The philosopher as gadfly: Daniel Callahan’s Critique of American Health Care

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“I like to say that during my lifetime I’ve seen three revolutions. Whether you like them or not, there are three that are important—environmentalism, civil rights, and feminism...I think health care is the next candidate for a revolution.”

--Daniel Callahan

Chapter One

Liberal health care reform dates back to the beginning of the 20th century. European countries were constructing government-funded health care systems. In an effort to duplicate these health care systems, politicians in the United States began vying for compulsory health insurance. These efforts met stiff opposition that prevented the United States from enacting government-funded health care. The failure of the Unites States to adopt a universal health care system prompted many historians to explore the process that led to failure to construct a state health care system. America’s lack of universal health care has also draw the attention of many scholars and politicians. The evolution of the health care system in the United States, however, goes beyond the debates of liberal health care reform. Daniel Callahan, a philosopher and one of the original thinkers in the field of bioethics, proposed an unconventional perspective on liberal health care reform. Rather than focusing on America’s lack of universal health care, Callahan argued that medicine’s unattainable goal to eradicate death is an unsustainable premise for any type of health care system. This work will examine Callahan’s vision and the implication of his ideas for the future of American health care.

American medicine was a two party relationship between the physician and patient during the 19th century. During this period, doctors collected payments directly from their patients—a widespread interest in health insurance did yet exit in the United States. Americans became interested in health insurance during the first decade of the 20th century.
due to illness and accident associate with industrialization facilitated the American Association of Labor Legislation’s (AALL) decision to push for workman’s compensation. Similar motives sparked the enactment of compulsory health insurance in other industrialized countries such as Germany (1883) and England (1911). Americans Progressives began vying for a similar system in the United States.  

1 In 1912 the (AALL) drafted a tentative plan that sought a bill providing income protection and health care coverage to workers. The AALL proposed health care premiums divided between the state, the employer and the employee to fund their initiative. America’s entry into World War I put the campaign for compulsory health insurance on hold. A number of other factors contributed to the dismantling of the compulsory health insurance campaign.  

America’s entry into World War I marked a period of anti-German sentiment in the U.S. Embracing anything German was seen as unpatriotic; this included compulsory health insurance.  

3 Following the war, anti-German sentiment was replaced by anti-Bolshevism fervor. During the Red Scare that followed the war, compulsory health insurance opponents equated socialized programs to communism. Again, socialized medicine was seen as anti-American.  

4 As the war came to a close California voters defeated a proposal for compulsory health insurance by a three to one margin. Proponents of compulsory health insurance also faced opposition from organized medicine. In 1920, the American Medical Association’s (AMA) House of Delegates

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1 Ronald Numbers “The Third Party” in *Sickness &Health in America* (Madison: The University of Wisconsin Press, 1978), 139. His history is not primarily focused on liberal health care reform. Instead, Numbers focuses on the rise of the third party. Although Numbers is talking about the rise of the third party, he provides a concise history of the health care coverage in the Unites States.

2 Ibid.

3 Ibid., 141.

“condemned” compulsory health insurance fearing that it would lower the incomes of physicians.⁵

The AMA also took issue with workman composition laws during this period. Employers in many states were legally obligated to provide medical assistance for on-the-job-injuries. Such laws did little in providing comprehensive health care coverage. Employers acquired accident insurance through private insurance firms. Physicians were paid through these companies based on an “arbitrary” fee schedule. The medical arrangements between Big Business and physicians left a sour taste in the mouths of many physicians towards social insurance. This experience solidified suspicion towards social insurance among segments of organized medicine.⁶ Compulsory health insurance became a politically dead issue through the 1920s. However, the arrival of the Great Depression dramatically affected both organized medicine and the public. The Depression also significantly changed the financial relationship between doctor and patient

The fiscal stability of both hospitals and physicians was threatened during the Depression. Patients began seeing doctors less and medical bills were often less a priority, if the bills were even paid at all.⁷ Hospitals, because they were capital-intensive institutions with high fixed costs, suffered during the Depression. As the number of patients decreased, and the number of charity cases increased, a number of hospitals saw health insurance as a way to alleviate their financial woes. The model for modern private health insurance, Blue Cross, emerged from this financial dilemma.⁸ At a Dallas University Hospital (Baylor University) citizens paid 50 cents every month to the hospital in return for 21 days of hospital care in the event of illness.⁹ This

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⁵ Numbers, 141.
⁶ Ibid., 141-142.
⁷ Starr, 270.
⁸ Numbers, 142.
⁹ Ibid.
type of health insurance was adopted by other hospitals and became the model for the private health insurance industry. Both the financial security of the hospital and the physician was saved—as was the patient’s health security.\textsuperscript{10} These events, however, did not quell the push for compulsory health insurance—political debates over the enactment of government-subsidized health care continued through the 1930s.

In 1935, President Franklin D. Roosevelt’s administration considered the possibility of enacting national health insurance.\textsuperscript{11} As the Committee on Economic Security began drafting social security legislation, compulsory health insurance was left out.\textsuperscript{12} Pressure from organized medicine and Roosevelt’s general ambivalence towards national health insurance kept it from becoming part of the Social Security Act (1935).\textsuperscript{13} Following the exclusion of national health insurance from the Social Security Act, health care reformers pressed Congress to introduce health reform legislation. Consequently, private health insurance during the war became a major fringe benefit which substituted for increase in wages, which were severely limited by government fiat. Many Americans became enrolled in employer-provided health insurance plans, especially

\textsuperscript{10} David Rothman \textit{Beginnings Count: The Technological Imperative in American Health Care} (New York: Oxford University Press, 1997), 19. Rothman also points out that by “1945, Blue Cross insured 2 million Americans; by 1950, 40 million.”
\textsuperscript{11} Starr, 275.
\textsuperscript{12} Numbers, 143.
\textsuperscript{13} Jaap Kooijman, “Just Forget About it:” FDR’s Ambivalence Towards National Health Insurance.” Found in \textit{The Roosevelt Year: New Prosperity on American History, 1933-1945.} (Edinburgh: Edinburgh Press, 1999), 30-38. Kooijman asserts early in the piece that historians have made the argument that the AMA was the sole reason for the exclusion of national health insurance from the Social Security Act. Instead, “national health insurance was not so much a ‘lost reform’ as an option that was not chosen.” He also mentions that “the opposition of the AMA was real,” however, “the overestimation of its influence reduces the history of national health insurance to a battle between idealistic reformers and medical obstruction.”
when labor unions also began bargaining for health insurance and the federal government avoided taxation on employer-based health insurance plans.\textsuperscript{14}

After World War II, Harry Truman provided stronger presidential support for national health insurance. However, Truman was unsuccessful in pushing through compulsory health insurance. Truman also faced opposition from the AMA, which successfully steered public opinion away from national health insurance.\textsuperscript{15} But as public opinion polls suggested before and during the war, Americans had mix feelings concerning national health insurance.\textsuperscript{16} Privately funded health care plans reached millions of Americans by the 1950s. Middle class Americans were experiencing an economic boom that was absent during the Depression; thus the need for governmental intervention in health care seemed unnecessary. There was no political pressure from the middle class to change the system since there was little threat to their health security.\textsuperscript{17} Health insurance was affordable for many middle class families and private health care companies covered 60\% of Americans by 1954.\textsuperscript{18}

By the 1960s health insurance coverage reach nearly three-fourths of American families, but this only represented 27\% of medical bills paid. For the elderly and poor little to no protection against high medical costs was available. This prompted some legislators to take action. In 1960 Oklahoma Senator Robert Kerr and Representative Wilbur Mills from Arkansas, then chairman of the House Ways and Means Committee, proposed a bill to remedy the problem

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\begin{itemize}
\item \textsuperscript{14} Jacob Hacker, \textit{The Road to Nowhere: The Genesis of President Clinton’s Plan for Health Security}. (Princeton: Princeton University Press, 1997), 78.
\item \textsuperscript{15} Gordon, 21.
\item \textsuperscript{16} Starr, 278-279.
\item \textsuperscript{17} Rothman, 70.
\item \textsuperscript{18} Ibid., 20. Rothman argued that the success of Blue Cross was the impetus for the creation of similar private health care companies.
\end{itemize}
of covering the poor.\textsuperscript{19} With the approval of the AMA the Kerr-Mills amendment to the Social Security Act in 1960 gave federal assistance to states to care for the “medically indigent.” President John F. Kennedy even mentioned the possibility of insuring all social security beneficiaries, which was something he proposed while in the Senate. The AMA was concerned, however, that government interference into the medical profession might undermine the physician’s ability treat patients effectively.\textsuperscript{20} Although Kennedy supported Medicare, Congressional approval fell short until Democrats took control of Congress in 1964. With Lyndon Johnson in the White House, Medicare and Medicaid became a crucial component in his Great Society initiative, which sought to wage war on poverty.\textsuperscript{21} In 1965 Congress voted to include health insurance for the elderly (Medicare) and for the indigent (Medicaid) as a social security entitlement. Finally, after some fifty years of debate, some Americans received compulsory health insurance.\textsuperscript{22} The adoption of Medicare and Medicaid, however, came with a hefty price tag. The government ceded oversight for the allocation of medical resources to health care professionals. This was part of the agreement with organized medicine to ensure that government would not interfere in the doctor patient relationship. Controlling the cost and allocation of medical resources was left to health care providers, thus rapidly driving up cost for both programs. The drastic rise in government spending for Medicare and Medicaid were unanticipated by most policy makers. The ten years after the enactment of Medicare saw cost rise exponentially from $10 billion to $40 billion. By 1975 this amount to nearly 9 percent of federal spending.\textsuperscript{23} Medical inflation and general inflation began to rise through the late 1960s and early

