THE ELDERLY AND HIGH TECHNOLOGY MEDICINE:
A CASE FOR INDIVIDUALIZED, AUTONOMOUS ALLOCATION

PETER D. MOTT

Geriatric Medicine Unit, Monroe Community Hospital,
435 East Henrietta Road, Rochester, NY 14620, USA

ABSTRACT. The issues involved in decision making about the aggressiveness of future medical care for older persons are explored. They are related to population trends, the heterogeneity of older persons and a variety of factors involved in individual preferences. Case studies are presented to illustrate these points, as well as a review of pertinent literature. The argument is offered that, considering these many factors, a system of flexible, individualized care by informed patient preference, is more rational than the rationing of technological services by age.

Key words: allocation of resources, ethics, geriatrics, health care for the elderly, high technology services, medical technology, patient preference, rationing

INTRODUCTION

Nowhere are the issues about high technology and prolongation of life more fascinating, and more dangerous, than in current debates concerning older persons. Opinions vary from a cost-conscious societal view that would 'ration' all expensive, procedurally oriented health care, which would exclude people over age 70 or 80 [1], to the viewpoint that one cannot safely limit any care even if the patient is permanently comatose (among a variety of legal opinions) [2–4]. The term “geriatric imperative” applies to these questions, just as it does to the responsibilities of social and educational institutions to provide services and trained professionals to care for more and more older persons. Thus, if mortality rates in the U.S. are now decreasing at 2–1/2% per year, if the well elderly soon will be expected to live normal life spans of 105 to 115 years, and if 25% of our population by the year 2020 will be over age 65, then life and death decisions, and conflicts between the capability of high technology and personal wishes, will be increasingly within the provinces of geriatric medicine. In 1987 we spent $140 billion for the health care of those over 65, with 14% of all Medicare expenditures being spent on the last two months of life. These figures, rapidly increasing each year, have led not only families and physicians but also insurers, both private and public, to involve themselves more and more in the debate. Should such issues be settled in courts, legislatures, or around hospital beds by

professionals? Or are they better handled by older persons themselves in private and in advance of mentally incapacitating illness? Should there be general laws or guidelines, such as limitations on the use of high technology by age? Or should each patient's future plan of care be individualized? If so, how should such individualization come about?

Setting costs aside for the moment, and simply putting the question to older persons themselves, their families or surrogates, one is struck by the tremendous variability in the responses. A diversity of responses is also received from ethical, philosophical and legal experts. The varied responses from older persons is expected, and relates to the well documented heterogeneity of the elderly themselves [5]. Is it reasonable that the master athlete of 85 who has no serious disorders should have the same guidelines for future care as the bedridden, demented, end stage Alzheimer's victim of 70?

Extreme variability also is found in other aspects of the lives of older persons. A group of 75 year olds may feel entirely differently about whether or not to allow regrafting of their coronary arteries, for example, depending not only upon their varying amounts of disease, but also other disorders: e.g., vision, hearing, balance, even the condition of their feet, all of which increasingly affect the quality of life as we age. Their economic well-being may or may not be a factor. More often, the significant factors affecting whether they accept or reject major surgery are their interest in work or play and attachments to family and friends. Apart from their varied interests in items of this life there are, of course, extreme variations in their beliefs – if any – about a 'next life'. How does each person view death? How responsible does each feel for attending to people, pets or affairs that might be left behind? How much do these kinds of concerns influence older people's choices about how aggressive and high tech should be their future care?

Because of the almost limitless variability in these components of decision making, it appears to be irrational and arbitrary for courts to decide or legislatures to determine rules governing our distribution of expensive, life-extending technologies. Moreover, the idea that an outside individual such as a physician, should take it upon him or herself to make such a determination also would appear to be arbitrary and irrational.

Ethicists refer to the individualized approach as preference utilization: i.e., that one way to allocate resources, in order to get the greatest possible good (or the least possible harm) to the greatest number of people, is by eliciting individual preferences. Advocates believe that this is preferable to a traditional utilitarian view that such resources should be distributed more uniformly, based on agent-neutral values. In this paper the argument will be that individual preference should be the basis for allocations of health services, not an arbitrary distribution based on such a criterion as age (e.g., that no high tech services