensity in the demands that vulnerable elderly parents can make upon their children (pp. 97-8).

No common coherent vision. No shared understanding. Communal deficits. These are the deep problems that make decisions about appropriate care for aging people intractable. Far more is needed to meet our health care needs in the future than fine-tuning our national budget or finding one more magic bullet to keep death at bay a little longer. We need to arrive at publicly shared understandings of death, aging, medicine, and the obligations between parents and children.

Read on with Callahan. Asserting that our traditional moral language of rights and obligations "does not seem to fit" the current situation of many parents and children, he concludes that "our secular morality (though perhaps not our religious traditions) provides few resources for living lives of unchosen obligations" (p. 96). I will say more below about Callahan's parenthetical comment. For now the main thing to note is that Callahan's big problem is our culture's operative moral tradition. It is, he claims again and again, inadequate for our new needs.

Beneath the reigning "medical needs" model of determining health care strategies and what Callahan calls our "spend down" approach to the illness of elderly people (policies that require the elderly to spend their life savings before receiving financial aid) is a thin but powerful cultural mind-set that puts its hopes in technology and its priorities on defeating death. We need, says Callahan, "a full reform" of our health care system. But he is quick to say that such a reform is not likely. "Many years will be required to bring about the kind of shift in values needed to change attitudes and practices pertinent to the provision of life-extending technologies to the elderly"



(p. 147). If we accepted natural limits to life, research priorities could change from the glamorous high technology items like artificial hearts that benefit a few to the problems that diminish the quality of life for the many—problems like dementia, urinary incontinence, hearing impairment, osteoporosis. But those problems will only become priorities if we overcome a “national bias” in favor of acute-care medicine (p. 151).

Could that happen? Should it? Callahan leaves no doubt about his position on the latter question. If we are going to deal in a humane, fair, and intelligent way with the shifting health needs of our nation we must change our priorities. To do so “will require a major effort to reorient medicine away from its captivity by the modernizing, technology-driven, borderless ‘medical need’ model of care for the aged. It will no less require a parallel reorientation of the general public, who will be as reluctant to give it up as will physicians” (p. 158). The pessimism lurking behind the last phrase hints at Callahan’s ambivalence about the first question. He knows what is needed: “Nothing other than a long-extended public debate over many years is likely to suffice to bring about that kind of change” (p. 158). But he also has doubts about the possibility of such a debate and reservations about the possible symbolic meaning of his proposal. “If that kind of policy were instituted without a change in our present understanding of old age and death—without a reformulation of the ends of medicine and aging—it could do great harm and convey damaging messages to the old. *Cessation of life-extending treatment for the aged as a matter of social policy can be morally acceptable only within a context that accords meaning and significance to the lives of the individual aged and recognizes the positive virtues of the passing of the generations*” (pp. 197–98, italics in original).

Why make a proposal and then turn around and partially pull it from the table? More than anything else Callahan wants to get the debate going. And *Setting Limits* contains much that is provocative of such debate—at the specific level of proposals for criteria to

guide termination-of-treatment decisions and at the “macro” level of cultural diagnosis. (I find especially provocative his discussion of the special meaning-bearing and meaning-giving role of aging people vis-à-vis the younger generations. By relegating the elderly to the “nonproductive” zones of retirement and leisure are we silencing a precious source of meaning that might help us through this time of searching? Callahan thinks so and I tend to agree.)

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But Callahan provides little help in creating, sustaining, and shaping the debate he believes we so desperately need. His book sets forth an issue and a point of view that cannot be ignored and calls for a debate to begin. So far so good. But more needs to be said than that we need to talk. Here I would return to his parenthetical comment noted above. Perhaps to create the kind of ongoing public debate our society needs we must move it beyond the walls of our legislatures and the editorial pages of our newspapers. Not that senators, commentators, and other experts should keep quiet. On the contrary, they must participate in the discussion Callahan wants. But most such discussions use the “secular morality” language of rights and obligations that Callahan has doubts about.

His tentative admission that there might be better resources elsewhere (“perhaps” in “our religious traditions”) suggests that many debates need to take place—and not just between society’s elites. What if each of the more than 300,000 religious congregations in our land began to stimulate discussion about these basic questions—first

within themselves and later with members of the surrounding communities? What if they began to host these debates rather than passively waiting for them to begin and then, when things seemed to be taking a wrong turn, demanding to be heard? These religious communities have answers—even if underused and contradictory—to meaning questions about death, aging, family obligations, and justice different from those that dominate our television screens and political rhetoric. Do those communities have a public duty to offer their resources to a society searching for answers? Callahan did not extend a direct invitation to the religious communities to join the debate, yet it seems apparent that help is needed and that a serious reckoning with our pluralism of beliefs and practices must occur for consensus to emerge.

