# Correspondence

rial is, obviously, a parody of Daniels' title. *See also* N. DANIELS, JUST HEALTH CARE (Cambridge University Press, Cambridge, Eng.) (1985).

2. PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, SECURING ACCESS TO HEALTH CARE: THE ETHICAL IMPLICATIONS OF DIFFERENCES IN THE AVAILABILITY OF HEALTH SERVICES (U.S. Gov't Printing Ofc., Washington, D.C.) (vol. 1: Report) (1983); Lynn, J., *Ethical Issues—Equitable Distribution and Decision Making*, in LEGAL AND ETHICAL ASPECTS OF HEALTH CARE FOR THE ELDERLY, M.B. Kapp, A.E. Doudera, H. Pies, eds. (Health Administration Press, Ann Arbor, Mich.) (1985—in press) [hereinafter referred to as HEALTH CARE FOR THE ELDERLY].

3. *See generally* Wallach, S.F., *Alternative Methods of Financing Long-Term Care*, in HEALTH CARE FOR THE ELDERLY, *supra* note 2.

4. *See generally* Callahan, D., *What Do Children Owe Elderly Parents?* HASTINGS CENTER REPORT 15(2): 32–37 (April, 1985). *Cf.* Kapp, M.B., *Residents of State Mental Institutions and Their Money (Or, the State Giveth and the State Taketh Away)*, JOURNAL OF PSYCHIATRY AND LAW 6(3): 287–356.

5. *See generally* Wallach, *supra* note 3; Greenberg, J., *et al.*, *S/HMO: The Social/Health Maintenance Organization and Long Term Care*, GENERATIONS 9(4): 51–55 (Summer 1985).

6. *See* Guncheon, K.F.F. *Insurers Ironing Out Wrinkles in Long-Term Care Coverage*, HOSPITALS 58(14): 110–13 (July 16, 1984); Meiners, M., *Long Term Care Insurance*, GENERATIONS 9(4): 39–42 (Summer, 1985).

7. *Cf.* Metropolitan Life Insurance Co. v. Massachusetts, 53 U.S.L.W. 4616 (U.S. June 3, 1985) (empowering the state to require that minimum mental health benefits be provided to state residents insured under general health insurance policies or employee health care plans that cover hospital and surgical expenses).

8. *See* Leonard, L.R., *Comment: The Ties That Bind: Life Care Contracts and Nursing Homes*, AMERICAN JOURNAL OF LAW & MEDICINE 8(2): 153–173 (Summer, 1982), *reprinted in* HEALTH CARE FOR THE ELDERLY, *supra* note 2.

9. *See* Loeser, W.D., Dickstein, E.S., Schiavone, L.D., *Medicare Coverage in Nursing Homes—A Broken Promise*, NEW ENGLAND JOURNAL OF MEDICINE 304(6): 353–55 (February 5, 1981); Smits, H.L., Feder, J., Scanlon, W., *Medicare's Nursing Home Benefit: Variations in Interpretation*, NEW ENGLAND JOURNAL OF MEDICINE 307(14): 855–62 (September 30, 1982).

10. *See* Oday, L., *Medicare and Medicaid Update*, in HEALTH CARE FOR THE ELDERLY, *supra* note 2.

## Cost Containment and Humanizing Medicine

Dear Editors,

I read with interest Marshall Kapp's book review essay in the April issue concerning the attorney's role in helping to humanize medicine. However, the medical profession is getting mixed messages from society in this era in which cost containment is a key goal, with physicians being told they are participants in a competitive industry in which traditional business precepts are to be followed. Convincing physicians to devote more time (for that is what a caring approach will require) in interacting with their patients is no small task. Who would relish accepting the responsibility to urge a physician to be more attentive, and listen more, to his patients, when the physician has been recently solicited to enter a Preferred Provider Arrangement, which will lower his revenue per item of service in order to maintain and, perhaps, to increase his patient population?

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## Heart Transplantation in Massachusetts and the Prince of Denmark

Dear Editors:

A Shakespearean controversy has evolved between George Annas, Chairman of the Massachusetts Task Force on Organ Transplantation, and some Massachusetts health care providers. The Task Force, in its report published in the February issue, has opted for a Procrustean measure and has chosen to "restrict the total number of transplants" to fit the demands on health care financing in the state. Professor Annas, also in the February issue, says that his physician colleagues quote *Hamlet* in defense of transplantation: "Diseases desperate grown by desperate appliances are relieved or not at all." The Chairman's preference is for the King's earlier speech: "How dangerous is it that this man [organ transplantation] goes loose! Yet must not we put the strong law on him. He's loved of the distracted multitude. . . . " (IV.iii).