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\item \textsuperscript{19} Starr, 368-369.
\item \textsuperscript{20} Numbers, 147.
\item \textsuperscript{21} Starr, 368-369.
\item \textsuperscript{22} Numbers, 147.
\item \textsuperscript{23} Hacker, 78-79.
\end{itemize}
1970s due in large part to the increase government spending on the Vietnam War and Johnson’s Great Society initiatives. This resulted in stagflation during the 1970s.

The 1970s also saw sharp rise in health care cost and an increase in government spending for medical care. Government spending, after the passage of Medicare and Medicaid, rose from $10.8 billion in 1965 to $27.8 billion dollars in 1970. Moreover, health care expenditures in 1970 rose to $69 billion and 7.2 percent of the GNP were spent on health care. Perhaps one of the largest contributors to the rise in health care inflation came from fee-for-service payments. Third party fee-for-service arrangements gave medical professionals and hospitals greater economic incentive to provide more health care services.24 Health care inflation drew the attention of the Nixon administration, who in 1971, proposed a solution for curbing the rise in health care costs.

The Nixon administration proposed the “national health strategy” to Congress in 1971 centering on Health Maintenance Organizations (HMO). Through HMOs the Nixon administration hoped to rein in cost by having employers offer at least one HMO (managed care plan) to employees instead of a traditional health insurance plans. The goal was to have some six hundred HMOs in place by 1980, which would cover 20 percent of the population: these goals were not met. Nevertheless, liberal politicians acquiesced to Nixon’s proposal and in 1973 the HMO Act was passed. Although liberal politicians would have like to see an alternative health care plan, the midterm elections were in 1974. Liberals in Congress hoped the elections would result in a Democratic majority, thus providing an opportunity to Pass Senator Kennedy’s “Health Security Plan” which sought universal health care coverage. But the Watergate scandal put a damper on liberal health care reform. Liberals in Congress felt that with out Nixon universal health care had a chance. However, when Nixon left so did any chance for adopting a

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24 Starr, 380-385.
national health insurance. Nevertheless, liberals in congress continued to press for health care reform. With the rise in health care costs, liberal politicians saw an opportunity to convince the public that there was a “crisis” in health care. These efforts echoed past attempts by liberal health care reformers dating back to the Progressive Era—politicians, organized labor and interest groups have since been the strongest advocates for health care reform. Consequently, public pressure for health care reform did not play an important role in pushing for health care reform. Although there was no concentrated public effort to bring about health care reform, Americans began feeling the sting from the inflation in the medical sector.

In the 1970s, most American’s health care coverage was through private health insurance plans as it was during the 1950s and 1960s. As wages began to decline while the medical sector was experiencing a period of inflation, employers who offered private insurance plans sought to lessen their medical coverage cost. Some of the larger corporations tried to share the burden of health care costs with their employees requiring them to pay a deductible. This was only a temporary fix. Employers were often forced to cutback or eliminate health care coverage altogether. To make matters worse, insurance companies sought low-risk groups, which culminated in “experience ratings”—in order keep cost low insurers looked for groups who possessed the lowest health risks. This lead to a number of middle class Americans to feel the pressure of rising health care cost. As private health care insurance became less affordable and available—middle class Americans saw the writing on the wall. For decades, middle class Americans was able to either afford private heath insurance or negotiate medical bills on their

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26 Starr, 381. Paul Starr points out the use of the word crisis originated with political leaders who wanted to draw attention the rise in health care costs.
27 Hacker, 11.
own; this changed by the late 1960s and early 1970s. The rising health costs in the 1970s, coupled with the loss in health security, was cause for alarm for many middle class Americans.

Liberal health care reformers saw compulsory health insurance as the best solution for providing health care for every American. Historians have been drawn to the failure to enact such a system to a remarkable degree and to the neglect of the history of the health care system that evolved. Assertions that health care system has been a failure because the United States does not have universal health care coverage sometimes server as a substitute for a careful analysis of the social and political structures that shaped events. Medicare and Medicaid provided health care coverage to many of those who could not afford it. Private insurance plans also brought affordable health care coverage to millions of Americans. Organized medicine has often been accused of impeding the enactment of universal health care, yet advances in modern medicine and public health initiatives such as immunization campaigns have increased the life expectancy for many Americans. Although in some cases organized medicine may have taken issue with government-funded medical coverage, there were other cases when organized medicine saw health care reform as beneficial.

One of the biggest concerns for organized medicine was autonomy for physicians. Leaders in organized medicine feared that stiff governmental control would interfere with the doctor patient relationship. Organized medicine was willing to compromise when it came to health care reform, while leading supporters of universal health care did not. Historians have focused too heavily on America’s failure to enact compulsory health insurance, often placing a
degree of blame on organized medicine. Yet, the problems inherent in the health care system transcend the failure to bring compulsory health insurance to fruition.

As liberal politicians began drafting national health insurance proposals in the mid-1970s, Daniel Callahan began articulating a critique of modern medicine that raised the specter of a system that would be unsustainable regardless of who paid for it. In Callahan’s view access to technologies of healing was always in the best interest of individuals or of the society. During the late 1970s Callahan would use his position at the Hastings Center to begin studying health care and health care policy through an ethical prism. As the price of health care rose in the 1970s and more Americans were unable to afford health care, his position as a moral philosopher found new focus.

CHAPTER TWO:

Callahan represented a new critical voice concerning the health care system in the United State from a discipline that was not often associated with this debate: bioethics. Callahan was one of the original thinkers in this discipline that emerged in the late 1960s as a response to advance in science and medicine. Government-funded biomedical research created new medical technologies such as the respirator and organ transplantation that represented new ethical dilemmas in medicine. A number of scholars pondered the potential moral and ethical dilemmas raised by new medical technologies. Other events, such as the Nuremberg trials after the war,

Daniel Fox, “History and Health Policy: An Autobiographical Note on the Decline of Historicism” found in The Journal of Social History Vol. 18 no. 3 (Spring 1985), 351-352. Daniel Fox points out that: “Determined to promote their beliefs, they refused to negotiate and they were excluded from, or became peripheral to, the settings in which policy was made. Having chosen purity over power, many of them, with time on their hands and scores to settle, wrote histories of the failed crusade for compulsory health insurance.”
have also been credited for influencing a number of intellectuals who became involved in the field of bioethics. Nazi researchers who used live human subjects raised questions regarding participant’s consent in medical research. The evolution of Callahan’s ideas provided a narrative that placed the history of health care reform into a different perceptive. From his position as the president and cofounder of the first bioethics center in the country, the Hastings Center, Callahan helped bring bioethics to prominence while honing his skills as one of the premier bioethicist in the country. During these years, Callahan’s vision concerning our nation’s health care system also developed.

This position outside of political and academic institutions allowed Callahan the necessary intellectual breathing room to develop a different vision about health care in the United States. Callahan and his colleagues at the Hastings Center, moreover, studied the ethics of health care delivery in the mid-1970s. This experience helped reshape Callahan’s ideas about health care in the United States and what role bioethics should play in discussions concerning health care delivery. Consequently, when one looks back into Callahan’s past, an intellectual career was not necessarily a foregone conclusion.
Callahan was born in 1930 to an upper-middle class Washington D.C family. While attending Catholic schools in Washington, Callahan became a good student and a dedicated swimmer. It was his love of swimming, rather than academics, that allowed Callahan to attend Yale University. During the 1940s and 1950s Yale’s swimming program was “the place to go” for competitive swimmers. By his junior year, however, Callahan was finished as a swimmer and looked for something new to “amuse” himself. At the time Callahan did not have a specific career path in mind, but he did have an affinity for the humanities. This love for the humanities lured Callahan to Yale’s experimental program in interdisciplinary studies. He did not have a clear vision of the vocation of public intellectual, but he became a convert to philosophy during his senior year. Callahan attended a class taught by a visiting professor named John Courtney Murray that focused on Thomas Aquinas. Afterwards Callahan realized that he wanted to be a philosopher. Callahan’s interdisciplinary work earned him a bachelor’s degree in English and psychology, but it was his introduction to philosophy that would shape the rest of his life.