Just as Callahan was hesitant in making his proposal about changing medicine’s goals, so am I in suggesting that the religious traditions join the discussion. We will only further our confusion if various traditions try to cancel each other out with exclusive positions. Only if various religious communities can muster a deep commitment to the good of a diverse public can anything more than cacophony result. Only if each religious community is willing to confront the fact that there are as Paul Tillich once reminded us “sick traditions” not just in everybody else’s way of life but also in our own, can there be the possibility of new insight and agreement. Only if each group searches not for the way it can prevail, but for what its special contribution could be, can we hope to find new approaches to our problems. The track record of religious communities in public debate is pronouncedly mixed—suggesting that our various religious communities need to prepare themselves for the kind of debate that Callahan and others think we need. Such preparation is far from being optional. The magnitude of the decisions we face in health care and public policy may make failure to prepare for this debate hazardous to our societal and individual health.



# Health care for an aging America

*Dr. Christine K. Cassel, M.D., Chief of Internal Medicine at the University of Chicago Hospitals, is one of the country's foremost authorities on geriatrics and has written extensively on medical ethics and the elderly. The following remarks are excerpted from a paper she presented in the lecture series, "Major Issues in Clinical Ethics," co-sponsored by the Park Ridge Center:*

By the year 2020, between 15 and 20% of the population of the United States, or approximately 50 million people, will be over age 65. Close to half a million will be over age 100! The increasing life expectancy of Americans, unprecedented and greater than all forecasts, has resulted in larger numbers as well as a larger proportion of older people in our population. The "oldest old," the age group above 85 years old, are increasing at the fastest rate. They also have the highest incidence of chronic debilitating illness, causing dependency and requiring increased use of both acute and long-term health care services.

While all studies show that the elderly use hospital services more than younger persons, this statistic does not adequately describe the clinical implications of an increasingly aging population. For one thing, even among the very old, it is a small percentage of the total who account for that increased use. For the majority of elderly people a hospital stay is a rare event. Furthermore, the acute care hospital days statistic would be smaller if other services were available.

These "other services" can be described under the broad rubric of "long-term care," a range of personal services including everything from medical care to household help delivered outside the acute care setting (such as home care, nursing homes, retirement homes, respite care, day hospital, and "step down" units). Long-term care services have increased as the aging of our society has led to an increased number of persons with chronic illness or disability. While chronic does not necessarily mean irreversible, most chronic illness is of

long duration and requires periodic episodes of more intense care. Chronic illnesses are the major challenge facing health care today, and the proportion of chronic illness to acute illness on an epidemiologic basis will continue to grow. The major causes of mortality in our society—cardiovascular and cerebrovascular diseases and cancer—have become chronic diseases. Successes in treatment, while not predominantly curative, have prolonged the life expectancy of persons with these diseases. There are a growing number of persons who suffer from other dis-

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expertise.*

orders that are not lethal but that do cause significant impairment: arthritis, chronic pulmonary disease, Parkinson's disease, visual and hearing impairments, and, of course, Alzheimer's disease. These are the diseases of old age, and as we are increasingly successful in prolonging life span, they will become more prevalent. The price of longevity, and of active life expectancy, is that while the proportion of dependent persons does not change, the absolute number grows dramatically. And the notion of compression of morbidity—that active life can continue until its end in a sudden collapse—has no basis in current promises of medical progress.

What would it mean to really design a system that would meet the needs of this growing population of chronically ill and disabled adults? One would have to collapse together all the expenditures from many different sources

and then consider how most effectively to care for the needs of most people. This requires both real imagination and real politics. It would have to be a system in which resources were allocated where they would have the most benefit—the most meaning to the patient's quality of life, thinking beyond current reimbursement policies. If the health care delivery system is to be rationalized at all, considered as a whole, quite a more radical set of options appears.

To provide appropriate care for this population requires extensive progress in the development of community services to assist families who care for such persons in the home. There should be day hospitals and care centers that provide treatment and rehabilitation therapies aimed at slowing the rate of decline. Respite care should be available so that the sickness of one person is not made to cause the sickness of the spouse through exhaustion or the atrocity of elder abuse through unrelenting stress and frustration. Home care, while it remains an ideal in long-term care, is often a more romantic ideal than a practical goal. There are certain kinds of disabilities, particularly cognitive disorders, which require such intensive services that they are often much better done by professionals in a setting designed for such a purpose. Families are better able to provide human interaction, love, and affection—among the most important medicines for such patients—if they are not also changing soiled sheets and managing enteral feeding devices 24 hours a day.

Thus, a broad range of services is the key to long-term care and also the key to limiting unnecessary use of acute care services. In the year 2020 we will not be able to afford the practice of "lodging" disabled persons in hospital beds because community resources necessary for their care are unavailable. More rational decisions will require more reasonable options. If hospitals move into this future understanding both the benefits and the burdens of our successes in disease prevention and prolongation of life,



they will undergo even more significant changes over the next 15 years. But it is not the responsibility of hospitals only. Political changes are essential, perhaps driven by the growing political force of the majority of older adults who are not disabled themselves, but who seek more rational and appropriate options for long-term care for their family members and themselves.