Hamlet's fatal flaw was ambivalence. His quest for justice was marred by indecision. The Task Force choice for *propter hoc* limitation of heart transplantation is exemplary of the Hamlet Syndrome. The plan would fund an indicated health care intervention for only some of the time, and is a clear case of halfway decision making. This outcome derives from concern that transplantation is a halfway technology. It is also, according to Professor Annas, "extreme and expensive," and time is needed "to persuade the public that a free-for-all in organ transplantation is reckless, while a controlled system has pay-offs in terms of quality care, equity, and cost savings." The Report of the Massachusetts Task Force nonetheless acknowledges the relative success of heart transplants and renal transplants compared to other types of emerging transplantation technology. The expense of the Medicare-funded End-Stage Renal Disease program notwithstanding, renal transplantation represents only 10 percent of end-stage renal disease management and results in satisfactory levels of rehabilitation among a population for which death and dialysis are the alternatives.[1] Heart transplantation, a newer technology, has had increasing success, with Dr. Shumway's group reporting an estimated five-year survival in approximately two-thirds of cases.[2] Liver transplantation has been less effective but the results are encouraging with dramatic improvement in many cases.

One factor which beclouds the area of heart transplantation is the decision in 1980 by the trustees of Massachusetts General Hospital to abstain from heart transplantation. The decision, since reversed, was strongly influenced by a minority viewpoint among the clinical staff of the hospital that preventive health care measures were a priority in the health care system. The schism between proponents of primary preventive care and advocates of assertive tertiary intervention parallels the division between "old liberalism" and "new conserva-

tism" discussed thoughtfully by Robert Reich in the May issue of the *Atlantic*.[3] Professor Reich concludes that a new public philosophy is needed, rejecting the idea "that the central struggle of our age is over the division of a fixed quantity of global wealth," and suggesting instead "the possibility of an enhanced quality of life for all, contingent on mutual adaptation."[4] Polarities in the health care field based on competition for a common pool of dollars are equally unappealing.

Primary, secondary, and tertiary care, as they currently exist in our health system, are each incomplete and at the same time complementary. Intensive tertiary intervention, of which heart, liver and renal transplantation are exemplary, *is* costly. It promises to replace fatal illness with chronic, manageable illness. It does so with frequent success. In sharp contrast is the relative failure of therapeutic intervention for chronic tobacco smoking, our greatest health hazard. Here treatment is ubiquitous, inexpensive, and typically of transient merit. Alcohol abuse is another case in point. One plausible, if speculative, outcome of an accelerated heart transplant program could be a more educated populace, better motivated to abstain from self-abuse. Central here is Professor Reich's idea of adaptation. We may need a better integrated health care system, in which waste is eliminated for *all* treatments (consider the often discussed situation of extensive expenditure for terminal care), and in which an informed public determines its willingness to expand the health care percentage of the gross national product to extend the pursuit of quality living. And, possibly, it may be prudent and cost-saving to confine intensive tertiary care to our large teaching institutions with well-staffed multidisciplinary services and basic laboratory science support, while less demanding intervention is taken up increasingly by community care systems.

The Massachusetts Task Force has attempted an equitable approach, but what it offers for heart transplantation is a system of rationing. Discrimination is temporal rather than by age, race or wealth. If only twenty patients per year are allowed to receive transplants, the twenty-first annual candidate and each thereafter are simply left to seek treatment elsewhere or die. The system is only restrictive for the first two to three years—but those eliminated will not live to reapply. The precedent is dangerous.

It flies in the face of reason to legislate for underutilization of an effective health care intervention. Imagine a world with newly arrived penicillin made available to a prearranged number of young mothers with puerperal sepsis. A more current example is afforded by Acquired Immunodeficiency Syndrome (AIDS). There is no effective treatment for this disorder, and one financial writer has estimated that care for its victims would cost $5 billion to the health care system by 1990.[5] Would a policy committee designed to meet this looming problem limit the number of cases to be treated annually?

Professor Annas and the Massachusetts Task Force for Organ Transplantation have undertaken an enormous task and are to be lauded for the undertaking. But the task itself requires refinement.

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## References

1. Surman, O.S., *Renal Transplantation and the Current Treatment of End Stage Renal Disease: A Psychiatric Medicine Perspective*, in PSYCHIATRIC MEDICINE UPDATE, MASSACHUSETTS GENERAL HOSPITAL REVIEWS FOR PHYSICIANS (T.C. Manschreck, ed.) (Elsevier, New York, N.Y.) (1981) at 155–75.
2. *Report of the Massachusetts Task Force on Organ Transplantation*, LAW, MEDICINE & HEALTH CARE 13(1): 8, 14 (February 1985).
3. Reich, R.B., *Toward a New Public Philosophy*, ATLANTIC 255(5): 68–79 (May 1985).
4. *Id.* at 79.
5. Weis, G., *A Costly Disease*, BARRON'S NATIONAL BUSINESS AND FINANCIAL WEEKLY 65: 32 (1985).





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