After his undergraduate work at Yale, Callahan served in the Army for three years. While stationed in Washington D.C. Callahan attended Georgetown University at night and earned a masters degree in philosophy followed by a PhD in Philosophy from Harvard University.

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32 Lauritzen, 9.
33 Judith Miller “Must Government Pull the Plug” (a debate about the ethics of setting an upper limit on the amount of health care a society obliges itself to provide for individuals.) October 10, 1974 at the Hay Adams Hotel, Hastings Center Records, Box 6, group no. 1695 folder: Robert Wood Johnson grant correspondents. Yale University Sterling Library, New Haven, CT. This information comes from an event that discussed the ethics of health care delivery. Callahan’s educational credentials are listed on the event brochure. Hastings Center hereafter cited as HCR
at Harvard, Callahan slowly became agitated by the analytical philosophy taught there. Callahan yearned for a different way to apply his philosophical craft. He was very much influenced by the English historian Christopher Dawson. While working as his teaching assistant, Callahan saw the usefulness of applying historical analysis to his work as a philosopher. Callahan’s experience at Harvard fostered in him a desire to apply his ethical and moral training as a philosopher outside the academy. He thus searched for “serious intellectual work” that could be applied to tangible everyday ethical concerns. While Callahan contemplated his career path, biomedical research would come under close public scrutiny for the ethical abuses in clinical research that occurred during and after World War II.

During the war the federal government created the Committee on Medical Research (CMR) to oversee medical research essential to the war effort. Prior to the War, medical research was largely funded through philanthropic organizations. The urgency to find cures for diseases that hindered the war effort ushered in a new era of medical research funding that placed the federal government as the primary source of funding. This urgent need for vaccines and cures prompted the CMR to rely on live human experimentation, without their consent, because this type of extermination often yielded quick results. This type of experimentation was not new during World War II, but in the past it often required some form of consent. However, consent was “superceded” by the urgency to find cures that aided in defending the Axis powers. The notion that the greater good would benefit from unfettered research warranted the use of human

34 Laurtizen, 9.
35 Callahan, “The Hastings Center and the Early Years of Bioethics” 55. Callahan also mentions here that John Rawls’s *Theory of Justice* and the journal *Philosophy and Public Affairs* were two examples of the new direction that philosophy was taking. He argues that these works “signaled the beginning of a new era in moral and political philosophy. But that was not quite adequate for me.”
experimentation. Wartime researchers learned that the human expatriation was a necessity in finding cures quickly; a tradition continued through the postwar period.\footnote{David Rothman \textit{Strangers at the Bedside: A History of How Law and Bioethics Transformed Medical Decision Making} (Basic Books, 1991), 30-50}

The CMR’s efforts were successful in producing a vaccine for influenza as well as producing and distributing penicillin in large quantities. It was the distribution of penicillin that had the greatest effect on public perception towards medical research. Perceived as a “miracle drug” the CMR and medical researchers were now the stewards of life saving medicines that promised to eradicate many of the diseases that plagued Americans for years. The positive public response to the medical research imperative gave researchers credence to continue the fight against disease. However, the public was largely shielded from the techniques that were used during and after the war.\footnote{Ibid., 38-39.} These techniques were brought to public attention in 1966.

In June of 1966, Henry Beecher wrote an article in \textit{The New England Journal of Medicine} that “blew the whistle” on unethical clinical research experiments conducted on live human subjects without their consent. Beecher was a highly regarded professor of anesthesiology. In the 1930s Massachusetts General Hospital and Harvard sought to professionalize anesthesiology, and Beecher led the effort. In the 1940s Beecher became unsettled by the unethical research practices he witnessed as an insider in the medical research community. At the top of his profession, Beecher seemed like the last person to risk his career by exposing unethical practices in medical research.\footnote{Ibid., 70-72.} Nevertheless, he listed 22 examples of unethical procedures in his article with the hope of raising public awareness.\footnote{Henry Beecher, “Ethics and Clinical Research” \textit{The New England Journal of Medicine}, 274 no. 24 (June 1966):1356.} Beecher deliberately left the names of researchers out of the piece. Beecher’s main focus was to expose
how the nature of research fostered the abuses. The pressure for young and ambitious medical researchers to establish themselves in the scientific community was the underlying impetus for the abuses according to Beecher. The examples revealed in the article were quite profound. For instance, in example 16 researchers studying the rate of infection for hepatitis injected the disease into mentally “defective” children. In another example Beecher told of researchers studying immunity to cancer where “hospitalized patients” were injected with cancer cells; they were told the injection constituted of cells, cancer was never mentioned.40

In 1966, most major news periodicals were not looking in medical journals for news stories. Nevertheless, Beecher’s piece received unprecedented attention and helped make the study of ethics in science and medicine a priority. Medical research during the postwar period often consisted of patients admitted to research institutions or university hospitals. The physician and researcher were responsible for the ethical treatment of the patient or research participant. Coupled with the utilitarian research imperative of the postwar period clinical research abuses ensued. Ethical oversight in clinical research became a national concern in the mid-1960s. The lack of ethical oversight in medical research prompted ethical decision-making to come from those outside of science and medicine. Bioethics emerged as a check to the clinical research and medical abuses that became part of the national discourse.

Callahan was working as a visiting professor, and as the editor of the lay Catholic journal The Commonweal, when Beecher’s article became public.41 During this time, Callahan started paying attention to the “biotechnological developments” of the 1960s. Callahan perceived traditional ethics as inadequate for understanding these problems. Therefore, he saw an opportunity to apply his vision of moral philosophy towards the ethical dilemmas raised by these

40 Beecher, 1358.
41 Lauritzen, 9.
developments. Callahan’s concerns were shared by a growing number of intellectuals who were critical of the unqualified positivism characteristic of the emerging medical research establishment. Modern medicine was awe-inspiring to many Americans thanks to the life-saving technologies produced during the war. As a result, the medical establishment was given a political and public mandate to stamp out disease at all cost. The medical research community, therefore, was seemingly impervious to criticism since they were fighting the good fight against disease and death. This degree of hubris held by the clinical researcher that the ends justified the means was exposed in Beecher’s article as well. Within the context of the antiauthoritarian attitude of the counter-culture of the 1960s, it was no surprise that the authority of the medical research establishment was also challenged.

Two years after Beecher’s article became public, large-scale protests challenged the morality of the Vietnam War. A similar attitude developed among intellectuals and scholars towards the medical research community. Three of the most important social revolutions—the civil rights movement, feminism and environmentalism—were all in full swing and raised challenges to the established order of social authority in the name of those who lacked power. Callahan was receptive to these events and changes.

I find it most convenient to take up the story in the 1960s, when three streams converged to set the stage for bioethics in general and my entrance into it in particular. One of those streams was what we now think of as “the 60s,” a time marked by assorted political and cultural upheavals and marked, in the case of medicine, by a sharp public and professional scrutiny of its institutions and practices. Medicine was opened for public inspection, not wholly of course but enough to be noticed. And another stream was marked by both fear of and a fascination with the great technological changes medicine was creating…the third stream was a revolt in some branches of humanities against the social isolation of the academy and a desire to let certain fields, especially philosophy, have

42 Callahan, “The Hastings Center and the Early Years of Bioethics” 56.
some social bite some “relevance” as the operative term of that era put it.\textsuperscript{43}

In response to this, Callahan started the first institution, the Hastings Center, devoted to the study of ethics in medicine and biological sciences.\textsuperscript{44}

The story of the Hastings Center’s inception began at a Christmas party in 1968 where Callahan presented the idea to his neighbor and psychiatrist William Gaylin. Callahan needed help with starting the institution and he knew that Gaylin was interested in larger ethical and bioethical issues as well. Moreover, Gaylin who was a faculty member at the College of Physicians and Surgeons (Columbia University) had connections in law and medicine; connections Callahan lacked. Neither had experience starting an independent research institution, but they were confident that it would draw scholars and professionals interested in the emerging field of bioethics. With a plan in place, Callahan and Gaylin sought funding for their project.\textsuperscript{45} Initially, in 1969, the Hastings Center was funded by a loan that Callahan received from his mother, but by years end Callahan’s grantsmanship was reflected in rewards from Rockefeller Foundation, the National Endowment for the Humanities and Elizabeth K. Dollard.\textsuperscript{46} The Hastings Center wanted to avoid corporate donations and remain independent of universities and government institutions. Callahan saw the Hastings Center as an institution that would bridge the intellectual gap between the public and the university. He felt that independence was crucial to the success of the Center. Callahan thought that this would bolster the Center’s effectiveness and that the field would be made “stronger” by remaining independent. The Hastings Center did just that, but the next challenge was finding those who wanted to take part in the Center’s work.