Changes in the training of health care professionals, especially that of physicians, must also occur. Physicians must learn: how to work in the interdisciplinary model of managed care; the functional approach to assessment and to setting treatment goals; and how to work in a variety of care settings, including the patient's home. Teaching these skills will require changes in the curriculum and in the sites and manner of clinical training. Interns and residents would spend fully 70%-75% of their time outside the acute care hospital, instead of one-half day a week or so in the clinic. They would have both longitudinal and block experiences, experience in ambulatory care, long-term care, and home care.

Academic health centers must also look outside the hospital for the major focus of the research effort. The most important challenges for health care research in the next century will be chronic and disabling diseases—their etiology, their management, and perhaps their prevention or cure. Thus even the research enterprise needs to turn 180 degrees away from the acute care hospital as a temple of medicine and see it instead as one component of an array of services in a variety of settings. Laboratory space could exist in conjunction with a multilevel long-term-care center or clinic building.

The major underlying factors limiting the academic medical center from broadening its mission and its identity beyond the acute care hospital are related to institutional and professional ethos. Some of these are longstanding and have been examined in the field of bioethics and in medical education research. Others gained prominence more recently. Some that must be addressed if the academic health center is to flourish in the 21st century are the following:

*"Home care  
is often more  
a romantic  
ideal than a  
practical goal."*

—Dr. Christine Cassel



1. The heroic model of American medicine, in which greater technology is the mark of greater skill and even intelligence, has been the prevailing value system of the academic medical centers. Thus, the "heroes" of academe are the physicians who invent new technologies or who perform technically difficult and heretofore unsuccessful in-patient procedures or operations. This model then emphasizes technologies rather than personal care. What is needed is a medical science of personal care. Family practice is an effort in this direction, but adding chronic care increases the breadth of a field already spread too thin. General internal medicine has tried to make an academically credible research agenda by asking thoughtful questions about the discriminating use of resources, but has largely limited that effort to the acute setting.

2. The cure orientation of medical training. While physicians who are in practice for any length of time inevitably "unlearn" the unrealistic expectation of cure in most cases, it still pervades the values of the academic medical center. The incremental successes of maintenance or gradual improvement in function in a patient with multiple chronic illnesses has never been viewed as the central intellectual (or even moral) challenge of medicine in the academic center.

3. The general "ageist" bias physicians share with their culture. Espe-

cially the frail and decrepit elderly represent an image of a future that the "Pepsi generation" would rather ignore. Physicians' avoidance of human decline has been attributed to their personal difficulties accepting the finitude of human existence and the inevitability of death, compounded by a sense of professional failure because of their inability to "save" these patients.

4. The stereotype of physicians has been of the authoritative, arrogant, paternalistic solo figure. To the degree that this stereotype is accurate, it has prevented physicians from acknowledging and respecting others' expertise and from delegating those parts of the patient's care better done by someone else. Excellence in geriatric care requires a team approach. The concept of the interdisciplinary health care team has been much lauded and much maligned in the literature of geriatrics, but some version of it persists. The frustration for many physicians, particularly those in training, is the complex web of interacting factors involved in both the diagnostic process and the therapeutic strategies with elderly people. If the medical student or house officer is not willing to deal with these complexities and gets no support or prodding from faculty physicians, he or she will at best have limited success in treating the geriatric patient. Nurses and social workers are

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## AGING

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the other professionals who, with the physicians, generally make up the "core team." Others, such as psychol-

ogists, physical and occupational therapists, audiologists, speech therapists, nutritionists, and chaplains often play an irreplaceable role. The team model, however, has not been the classic

model of physician practice or of physician training.

5. Dealing with ethical dilemmas. All specialties of modern medicine face ethical issues, but geriatrics undoubtedly has more than most. The issues center in the doctor-patient relationship, informed consent, disclosure of bad news, decisions to forgo life-sustaining therapy, and the weighing of risk and benefit in the absence of good data on results of interventions in the very old. In addition, broader questions of social, professional, and institutional ethics surround the care of elderly persons. Many teaching hospitals lack a well-defined process and institutional structure to help trainees and faculty deal with ethical problems in geriatrics.

6. Reimbursement has reinforced an emphasis on technology, and the academic medical center has responded. The specialty areas with the highest visibility, the most glamor for attracting students, and the most support



*"The frail and decrepit elderly represent an image of a future that the 'Pepsi generation' would rather ignore."*

## Cassel considers *Setting Limits*

As an authority on aging and geriatrics, Christine Cassel is eminently qualified to discuss issues relating to America's elderly. In a recent issue of *American Medical News*, Dr. Cassel reviewed Daniel Callahan's book, *Setting Limits*, which argues, among other points, that one option for health care policy would be to not administer life-prolonging medical care to people after they have reached an unspecified "natural life span." (For another perspective on *Setting Limits*, see the article by James P. Wind on page 6.)

Following are some excerpts from Dr. Cassel's review:

For the individual, to counsel acceptance of death may be sage advice. But such counsel is dangerously misplaced when it is translated into public policy. For the foundation of the American legal system is acceptance and—indeed—protection of diversity and pluralism. The courts, with support from ethicists, have firmly asserted that decisions about life and death, and life-sustaining medical care, must be based on the right of self-determination....

Dr. Callahan [believes] that we are

running out of money, and the use of life-sustaining technology on behalf of elderly people costs more than it is worth....Some of the premises he accepts throughout are, however, highly questionable....The primary premise that must come under question...is that we as a society cannot afford appropriate health care as people grow older.

Economists have pointed out that a major part of the Medicare budget is spent on people in the last year of life. Yet it is not obvious that this is money wasted. All medical care in critical illness is a gamble. People who die may have spent the previous year struggling with illness. In not all cases was death inevitable or predictable....

[Dr. Callahan argues that] since physiologic and prognostic judgments are so difficult to make in the elderly, why not simply base life-prolonging clinical decisions on an arbitrary age limit? [The premise here is] that declining resources have placed us in a "life-boat" situation, in which some people must be thrown off the boat if others are to survive. But...we are not in a "life-

boat" situation, because there are many other ways we can pay for needed health care. There is an enormous amount of wasteful spending and profit-taking in the health care industry that must be addressed, morally speaking, before we start throwing people off the boat.

...A time when some 80-year-olds can expect to live in good health for 15 more years is not the time to propose an arbitrary age limit in health care delivery. It is rather the time to propose better training in geriatric medicine for physicians and a stronger scientific and moral capability to make appropriate decisions on an individual basis. Physicians as a group have been woefully inadequate at assessing individual patients and allowing death to come when that is appropriate. Better training in how to make these medical and moral judgments and better social support for physicians—that is, protection from unjustified liability litigation—would go a long way toward improving this decision-making process and making it more individual, humane, and morally correct.



from both academic and hospital administration, are high-volume, technology-centered specialties. Rarely does primary care or general internal medicine, where intellectual rigor is demonstrated by technical restraint rather than technical display and where the tools of the trade are interaction with the patients and their families, analytical approach to consultation and resource utilization, commitment to follow-up, and understanding of community resources, command the prestige awarded to critical care or transplant surgery. It is not surprising that geriatrics has not flourished in such an environment.

7. Financial constraints have affected the educational enterprise as the generous clinical income previously used to supplement funding of education has dried up. Geriatrics has had the misfortune to emerge during a period of increasing limits on income in academic medical centers. Current and predicted changes in reimbursement for services will change the balance between acute and long-term care, but unfortunately not in a way that enhances either education or research. These limits have been noted in all three of the major sources of income for academic medical centers—tuition, research, and patient care.

### The Future

Only a thoroughgoing revolution in academic medicine could create all the changes necessary to address these problems. Perhaps the nascent political power of older adults combined with the clear inadequacy of the cur-

rent system and the destructiveness of cost-containing efforts aimed at a single sector will lead to such a revolution. Ideally, it should come from the thoughtful analysis of health care providers, policy experts, and public officials. The premise for seeking a coherent policy is not idealism. On the contrary, it is purely pragmatic. Improvements born out of disaster are much less likely to be as comprehensive as is necessary. It seems, however, that in the real world change occurs through the process of economic and

### *Geriatrics and long-term care is potentially the salvation, both practically and intellectually, of the academic medical center.*

political negotiation among those with conflicting interests. Change must be incremental, but need not therefore be cynical.

If I had to recommend a single change which would make the greatest impact given an imperfect world, it would be the serious extension of academic medical centers beyond the acute tertiary care hospital. It is not enough to have a token affiliation with one nursing home. Rather, the entire continuum of long-term care must account for as much or more of the

training time and research effort as does the hospital.

In response to the new and commercial environment a number of authors have suggested specific reforms in the academic medical centers. The common unanswered question in all of these reports is how the academic medical centers can be economically viable while continuing their teaching and research missions. The answer depends in part on the willingness of the institutions to expand their traditional clinical role to chronic care on the undeniably political basis of need. The federal government has been generous in research and Medicare funding in the past but has never accepted any specific responsibility to support the academic medical center as such. The government is not going to bail out the teaching hospitals. But that is not to say that the academic medical centers ought not, perhaps for the first time, define their mission and defend it politically. Long-term care poses complex issues that are not going to disappear and that have no coherent academic base. The need for such care is but one of a number of other major political realities of health care financing. A coherent system must be comprehensive, and for this reason care of the elderly is not an incidental obligation of the academic medical center. It is potentially their salvation, both practically and intellectually, to focus on geriatrics and long-term care, and to learn lessons there which can be applied to the entire community.