\textsuperscript{43} Callahan, “The Hastings Center and the Early Years of Bioethics” 54.
\textsuperscript{44} Albert Jonsen \textit{The Birth of Bioethics} (Oxford: Oxford University Press), 20
\textsuperscript{45} Callahan, “The Hastings Center and the Early Years of Bioethics” 56.
\textsuperscript{46} Stevens, 50.
The Hastings Center eventually attracted scholars from many different disciplines, but this task was not easy. Early in 1969 Callahan tried to get Rene Dubos, the very prominent scientist and ground breaking author of *The Mirage of Health: Utopian, Progress, and Biological Change*. Since the Hasting Center was an interdisciplinary intuition, scientists were needed in the bioethical analysis that took place at the Center. Dubos’ participation would have helped the Center because Dubos was an outspoken critic of the advances of science. In the 1950s and 1960s, Dubos challenged the popular scientific notion that the eradication of germs was beneficial to public health. For Dubos, this “eradication mentality” would cause ecological disequilibrium. The elimination of one pathogen would leave room for another, which would have “unpredictable consequences.” Dubos felt that humans could live with many diseases by bringing them under control, rather than trying to stamp them out completely. This notion was bolstered by the fact that death rates from tuberculoses declined prior to any scientific knowledge of the cause. Dubos’ work on retaining ecological equilibrium tied the ethos of environmentalism with public health, and he became an important figure in the history of the new conservation movement.47 Early in 1969, Callahan tried to get Dubos to join the Hastings Center as a fellow. Dubos responded:

> like you, I believe that the problem of social ethics created by biomedical science is a timely topic…I have been a participant in four symposia bearing on this subject…on the other hand, my participation in these symposia (and many other contacts with people in these fields) has made me somewhat skeptical as to the usefulness and effectiveness. The range of philosophical and social influences that play a role in the formation of ethics in so broad that discussions tend to become unrealistic and attitudes non-operational.”

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Dubos eventually allowed the Hasting Center to his name “in support of the center.”\textsuperscript{48} Although Dubos challenged certain predominant scientific pretensions in the 1950s and 1960s, he did not agree accept Callahan’s vision of applied ethics. This also demonstrated how some in the scientific community viewed the work of the bioethicist in the late 1960s. This ambivalence towards the philosophical analysis of hard science was an obstacle that Callahan and the Hastings Center had to overcome. It was difficult during the early years for Callahan to attract people such as Dubos, but the center would eventually gain the scholarly support that was needed.

The scholars that signed-on to work with the Hastings Center in the early years were from various different fields. The highly regarded evolutionary biologists Ernst Mayr and Theodosius Dobzhansky were affiliated with the Hastings Center. Working together in the 1930s and 1940s they developed the “modern synthesis” which combined Darwin’s theory of evolution with Gregor Mendel’s theory of heredity.\textsuperscript{49} Other intellectuals included: Leon Kass, a medical doctor and biologist whose views towards the modern medical enterprise attracted him to bioethics. His work as one of the first bioethicists in the county would eventually earn him the chairmanship of President George W. Bush’s President Council on Bioethics. Kass, in the early 1970s was working at the NIH. Henry Beecher was also present as a fellow for a short stint during the early years of the Hastings Center. Callahan and Gaylin, sticking to their interdisciplinary approach, sought the help of theologians, social scientists and experts in law. Paul Ramsey, a theologian who’s \textit{The Patient as Person: Exploitation in Medical Ethics} has been

\textsuperscript{48} Rene Dubos to Daniel Callahan, February 25, 1969. Box 17 group number 1695 folder A-K, HCR.

\textsuperscript{49} \url{http://www.pbs.org/wgbh/evolution/library/06/2/l_062_01.html}. The PBS website provided a brief overview of their works and biographical sketches.
argued as the first modern analysis in bioethics. Medical sociologist, Renee C. Fox brought a
social science analysis to the Hastings Center and lawyer and law professor Alexander M.
Capron, who, after working with the Hastings Center, went on to head a bioethical program at
the University of Southern California. These early fellows—though not an entirely inclusive
list—provided, in a sense, the intellectual credibility of the Center. Moreover, many of the
fellows associated with the Center in those early years became influential figures in bioethics.
The Hastings Center provided a place were these early bioethics could develop their bioethical
craft, therefore, both Callahan and Gaylin, unintentionally helped to legitimize and
institutionalize bioethics.

The Hastings Center saw rapid growth and acceptance during the early years and by 1971
the Hastings Center began publishing the influential Hastings Center Report, a landmark and
leading bioethical publication both within bioethics and outside the discipline. Also in 1970s
the Hastings Center began summer workshops and established a visiting scholar program. Taken
together, the Hastings Center Report and the summer workshops brought together intellectuals
involved in this burgeoning field. These ventures also helped legitimize the Center as a serious
intellectual institution, thus gaining the acceptance of intellectuals and scholars across the
county.

50 Jonsen, 47-51.
51 Stevens, 48.
52 Both Stevens and Callahan here: Stevens pg. 54 and Callahan “The Hastings Center
and the Early Years of Bioethics.” pg. 61
53 Ibid.
54 Stevens, 50. The growth in funding the Hastings Center received also reflected the
popularity of an independent bioethical research institution. This also helped the Hastings Center
gain additional funding. By 1977 the Hastings Center had a budget of $1 million, which
increased to $2.3 million by 1996
Also during the 1970s the federal government was becoming more receptive towards the ethical issues regarding medical research. In 1974 as part of the National Research Act, the National Commission for the Protection of Human Subjects provided government-approval.\textsuperscript{55} Callahan posits that although the commission focused on the ethical issues regarding human subjects in medical research, the work of the commission gave bioethics more public exposure\textsuperscript{56} The Hastings Center was not formally involved in the Commission’s work, but the public attention towards bioethics greatly helped and the Center would benefit from this attention. Moreover, the Hastings Center remained independent and apolitical; this was less threatening towards those who were still unsure of the bioethicists intentions. Also, the Center took on an anti-activist stance and was careful not to take on projects that sought to bolster a specific political agenda. Callahan saw these efforts as persevering an objectionable atmosphere where scholars who possessed a variety of viewpoints could converse in an open manner without the constraints of partisan thinking.\textsuperscript{57}

By the mid-1970s, the Hastings Center seemed to possess the proper ingredients to make for a successful independent research center. The media was also quick to pick up on both bioethics and the Hastings Center.\textsuperscript{58} Aided by public and political attention, the Hastings Center became an established institution. But for Callahan, the Center provided something more than just a place where bioethics would be discussed. As the Center evolved so did Callahan’s intellectual vision. From 1969 to 1973, Callahan and others working with the Hastings Center focused primarily on the ethical dilemmas between the doctor and patient. They promoted autonomy among patients and studied the growing national concern related to the ethical

\textsuperscript{55} Jonsen, 99.
\textsuperscript{56} Callahan, “The Hastings Center and the Early Years of Bioethics.” 62.
\textsuperscript{57} Stevens, 58.
\textsuperscript{58} Callahan, 67.
violations in science and medicine. The ethics in health care delivery was not a concern for Callahan, the Hastings Center or the field of bioethics. That changed when the Hastings Center began a three-year study on the ethics of health policy. In 1973, the Hastings Center received a $318,125 grant from the Robert Wood Johnson Foundation to study the ethics of health care delivery. The first year of this study did not result in the culmination of much in terms of literature; it was more of a fact-finding mission.

But by the end of this three-period the Hastings Center conducted a comprehensive study on the ethics of health care delivery. A research group affiliated with the Hastings Center studied the questions raised during the national debate concerning national health insurance. This group focused on ethical issues of justice and welfare in health care delivery. The debate over national health insurance during the 1970s prompted the group to look into the ethics of a how government-administered health care system would justly distribute health care. These policy debates of the 1970s raised ethical concerns related to the distribution of a government-funded health care system—the Hastings Center felt this needed immediate attention. A great deal of the work conducted by the fellows working with the Hastings Center focused on “the right to health care” and the “justice of health care delivery.” Some 19 scholars, including Callahan, contributed to this project.

59 Rothman, Strangers at the Bedside: The chapter “No One to Trust” provides a concise account of the Hastings Center’s beginning. Also, Tina Stevens’ Bioethics in America contains an entire chapter devoted to the Hastings Center titled “Leaders of Leaders:” The Hastings Center from 1969 to the Present.

60 Report to the Robert Wood Johnson Foundation March 1, 1973-December 31, 1973 from the Institute for Society, Ethics, and the Life Sciences, Box 6, group number 1695 HCR.