### Relocation

*(Continued from page 1)*

resources at the University of Chicago, Northwestern, Loyola, DePaul, and the University of Illinois, which all have branches within several blocks of the Center's new space.

Finally, Marty noted, many of the issues studied at the Center are related to the commercial world, and the new location "in the hub" of major print and

broadcast communications networks and public relations companies can help disseminate the Center's conversation to a larger public.

The name of the Park Ridge Center, membership costs and benefits, as well as the nature of the Center's publications, will remain unchanged. The complete new address for editorial correspondence is the Park Ridge Center, 676 N. St. Clair, Suite 450, Chicago, Illinois 60611. The new phone number is 312/266-2222. (All membership cor-

respondence, including orders and payments, should continue to be sent to the Center's Membership Division, P.O. Box 1347, Elmhurst, IL 60126.)

The 25-story 676 St. Clair building was designed by the renowned Skidmore Owings Merrill architectural firm; construction was completed in 1976. The administrative headquarters for Blue Cross/Blue Shield and numerous physicians' offices are also housed in the building.



## U.S. distributes AIDS brochure

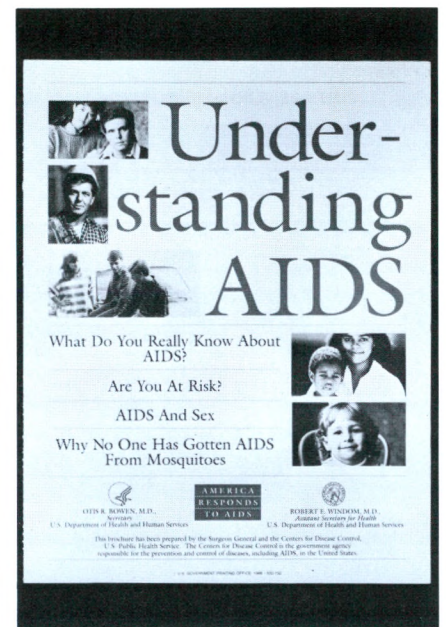
"Understanding AIDS," an educational brochure prepared by the U.S. Public Health Service and the Centers for Disease Control, was mailed at a cost of \$17 million to 107 million households across the U.S. in June as part of a national AIDS awareness campaign.

Surgeon General C. Everett Koop encouraged recipients of the brochure to "practice responsible behavior based on understanding and strong personal values." While admitting that "some of the issues involved in this brochure may not be things you are used to discussing openly," Koop stated that "stopping AIDS is up to you, your family, and your loved ones.... Get involved. Many schools, churches, synagogues, and community groups offer AIDS education activities."

The eight-page brochure, geared to the reading level of seventh graders, discussed how AIDS is transmitted, what behavior puts people at risk, condom use, treatment for AIDS, how to talk with kids about AIDS, and included an AIDS quiz. A concluding

section called "Helping a Person with AIDS" stated: "no one will require more support and more love than your friend with AIDS.... Feel free to offer what you can, without fear of becoming infected. If you don't know anyone with AIDS but you'd still like to offer a helping hand, become a volunteer.... This might mean dropping by the supermarket to pick up groceries, sitting with the person a while, or just being there to talk. You may even want to enroll in a support group for caregivers. If you are interested, contact any local AIDS-related organization.... Above all, keep an upbeat attitude. It will help you and everyone face the disease more comfortably."

Response to the mailing was generally positive, although some critics thought the language was too explicit for children and some AIDS activist groups said the brochure was "too little, too late." When asked whether he expected the brochure to spark more criticism from conservatives who have previously attacked his calls for sex



education in schools, Surgeon General Koop responded, "I expect everything all the time."

## Soviet health minister criticizes U.S.S.R.

Thanks to the unprecedented openness of last June's Communist Party conference in Moscow, for the first time Western journalists were able to hear high-level Soviet officials criticize their own government. The following speech by Yevgeny I. Chazov, minister of health, was translated and published by the *New York Times*. It provides an interesting inside perspective on health in the U.S.S.R.:

"We have been proclaiming for many years that everything is for the people, for their benefit. Before the 27th party congress this was the standard slogan, but it was never backed by concrete deeds. I refer to the past in order that its mistakes never again be repeated.

"We were proud of our health-care system, but we kept silent about the fact that we ranked 50th in the world

behind Mauritius and Barbados in infant mortality. We were proud that we had more hospitals than any other country in the world, but we kept silent about the fact that we ranked 32d in the world in life expectancy.

"Uzbek writer and party leader Sharaf Rashidov wrote about happy children and prosperity in Uzbekistan, but he didn't lift a finger to save the 33,000 children that died each year before reaching the age of one. Forty-six percent of the republic's hospitals were accommodated in buildings that were below minimum sanitary standards. Today, 400 buildings that were built for the benefit of party and government officials have been converted into health care institutions accommodating 10,000 patients.

"In Moscow, a hospital for war

veterans has been under construction for 11 long years. Many other examples could be cited. For example, many loud words were said about Kazakhstan, where, according to its leaders at the 27th party congress, there were unequalled accomplishments, happiness and joy over the quick pace of construction. How were these words received by the 60,000 residents of the republic suffering from tuberculosis, the disease which we hastily declare had been liquidated?

"Each year poor water supplies, sub-standard sanitation, and the improper processing of meat and dairy products are responsible for 2.7 million cases of acute intestinal infections in the Soviet Union."



## JAMA debate continues

Hardy, Alex, et al. "It's Almost Over—More Letters on Debbie," *Journal of the American Medical Association*, vol. 260, no. 6, pp. 787-90.

The long-running debate over JAMA's publication of "It's Over, Debbie," an essay in which an anonymous resident described administering a fatal dose of morphine to relieve the agony of a young woman suffering from ovarian cancer (see *Bulletin*, May/June, p. 16) continues. In the Aug. 12 issue, JAMA printed seven more letters on the case and the dispute over whether the essay should have been published.

One poignant letter, by an Alex Hardy of California, complained that in the euthanasia debate "the principal actor has been ignored completely. What about the terminally ill? Don't we have a voice and a choice in our time or means of dying?" Hardy, who describes himself as a terminally ill sinus cancer patient, recounts how his physicians, "all eminent in their field, [are] for the most part totally incompetent in human relations. . . . Most physicians don't want to face the fact that one of their patients is going to die."

"It is time for the AMA and all physicians to get their priorities in order," Hardy writes. "Your job is to heal our pain and suffering, not to decide when or how we will die." (The editors' postscript to Hardy's letter notes that he died three weeks after he wrote the letter.)

Several letter writers take issue with various points—as well as the overall tone—in the essay "Why Doctors Must Not Kill," by Seigler, Gaylin, Kass, and Pellegrino, which was published in JAMA along with the first round of "Debbie" letters. Noting the more liberal attitude of the public toward euthanasia as compared with the authors of that essay, one letter writer wrote, "there is an air of arrogance and seeming disregard for the opinions of the 'broader community' . . . Let us avoid rigidity and be willing to change our thinking as the times demand. After all, for whom are we striving to be ethical? I hope not just for ourselves."

In response to the criticism, Mark Seigler and Peter Singer of the Center for Clinical Medical Ethics wrote of "the difference between bioethics and medical ethics. . . . Medical ethics is not a value-free discipline and therefore cannot subscribe to the notion that all values are relative and open to question. Rather, medical ethics is based on the enduring ethical and philosophical principles that both limit and guide health care professionals when they respond to the requests of patients to be cared for."

## AIDS testing in religious orders

Kenkelen, Bill, "Dilemma for Religious Orders: To Test or Not to Test for AIDS," *National Catholic Reporter*, September 2, 1988, p. 1.

In this special report from San Francisco, Kenkelen says that some Catholic communities are flatly opposed to testing applicants for AIDS infection, while

*"We have an aging [Jesuit] community. This disease could [financially] wipe us out."*

others are actively testing and rejecting candidates who test positive for the virus.

Spokesmen for the orders that are testing applicants say that the issue is an economic one. The provincial of a large Jesuit province commented, "We have an aging community. The number of people we take care of is already large. This disease could wipe us out." He explained that his province's one AIDS case has already cost the order more than \$100,000, and because of the vow to celibacy their insurance company doesn't cover afflictions that can be traced to sexual activity.

On the other hand, William Glenn, a former Jesuit who heads the board of directors of the San Francisco AIDS Foundation, called the financial argu-

ment "nonsense." "It's an elaborate apology to refuse to follow the Gospel they preach," Glenn said. "It [also] gives credibility to the idea that people with HIV are dispensable."

Reporter Kenkelen quoted a Marianist who said those who support testing "are good men who do not reject people with AIDS. They say there is an obligation by the order not to accept anyone who will be a burden to the community." The average age of religious men in the U.S. is "56 and rising steadily," the author notes, adding that a conference is trying to find ways of funding adequate retirements for these aging communities.

## Callahan describes limits

Callahan, Daniel, "Vital Distinctions, Mortal Questions," *Commonweal*, July 15, 1988, pp. 397-404.

Callahan, Daniel, "Elderly Health Care: There Ought to Be a Limit," *U.S. Catholic*, July 1988, pp. 13ff.

Readers who don't have the time or the inclination to read all of Daniel Callahan's controversial book *Setting Limits* may want to spend a few minutes with these two articles.

Callahan, who once edited *Commonweal*, offers there a fairly detailed explication of his feelings about both euthanasia and resource allocation in the face of burgeoning health care cost. He draws what he sees as an important distinction, applicable to both issues, between killing and allowing to die: "The purpose of the distinction is to separate those deaths directly caused by human action, and those caused by nonhuman events. . . . At the heart of the issue is a distinction between physical causality—the realm of impersonal events—and moral culpability—the realm of human responsibility."