61 The majority of the work conducted during this study is compiled in Ethics and Health Policy. Roy Branson and Robert M. Veatch eds. Ethics and Health Policy (Cambridge Mass: Ballinger Publishing Co., 1976) The scholars who worked on the project are listed in this work.
Callahan’s written contribution towards this study provided an early glimpse into his evolution of his critique of the health care in the United States. In 1976, Callahan analyzed the language of “rights” in health care delivery. The language of rights in health care worried Callahan because absent from this argument was the language of limits. Callahan believed that by claiming an “absolute” right to health care, the individual could thus claim a right to whatever treatment he or she feels is important for their well-being. He blamed the World Health Organization’s (WHO) 1946 definition of health, which included the notion that an individual’s physical and mental well-being was just as important as the avoidance of disease and illness. Callahan thus asserted that biomedical advances, coupled with the WHO’s an “all encompassing concept of health” promoted the notion that every ailment could find a medical solution. Callahan was concerned that a health care system based on such premise could not be financially sustained. This analysis was in response to the national health insurance proposals of the mid-1970s, but he was also beginning to flesh out his vision of health care in the United States—a health care system based on limits.

In 1974, Senator Jacob Javits and Senator Edward Kennedy proposed bills that sought a government funded health care coverage for all Americans. One of the bills proposed by Edward Kennedy, The Health Security Act, called for full health care coverage for every American. Yet, The political priority for health care reform was trumped by the Watergate scandal in 1974. Consequently, there was no indication that the Nixon administration would have

62 Ibid., Daniel Callahan “Biomedical Progress and the Limits to human Health.”

Callahan provided the WHO’s definition in his essay: “Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.”

63 National Health Insurance Proposals, 93rd Cong. Provisions of Bills Introduced (July 1974): SSA 75-11920 In 1974, 22 bills were proposed aimed at reforming the health care system in the United State. All 22 proposals, including both Kennedy’s and Javits’ proposals, can be found in this collection of proposed bills. The Kennedy and Griffiths “Health Security Act” is on page 145.
endorsed Kennedy’s bill had he stayed in office. Be that as it may, liberal health care reformers such as Kennedy faced another obstacle—publicly speaking about limiting health care resources. In 1975, Kennedy and New York senator Jacob Javits—who also proposed a health care reform bill in 1974—approached Callahan to discuss the issue of limiting health care.

It was a very interesting encounter because at one point Senator Kennedy said, “The one thing that worries us is how you would set limits?” We said that’s a good issue. He and Javits both said that we can’t talk in public about that problem. He (Kennedy) said, “why don’t you guys (the Hastings Center) work on it?” I said this is ridiculous, they’re asking us? But they both agreed, and everyone there, that you can have a right to health care, but you can’t have any limits to a right to health care…that scared a lot of people off.

Although Callahan did not change the minds of Kennedy and Javits there was a moment of clarity—universal health care would be a difficult sell when the language of limits entered the conversation. The fact they could not talk publicly about limiting health care revealed a problem in liberal health care reform. Limiting health care resource was a real concern for politicians who sought government-funded health care, but they seemed to wrestle with how to inform the public about rationing or limiting health care. This also suggested that the public was not willing to compromise on health care delivery. More to the point, liberal politicians were unable to construct a publicly acceptable argument for limiting health care resources, which would be inevitable with a government-funded system. Nevertheless, the work of Hastings Center on the ethics of health care delivery made its way to Washington D.C., but the politically suicidal language of limits kept Callahan and the Hastings Center from furthering any relationship with policy makers in the 1970s.

It is unclear whether or not this had any impact on Callahan’s vision concerning the health care system. A year after the conversation with Javits and Kennedy, Callahan requested a
further three year-grant from the foundation in 1976, but the broad of trustees at the Robert Wood Foundation saw things differently.\textsuperscript{64} The Robert Wood Johnson Foundation did not further fund the project.\textsuperscript{65} Without funding, the Hastings Center would stop research on the ethics of health care delivery, but Callahan did not stop his work. By the end of the 1970s, Callahan was beginning to apply his brand of moral philosophy towards health care. The research project that the Hastings Center conduct between 1973-1976 mark a turning point in Callahan’s intellectual focus.

**Chapter Three**

After viewing the arguments made by those inside and outside of bioethics and witnessing the health care reform debates of the 1970s, Callahan felt that the language of justice and rights had little impact on legislation and the public. Callahan thus began to find a new way to talk about health care. He did not abandon his ideas about limits; instead he incorporated them into a new framework. Callahan’s response, therefore, was to construct a new approach, one that used the language of social solidarity coupled with the notion of sustainability—a concept borrowed from the new conservative movement. In the 1980s and 1990s, Callahan drew upon the attempts to mend the problems in Medicare, and by President Clinton’s health care reform initiative, to further his critique of the American health care system. These two decades proved to be the era in which Callahan would focus almost exclusively on the health care system in the United States.

\textsuperscript{64} Proposal to the Robert Wood Johnson Foundation July 1976 from the Institute for Society, Ethics, and the Life Sciences, Box 6, group number 1695 HCR

\textsuperscript{65} David Rodgers. M.D. letter to Daniel Callahan December 19, 1976  Box 6 group no. 1695 folder: Robert Wood Johnson Reports 1974-1975 HCR
Chapter Three

In the mid-1980s, efforts to fix the problems in Medicare converge represented how difficult it was to have a serious national discourse concerning health care costs in the United States. Since the enactment of Medicare in 1965, many beneficiaries found Medicare services were limited. In an effort to fill the gaps in Medicare services, a number of elderly Americans began purchasing supplemental insurance, or what became known as “medigap” coverage. By 1984, 74 percent of Medicare beneficiaries had some form of supplemental insurance. The gap in coverage revealed the inequalities inherent in Medicare coverage.66 The solution for filling the gaps came in 1985 from Otis Bowen, an ex-physician and former governor of Indiana. Using his position as President Reagan’s secretary of Health and Human Services, Bowen took it upon himself to fix the inequalities in Medicare coverage. Reagan had no inkling that Bowen was to try and tackle the problems in Medicare coverage prior to appointing him secretary of Health and Human Services. The Reagan administration, and other conservative Republicans, had made it a point to reduce entitlement spending. The administration thus feared that Bowen’s plan would expand government spending for Medicare. Bowen’s plan eventually gained Reagan’s acquiescence as away to sure-up political support among seniors in light of the administration’s proposed cuts in Social Security in 1981.67 Bowen’s plan was budget neutral by not adding to the deficit and by avoided new taxes to pay for his initiative; thus quelling any fears among fiscal conservatives in the administration and Congress that his plan would increase federal spending on Medicare. Financing the program relied on financially able Medicare beneficiaries to participate in a risk pool. Based on the Medicare beneficiary’s income, they would pay an

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67 Ibid., 54.
additional premium towards their part B premiums. For example, the lowest income beneficiaries would pay $4 and the highest income beneficiaries would pay, at the most, $800 (regardless of how wealthy the beneficiary was, $800 was the cap). Never before in the history of Medicare were premiums based on a beneficiary’s income. With Congressional approval the Medicare Catastrophic Coverage Act (MCCA) was passed in 1988.68

However, sixteen months later the MCCA was repealed after pressure from segments of the senior citizen population. Some of the more affluent Medicare beneficiaries were unhappy that they should have to pay for those who were less fortunate. Moreover, Congress “underestimated” the popularity of the medigap and supplemental insurance industry. Some 30 percent of seniors received coverage from such supplemental providers, which, in some cases, was better than what was offered under the MCCA. In short, seniors who were content with their supplemental insurance plans saw no need for contributing their own money to a program that would provide them with marginal services. Also, opponents of the legislation exploited the confusion among the elderly concerning the limits and benefits of the program, which also aided in the MCCA’s downfall.

Although the plan possessed some weaknesses, the financing scheme would have closed the gap in converge with little burden placed on the tax paying population. The demise of the MCCA ensured that politicians would avoid any future attempts at filling the gaps in Medicare coverage. Instead, private supplemental insurance converge became the only alternative for seniors to fill the gap in coverage. Moreover, seniors felt entitled to as much health care as they could receive at a minimum cost. The other legacy of the MCCAs failure was one that provided the public with a scornful attitude towards the elderly. These angry seniors were depicted as

68 Oberlander, 60-65.
“greed geezers” and *Newsweek* even proclaimed “hell as no fury like a senior scorned.” They were thus viewed by the public as not only greedy, but indifferent towards their less fortunate counterparts.\(^{69}\) This sense of entitlement to health care reflected in the opposition to the MCCA was quite telling. Asking those who could afford to contribute a marginal sum of money to help those less fortunate was too much to ask. This also reflected how difficult it was for politicians to seriously talk about health care costs.