To elucidate the distinction, Callahan summarizes his three "different, though overlapping" perspectives on nature and human action: "metaphysical, moral, and medical." After

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## RESEARCH SUMMARY

(Continued from page 13)

some elaboration, he moves on to discuss "the allocation debate," including "useless and financially burdensome treatment," before offering his "boundary standards," which have received much public attention:

1. "Government cannot automatically be required to pay the costs of whatever new treatments result from scientific advance. Government cannot be held hostage to medical progress...."

2. "Government cannot be obliged to meet every individual medical need, however valid that need...."

3. "Government has the obligation to encompass the full range of human needs that together make up a coherent society....Government would be imprudent to give over a disproportionate share of its resources to meet health-care needs...societies need education for their children, police and fire protection, national defense, roads and transportation systems, jobs and economic infrastructures, social welfare programs, and so on."

Callahan concludes: "We need to combine an ability to determine limits with sensitive and open public debate about just what it is that makes for a good society, and what is the proper and sensible place to be given to the pursuit of health and the avoidance of death."

Callahan's arguments receive much more cursory explanation in the *U.S. Catholic* piece (only a dozen short paragraphs) but it is followed by an interesting "Feedback" poll and several pages of readers' comments.

The poll, mailed to *U.S. Catholic* subscribers, asked for responses to such statements as "Callahan's suggestion would pave the way for encroachment of euthanasia after a certain age" (38% agreed, 53% disagreed) and "If I were over 75 and on the verge of death, I'd want everything possible to correct my condition as long as there was any chance I could recover" (20% agreed, 64% disagreed). Interestingly, 74% agreed with the statement that "Christians would be better off if they worked more at accepting death and less at

fighting it off," but almost half of those with an opinion disagreed with the statement "People who desperately want to prolong their lives at any cost probably don't really accept Christ's promise of an afterlife."

Provocative readers' comments range across a wide spectrum, from "I'll be happy to eliminate government [medical] assistance—when I am 119" to "I agree with Pope John XXIII: 'My bags are packed'."

### Ethical problems in the medical office

Connelly, Julia E., M.D., and Steven DalleMura, M.Div., "Ethical Problems in the Medical Office," *Journal of the American Medical Association*, vol. 260, no. 6, pp. 812-15.

Although most discussions of medical ethics focus on dramatic problems that occur in the hospital, the majority of American health care is provided in doctors' offices. The authors set out to identify and analyze the quantity and type of ethical problems in a typical, community-based internal medicine office practice.

Because there was no accepted means of categorizing ethical problems for outpatients, the authors relied on classifications detailed in *Clinical Ethics* (by Jonsen, Siegler, and Winslade)—specifically, problems related to preferences of patients, quality of life, or socioeconomic factors. The authors created numerous subcategories for specific types of cases and list examples of some: competence to choose, psychological factors that influence the patient's preference, informed consent, refusal of treatment, confidentiality, and cost of care.

The researchers found that "almost one third of the patients seen in office visits present ethical problems that influence their health care." The problems were most common in patients more than 60 years old.

What should be done to address this neglected area of medical ethics? Connelly and DalleMura suggest that medical students be made aware of these problems and the principles behind them. "In recent years, the practice of medicine has focused on

naming diseases rather than recognizing and caring for the overall clinical problems of the patient," the authors write. "Previously, experienced clinicians who are now largely gone from teaching hospitals and medical schools taught the art of caring for patients' problems rather than simply naming the disease."

### AIDS and Christianity

DeWolfe, Mark Mosher, et al., "AIDS," *Christianity and Crisis*, July 4, 1988, pp. 219-54.

Of the numerous magazine issues devoted entirely to the AIDS crisis, this is one of the best. The articles run a full range from contemplation and commentary to detailed statistical accounts and specific policy proposals. Some highlights:

—Mark Mosher DeWolfe is a Unitarian Universalist minister in suburban Toronto who has AIDS, and his account of how the disease has affected his ministry ("Love and Let Love," pp. 221-23) is useful reading for all who minister. "I have discovered that my most powerful sermons are the ones I most need to hear preached myself. I need to hear reassuring good news that the worth of an individual's life is not measured by the length of it....I need to hear about the healing powers of the religious community, and I find I tell those stories well.... AIDS discussion always includes 'risk behaviors.' Ironically, I have risked more since my diagnosis than before; I have had to risk looking inward, risk letting myself be loved, and most of all, risk speaking publicly of my new growth and understanding."

DeWolfe has found strong support from his congregants, who knew he was gay when they unanimously voted to call him in 1981: "In the first month after my diagnosis one church member, a woman whose children are my age, said to me that if there were any way she could die in my place she would....My story has many heroes—the members of my congregation. They could have pensioned me off right away, removing me and the stigma of my disease from the church.