Financing health care for the elderly seemed to come under close public and political scrutiny during and after the MCCA debacle. In 1987, while discussing health care for the elderly, he began fleshing out his ideas a sustainable and affordable health care system. The endless pursuit to overcome death was an underlying theme in his work. Callahan became interested in the plight of the elderly after visiting a nursing home and seeing how isolated and lonely the elderly seemed.\(^{70}\) He was also concerned that the increasing number of elderly citizens would place a financial burden upon the health care system and on working age Americans whose tax revenues funded programs such as Medicare.\(^{71}\) Callahan argued that a disproportionate amount of health care expenditures were being spent on the elderly and end-of-life-care.\(^{72}\) Callahan, therefore, argued for limiting certain forms of medical care and for a different outlook on aging and death. Medical goals for the elderly needed a new set of priorities according to Callahan. He saw quality-of-life medicine taking precedence over attempts to

\(^{69}\) Oberlander, 65-72.


\(^{71}\) Ibid., 20-21.

\(^{72}\) Ibid., 225-228. Callahan provides some figures here in the appendix that he hoped to support his argument that health care expenditures for those reaching 85 years of age was on the increase in 1987. He also provides some statistics that showed the decreasing amount of young in the United States would, according to Callahan, bare the financial burden of health care for the elderly.
prolong life once an individual reached the end of their “natural life span.” Callahan defined this concept in abstract terms positing that an individual would feasibly accomplish all of their lifetime-goals between the ages of 65 and 85—the elderly individual should then accept their death instead of trying to prolong life at extraordinary price. He was certain that expensive live-prolonging technologies, for example kidney dialysis, would have to be rationed. Those who reached their natural life span should therefore be excluded from receiving such a procedure since kidney dialyses does not result in curing the elderly patient. These types of life-prolonging technologies should be reserved for younger patient who have not yet reached their natural life span. Moreover, Callahan used kidney dialyses to make a point about the limits of government subsides medicine—that government should consider age-based rationing for specific medical procedures. Although he claimed empathy as the impetus for arguments about health care for the elderly, the economic component seemed to echo the concerns about Medicare circulating during the late 1980s. Callahan’s ideas of rationing health care and redefining health care values were not just researched for the elderly. In 1990, Callahan built on these principles and began refining his argument concerning what he saw as the underlying problem facing health care in the Untied States.

Callahan believed that piecemeal attempts by health care reformers in the past did not address the nature of health care values possessed by Americans. For Callahan, health care

73 Ibid., 66. For Callahan, “a ‘natural life span’ may then be defined as one in which life’s possibilities have on a whole been achieved and after which death may be understood as a sad, but nonetheless relatively acceptable event.”
74 Ibid., 143.
reform could not be accomplished until societal perceptions concerning health were changed.\textsuperscript{76} Callahan asserted Americans became obsessed with health and desiring new and better medical technologies that promised a better life. A health care system that focused on individual health care needs could not be financially sustained especially when medicine sought “indefinite progress”.\textsuperscript{77} Medical progress, according to Callahan, created a false perception that and illness could be eradicated.\textsuperscript{78} Callahan argued that a health care system that is predicated on the eradication of death and illness could not be sustained, nor could it be made equitable.

Beginning in the 1990s, after the publication of Setting Limits: Medical Goals in an Aging Society and What Kind of Life: The Limits of Medical Progress Callahan received some harsh criticism. In 1991, Robert Barry a visiting professor of religious and Gregory Bradley a professor of law at the University of Illinois at Urban-Champaign saw Callahan’s aged-based rationing as discriminatory.\textsuperscript{79} They called Callahan’s views on rationing care “totalitarian medical care” because they disregarded the individual rights of the elderly through mandatory rationing of health care needs. They found his cost containment strategy “bad ethics” because it narrowly focused on the financial burdens of end-of life-care rather than the effects of rationing schemes on the individual. This “unidimensional” approach for curbing health care expenditures placed too high a value on economics instead of creating an equitable system that treated all patients, elderly and non elderly alike, fairly.\textsuperscript{80} Bradley and Barry, both free market enthusiasts,

\textsuperscript{76} Callahan mentions What Kind of Life in his interview and how people are now reading it and saying how “relevant” his arguments are. He comments on how people are now more “sympathetic” to his ideas in the book.
\textsuperscript{77} Callahan, What Kind of Life, 20-23
\textsuperscript{78} Ibid., 253.
\textsuperscript{80} Robert L. Barry, O.P. and Gerard V. Bradey, 122-123.
also took issue with Callahan’s “naïve” argument that government would distribute health care needs efficiently, equitably, and without problems. They felt that Callahan’s approach was no different than past liberal health care reform efforts. Consequently, They did not believe that government could pursue age-based rationing because of the political pressure the elderly would pose. 81

Callahan’s claim that end-of-life care cost was a key factor in the rise of medical inflation was also taken to task. The renowned medical sociologist David Mechanic felt that Callahan was incorrect in presenting some of the financial data on end-of-life care. Such care for the elderly became less “aggressive” as a patient got older which can result in less expensive health care costs. Moreover, physicians often make decisions on what kind of care is required based on the health circumstances of the elderly patient. If a physician is unsure, however, whether or an elderly patient had a chance to live, a variety of treatments might be administered. This would lead to “intensive efforts” to cure the patient, thus resulting in increased cost. 82

Although Callahan’s aged-based rationing drew a great deal of criticism, his vision for a health care “symmetry”—a health care system balances life-saving medicine with quality-of-life health care—was also called into question. Barry and Bradley seemed incensed at Callahan’s view that individuals must embrace limits on their personal health care needs in order to create a sustainable system. They disagreed with Callahan’s argument that medical technologies and new medicines were developed to serve individual health care aspirations rather than societal health care goals. Both scholars could not see why Callahan would want to limit spending on medical research. They claimed that some research might be expensive at first, but the long-term effects

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82 Email from David Mechanic
would better the health of society. Though Callahan argued for a sustainable health care system
that was best for society, Barry and Bradley were unsure of what kind of society Callahan had
envisioned. In a complex society, with complex health care needs, Callahan’s vision fell short of
proposing a clear guide for delivering health care. In short, Callahan was obviously making
some intellectuals uncomfortable given the fact that an entire book was published rebutting
Callahan’s views on rationing.

Callahan’s proposals for making the health care system more sustainable and equitable
also drew the criticism of one historian. Callahan proposed a three-tier system for delivering
health care in 1990; this proposal was trumpeted as having glaring inequalities. The historian
David Rothman, who wrote the first comprehensive history on bioethics Strangers at the
Bedside: A History of How Law and Bioethics Transformed Medical Decision Making, took
issue with Callahan’s multi-tiered health care system. Callahan saw the federal government as
providing a basic level of care for all Americas, especially the poor and elderly poor. The second
tier was an employer based system—the government provide funding for small businesses—
which would cover the “majority” of Americans. And the third tier was a market friendly
proposal providing Americans with a choice of providers.

Thus what began as a sermon closed with an endorsement of market-driven
inequalities. Rationing became the fate awaiting the poor, not the middle
classes. In the end, Jeremiah embraced Herbert Spencer.

This suggested that Callahan’s arguments for a three-tier health care delivery system favored the
haves rather than the have-nots. This perception that Callahan was preaching health care reform
rather than analyzing it is one of the sharpest criticisms that came out of 1990s. The hostility

83 Bradley and Barry, 124-125.
84 Callahan, What Kind of Life, 200-207.
85 Rothman, Beginnings Count, 122.
towards Callahan’s work on rationing was exacerbated by the fact it influenced others to take Callahan’s side. For some inside and outside bioethics, rationing care became a mantra for proving citizens with the health care they needed rather than with the health care they desired.86 Nevertheless, Callahan’s reputation, as the “limits man” was secured.87 Callahan continued his rationing and limits arguments through the 1990s.

The criticism directed towards Callahan had a general theme—rationing health care to create a sustainable health care system did not seem plausible. Yet, Callahan’s intentions seemed to raise questions concerning health care values, rather than an implementation of a specific health care system. Writing in 1990, Callahan wanted to make clear that any attempt at mending the U.S. health care system would be difficult:

“Nothing I have said here should be taken to imply that we will not need an open political process, a policy compromise, or and adjudication of competing interests. We will never find total agreement on something as central, as constantly changing, as complex, as health and health care. But we need some significant degree of consensus, much more than we now have, and on matters of basic values and perspectives. The change must come from inside, from ourselves, those selves that must wrestle with the fact that we are both patients (or would-be patients), hurting and needy, alone with our individual needs, and yet members also of local communities, families and a larger society, whose collective well-being gives our individuality a place and an enhanced meaning.”88

The criticism directed at Callahan’s utilitarian rationing schemes in the early 1990s, possessed a tone that implied that his ideas would be embraced by political health care reformers, thus endangering the lives of the elderly and poor. Callahan was concerned with the state of American

86 Ibid., 118-127. Here Rothman takes a harsh stance against Callahan’s arguments. He implies that Callahan contradicted himself by addressing the health care needs of the society rather than the individual. Callahan began his career arguing for the ethical treatment of the individual against the “paternalism” of the physician.
health care in the late 1980s and 1990s—a health care system that was becoming more expensive and less equitable. Questioning the underlying values of the American health care system seemed to be the central focus of Callahan’s vision. Although he proposed what he saw as the essential component for health care change, he was in no position to implement his ideas.

Rationing and limiting health care remained a staple argument for Callahan through the 1990s. As criticism of his worked mounted during the mid 1990s, health care reform was taken up by the Clinton administration. Clinton’s campaign for president in 1992 made comprehensive health care reform a major part of his campaign. Clinton’s health care reform strategy “managed competition,” sought to deliver health care coverage for all Americans. In 1993, President Clinton announced the establishment of his “presidential task force” which was in charge of putting together Clinton’s health care reform proposal. The task force was split up into two groups. One was a twelve-member group comprised of administration officials and chaired by Mrs. Clinton. The other group, “the advisory group,” was much larger pulling together over five hundred experts who were split into thirty different working groups. Experts in ethics were part of the larger advisory group according to Callahan:

She (Hillary Clinton) invited a number of people in ethics to take part on the ethical things. They were told from the beginning nobody could use the word “ration.” Everyone knew you weren’t going to give everyone everything and that you would have to ration, but they were told not to use the word “ration,” so they didn’t. But the net result is that it got kind of bypassed in the actual nuts and bolts.

89 Hacker, 3. Here Hacker defines managed competition: “the cornerstone of this approach was universal health insurance through competing private health plans. Under managed competition, most Americans would obtain health insurance through regional insurance purchasing cooperatives that would contract with private health plans and monitor the competition among them.”

90 Hacker, 122.

91 Interview with Callahan
The Clinton administration was aware that the public might raise questions concerning the rationing of health care. They prepared a question and answer script that acted as a guide for administration officials responsible for publicly presenting the Clinton health care plan. The script was aimed at swaying public perception away from the specter of rationing. Ethics experts on task force also raised the issue of rationing health care and budget caps. A memo was sent to Ira Magaziner—who headed the policy expert group for the Clinton task force—recommending that the public should be made aware that rationing or capping services was inevitable. Because this was a difficult topic to present to the public, the ethics experts made it a point to try and come up with a way to present the realities of rationing care under the Clinton plan. They also mentioned that opponents to the plan would use rationing against the Clinton plan if the public was not properly informed about rationing. These recommendations were ignored.92

The Clinton administration avoided a public discourse concerning the limits of a federally funded health care plan fearing public disapproval. When the task force analyzed the potential cost of the plan, they estimated between $30 and $80 billion of additional funding would be needed. President Clinton promised on the campaign trail that tax increases would not be necessary for funding his health care initiative. Instead of seriously addressing the public about the addition spending the Clinton administration left the numbers out of the proposal.93 Nevertheless, the Clinton plan failed to deliver what was promised during the campaign even with the language of limits and rationing omitted from explanations of the plan. This revealed a contradiction in the Clinton plan and perhaps in liberal health care reform. By avoiding public conversations concerning the limiting or rationing and the addition costs necessary for funding a

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92 Rothman, *Beginnings Count*, 142-144.
93 Hacker, 125.
universal health care system, liberal health care reformers in the 1990s met the same fate as their predecessors in the 1970s.

Callahan was hopeful that Clinton plan would bring comprehensive health care reform. Callahan thus tried to understand why the United States was incapable of universal health care coverage. Through the language of sustainability, Callahan began reshaping his vision on health care.\(^\text{94}\) Callahan’s different concepts concerning health care began to coalesce. Callahan’s idea of sustainability and social solidarity in health care became concrete by the mid-1990s. Callahan looked to the European models of health care for his argument for social solidarity in health care—arguing that Europeans did not possess and individualistic mindset when it came to health care. For such ideas to take hold in the United States some “historical moment” must occur, though he was not specific as to what sort of event would facilitate change in the health care system.\(^\text{95}\) Callahan was fully aware that European ideas of health care and social solidarity were different than those in the United States. He emphasized the point of social solidarity because a degree of “self-sacrifice,” was necessary if a universal health care system was to take hold in America.\(^\text{96}\) However, Callahan did not believe that Americans would embrace a system based on the notion of social solidarity.\(^\text{97}\) Callahan began to combine his ideas of social solidarity with sustainability during the 1990s. Callahan drew upon the environmental movement of the 1960s and 1970s to make his argument for a sustainable health care system.

Callahan saw a parallel between the language of a sick and unhealthy environment with that of a sick and unhealthy health care system. Environmentalism sought to halt the degradation

\(^{94}\) Daniel Callahan *False Hopes: Overcoming the Obstacles to a Sustainable, Affordable Medicine* (New Brunswick: Rutgers University Press, 1999), 13.

\(^{95}\) Interview with Callahan.

\(^{96}\) Callahan, *False Hopes*, 171.

\(^{97}\) Interview with Callahan.
of the environment through legislation and activism. Moreover, a degree of sustainability was needed to preserve the environment from further destruction. His critique of the health care system in the United States has been labeled as a “finite Model.” He was influenced by Rachel Carson’s Silent Spring and his father also published newsletters in Washington D.C. during the 1950s “aimed at businessmen” to try and raise awareness about cleaning up the water in the United States.98 Prior to the 1990s, the influence of environmentalism was implicit in Callahan’s works, but by 1998 Callahan was explicitly emphasizing that the ideas of environmentalists could help create a new way of thinking about American health care. For Callahan, a suitable health care system must have three characteristics. First, it must provide adequate medical care for the entire society so that a person can live a full life span. Second, it must distribute an affordable and equitable health care system. Third, it must have public support, embrace “finite health goals” and place limits on biomedical innovations.99

As the 1990s came to a close, Callahan began to further analyze the values and goals of medical research. Callahan began to reshape his arguments about infinite medical progress as the 21st century began. He saw that one of the underlying factors contributing to the rise in health care costs was expensive new medical technology. Moreover, Callahan saw the research imperative as the driving force behind infinite growth in medical research.100 Callahan argued that advances in biomedicine posed a “threat” to the formation of an equitable health care system if cost containment measures in medical research were not taken seriously.101 Callahan pointed

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98 Interview with Daniel Callahan
99 Callahan, False Hopes, 35.
100 McDonough, 173.
101 Daniel Callahan “How Much Medical Progress Can We Afford? Equity and the Cost of Health Care” in Journal of Molecular Biology vol. 319 issue 4 (June 2002). Also, Callahan define the research imperative as: “the felt drive to use research to gain various forms of knowledge for its own sake, or as a motive to achieve a worthy practical end. As with
to the allure that modern medical technology and innovations had on the public, politicians, and the market. This represented billions of dollars allocated for research at the national level (the NIH) and in the private business sector (the pharmaceutical companies). \textsuperscript{102}

Callahan did not completely disregard the advances in medical progress. He paid homage to the important medical breakthroughs that led to greater life expediency, reducing of life-threatening diseases and chronic illness and the alleviation pain and suffering. However, this led to a “paradox” according to Callahan. The research imperative created an ever-increasing allure that health can be infinitely improved. Research on embryonic stem cells and the Human Genome Project were proof to Callahan that new biomedical breakthroughs promised that the specter of death could be avoided. \textsuperscript{103}

The scholar and author Ronald Bailey took issue with Callahan and others who wanted to impede research in areas such as stem cell research. Bailey edited Reason Magazine, where he also worked as a science correspondent. In an interview in 2005 on the PBS program “Think Tank” Bailey labeled Daniel Callahan, Leon Kass and Francis Fukuyama as “bioconservatives” for trying to impede stem cell research. Bailey believed that these individuals would endanger the lives of millions if they were able to slow research on stem cells. Believing that stem cell research was one of the most promising new medical breakthroughs in the 21\textsuperscript{st} century, Bailey viewed any objection to this research as preposterous. Moreover, Bailey believed that in a

\textsuperscript{102} Ibid., 32-33.
\textsuperscript{103} Ibid.
pluralistic and secular society, science is the only “authority” left.\textsuperscript{104} Callahan would begrudgingly agree with this statement, but not as a triumphant claim that science is the only authority left in society. Medical research and the false promise that it will yield a better and longer life sounded more like a new religion to Callahan. Rather than look for the good life in family ties or religion, Americans have put their faith in science to save them from death.\textsuperscript{105}

Callahan saw medical progress as one component of many that helped better the lives of individuals. Biomedical research should focus on relieving pain and suffering instead of pursuing the eradication of death. Moreover, money spent on medical research should not trump other social goods such as housing, education, food and jobs.\textsuperscript{106} He argued, not against medical research, but for a more balanced allocation of funds.\textsuperscript{107} Moreover, the cost effectiveness of funding research to find cures for incurable disease did not seem feasible to Callahan. Spending on research for the next possible cure seemed to divert funds that could be spent on developing an equitable health care system. He lamented that the NIH spent the majority of its funding on disease that have historically proven to be incurable.\textsuperscript{108}

In a speech to the President’s Council on Bioethics in June 28\textsuperscript{th} 2007, Callahan tied together his ideas concerning the price of medical technologies an America’s health care system. For Callahan, controlling health care costs meant controlling cost on modern medical technologies. However, he argued that American’s were infatuated with medical progress, which could be major obstacle in controlling cost and in controlling the use of modern medical technologies. He proposed a 2 or 3 percent annual increase in spending on developing new medical technologies.