They could even have done that in the name of compassion, claiming that it was best for me. But they stuck to their religious principles, and are showing the world that people with AIDS are not to be feared; people with AIDS are to be loved."

—In "Silence in the Sanctuaries" (pp. 225-27) Bishop William Swing of San Francisco criticizes "the church" as a whole for its avoidance of the AIDS issue. "There is only silence in the pulpits while the insurance executives and legislators and doctors and city officials who sit in the pews are left to wink shorthand messages of disregard or else to create an AIDS morality despite the church. The church is neither teaching nor learning in regard to AIDS; the church is abdicating its moral responsibility." Swing says the church had a convenient alibi when confronted with the epidemic because "the wrong kinds of people—mostly homosexuals, drug addicts, and prostitutes" were dying. "Before the church could arouse itself to a Christ-like response, it stumbled into self-righteousness."

—Mary Ellen Phelps's account of a small Maryland town that did not reject a small boy with AIDS ("The Little Town That Could," pp. 230-31) provides useful lessons for other communities. "Denton handled the AIDS crisis so well, I believe, because of carefully considered openness," Phelps writes. "Rather than bow to emotion and panic, officials followed preset policies. Health and school leaders teamed up to answer each other's questions and those of the community. Officials did not seek publicity but did not shun it either.... Local newspapers ran stories and editorials full of AIDS

background information.... Denton learned what some still find difficult to grasp—that people are going to have to learn to live with AIDS even as it kills their neighbors."

### Surrogate motherhood through history

Götz, Ignacio, "Surrogate Motherhood," *Theology Today*, July 1988, pp. 189-95.

Noting that amidst all of the controversy over surrogate motherhood "few efforts have been made to gain such perspective on the facts as history is designed to give," the author traces historical roots of the practice to "offer a moderate remedy to this malady."

Götz traces surrogacy back as far as the 19th century B.C.E., finding that "surrogacy was not merely practiced; it was legislated in detail, so that the rights of the various persons involved, most importantly, those of the wife and the surrogate, would be safeguarded." In societies where continuation of lineage was very important to keep property in the family, wives unable to bear children were entitled to "bring a handmaid to [their] husbands" to be surrogates; the wife would maintain pre-eminence over the surrogate and raise the child as her own. Götz also cites several examples from the Old Testament, including Sarah and Abraham (Gen. 16:1-6) and Rachel and Jacob (Gen. 30:1-13).

Götz highlights differences between ancient and modern versions of surrogacy—there are now many more options for insemination than intercourse, and there are more choices for childless couples—but concludes that

"the most important difference is that we have no legal statutes to regulate the practice of surrogacy and to protect the rights of all involved."

Claiming that "in the entire body of literature on incarnation and the virgin birth, there isn't a single voice that even raises the question of the appropriateness of Mary's decision to be a surrogate," Götz argues that "it must be granted that artificial insemination is not more *unnatural* than the Holy Spirit's 'coming upon' Mary.... Against this background is it reasonable to maintain that surrogacy is morally wrong because it is *unnatural*?"

Götz sees two major implications for Christian morality: (1) the acceptance of surrogacy—and therefore, of artificial insemination—"would weaken considerably" the Catholic Church's opposition to birth control because both rely on "unnatural means" to achieve pregnancy; and (2) the issue of who controls the womb—and ultimately, the question of whether males are necessary for procreation—is raised because artificial insemination makes access to the womb "multiple and non-sexual.... There is a certain emancipation here, [an] independence [that] threatens male control." Götz asks: "Is it some such freedom that the Catholic Church fears will ensue if the control over sexuality is lost due to a proliferation of methods of non-sexual fecundity? Is some such fear behind the opposition to surrogacy?"

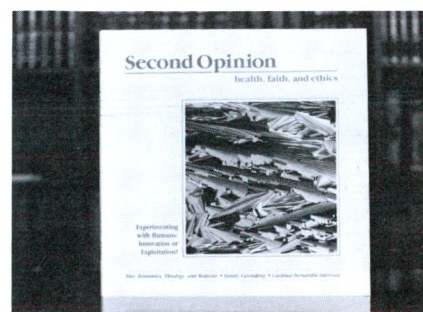
Götz concludes that "historical examples show that surrogacy cannot be judged morally wrong *a priori*.... [we should] address ourselves to safeguarding the process in a creative fashion rather than eliminating it."

## DNA pictures available

The cover picture on volume 8 of *Second Opinion* is one of a series done in connection with DNA research by Professor Randolph Rill and his associates and students at Florida State University. A number of persons have expressed interest in buying copies of the prints, and Professor Rill is considering reproducing them in larger quantities to sell.

Proceeds from the sales will be used to send students and staff members to workshops and conferences. Interested persons should contact: Prof. Rill, Department of Chemistry and Institute of Molecular Biophysics, Florida State University, Tallahassee, FL 32306.

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