\textsuperscript{104} Ronald Bailey on “Think Tank.” A transcript is available on the PBS website: http://www.pbs.org/thinktank/transcript1213.html
\textsuperscript{105} Callahan, \textit{What Price Better Health?} 260-261.
\textsuperscript{106} Ibid., 85.
\textsuperscript{107} McDonnough, 179.
\textsuperscript{108} Callahan, \textit{What Price Better Health?} 270.
medical invocations instead of the 7 percent annual increase that wreaked havoc on the health care system. At the heart of this argument was a reoccurring theme in Callahan’s vision of health care in the United States. The endless pursuit to thwart death, Callahan reiterated, was not a feasible goal for modern medicine. If people were to live to be 200 years old, Callahan argued, medical progress will find away to push that life expectancy further.\textsuperscript{109}

Modern medical technologies have been used in early detection of disease to great success. Scanning technologies such as MRIs, CAT scans and PET scans are a few examples. However, the overuse of these technologies could drive up health care costs. These scanning techniques have led to misdiagnosing of disease. Physicians may recommend aggressive treatments for a supposed disease found by scanning resulting in excess spending on treatment. In part, the public demanded the use of these technologies to ensure their health security. However, there is an economic component that has also exacerbated the overuse of such technologies. Motivated by economic intensives, companies that manufacture medical technologies were quick to promote the effectiveness of using their early detection technologies based on modest results. Also, when fee-for-service were used to pay for such procedures, hospitals, physicians and specialist who administer scanning technologies were in a position to profit.\textsuperscript{110} The use or misuses of expensive medical technologies were a major factor in the rise of health care cost, but health care cost rose for a number of other reasons.

In 2006 health care spending surpassed the $2 trillion mark. Health care expenditures have increased 64 percent since 1995. On average, health care spending per person amounted to around $7,000. A number of factors contributed to the high cost of health care in 2006—

\textsuperscript{109} Email from Callahan, speech to the President’s Council on Bioethics June 28, 2007
\textsuperscript{110} David Mechanic \textit{The Truth About Heath Care: Why Reform is not Working in America} (New Brunswick: Rutgers University Press, 2006), 24-26.
increased spending on biotechnologies, the larger role private insurers played in Medicare, the high cost of prescription drugs and, and an increase in drug spending—particularly among Medicare recipients. In sum, the cost of health care have not diminished or leveled off in the 21\textsuperscript{st} century. Efforts to reign in cost have proved ineffective.

\textbf{Conclusion}

As Callahan delivered his speech to the President’s Council on Bioethics, he reminded his colleagues that providing a “humane health care system” was an extremely difficult task.\textsuperscript{113} for many inside and outside of bioethics health care is thought to be ‘political’ and thus not bioethics at all—or the province mainly of other disciplines, notably law, medicine, political science, policy science, and economics. I think that is wrong.

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\par\footnotesize\textsuperscript{111} Robert Pear “Health Spending Reaches Record $2 Trillion in 2006” \textit{The New York Times} January 8, 2008
\par\footnotesize\textsuperscript{112} Scott Biddle and Jean Johnson \textit{Where Does the Money Go? Your Guided Tour to the Federal Budget Crisis.} (New York: Harper Collins Publishers, 2008), 83.
\par\footnotesize\textsuperscript{113} Speech to the President’s Council on Bioethics Thursday, June 28, 2007
\end{flushright}
Health care should be a central concern for bioethics, and those other disciplines need our help as much as we need theirs.\textsuperscript{114}

Some in bioethics, most notably Leon Kass, have argued that health care is a policy issue and that bioethics should not analyze policy decision-making.\textsuperscript{115} Nevertheless, Callahan continued to sum up what he saw as the most feasible remedy for America’s health care woes. In many ways the speech represented a summary of Callahan’s ideas regarding America’s health care system over the last few decades. Callahan favored a universal health care system, but he recognized that the private market oriented health care approach might not be inescapable. The private health care industry became an important component in the American health care system; to dismantle it would be chaotic. Callahan looked to Europe to make his arguments for mixing of public and private health care coverage. In Europe this worked because there were regulatory bodies that mange cost. But what makes the European systems work so well, Callahan asserted, was the presence of social solidarity in most European countries.\textsuperscript{116}

This notion of social solidarity in health care was an essential component to Callahan’s vision for universal health care coverage. In order to sustain a universal health care system, society must be willing to sacrifice personal health care goals for the health care goals of the society.\textsuperscript{117} Callahan was unsure, however, if the United State is prepared to adopt a universal

\textsuperscript{114} Email from Callahan speech to President’s Council on Bioethics.
\textsuperscript{115} Interview with Callahan. Also, I meet with Callahan in January 2008 when he also mentioned an email he received from Leon Kass that mentioned his strong stance against bioethics entering the discussion over health care policy. Kass felt, according to Callahan, that discussion concerning health was not bioethics.
\textsuperscript{116} Speech by Callahan. He particularly point to the Bismarck Social Health Insurance (SHI) arguing that universal health care systems can also be financed through mandated employee and employer contributions. He was attempting to discredit arguments that government run health care systems are inefficient. Callahan argued that the efficiency of the SHI was due to the “quasi-independent” insurance programs that handle health care coverage.
\textsuperscript{117} Ibid.
health care system based on the notion of social solidarity. Americans tend to be too individualistic when it came to health care delivery. Moreover, rationing health care and medical technologies have been a politically “hot potato” which many politicians, both liberal and conservative, were not willing to address. Before health care policy change could occur, Callahan argued, a change in the underlying values in health care must first occur. 118

Callahan’s intellectual vision concerning health care delivery emphasized some sobering truths about liberal health care reform. Health care is essential to the individual and the society; this was something that Callahan did not dispute. In constructing a universal health care system, however, health care should stand as one social necessity, but not the only one.119 The public, the polity and scientific community must acquiesce in this vision in order to create a sustainable and affordable health care system. However, modern medical breakthroughs were just around the corner; falsely promising that death could be averted. For Callahan, the infinite desire to overcome death and the desire to possess an affordable health care system could not coexist. But to ask Americans to accept death and give up all possibilities of extending life could prove to be improbable. When facing death, it would be difficult to ask an individual to bypass the procedure or medicine that would prolong their life, even if it were only for a few years. Callahan’s abstract vision for changing the underlying health care values in the Unites States might be a difficult proposition. On the contrary, David Mechanic provided a pragmatic alternative to Callahan’s larger philosophical scheme for changing America’s health care system.

David Mechanic also voiced his concerns about the state of the U.S. health care system. Mechanic prescribed incremental change focusing on specific components of the health care system that needed change. This effort, Mechanic asserted, will circumvent the political and

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118 Interview with Callahan
119 Callahan, False Hopes, 289.
Addressing the uninsured in one such concern. Mechanic focused on those who were unable to afford converge—the working poor and their children and young working Americans. He did not see national health insurance as a realistic remedy since public and political ideologies against higher taxes and notion of “free riders” have resulted in a number of impasses over the years. Instead, small steps towards addressing each uninsured group, outside the “larger political and ideological debates” would work in filling providing converge. An additional problem in the health care industry was wasteful administrative spending. Private health insurers spent $1,059 per person in 1999 and health care administrators made up 27 percent of all health care workers. A centralized administering system would reduce waste, but this would be difficult since health care administrators span different areas of the health care system. Reducing wasteful spending through small incremental steps, Mechanic argued, could produce better results for providing health care coverage.

Mechanic also argued that much health care spending was wasted on expensive medical technologies. Expensive medical technologies, Mechanic argued, were too often administered. Without knowing whether the “value” of these procedures will yield positives results, patients and physicians demand them with the hope that they might improve the lives of the patient.

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121 Ibid., 162-164.
122 Ibid., 175. Here Mechanic argues that reducing cost would be difficult because “it is generated by millions of different actors, including health plans, professionals, hospitals and other institutions, researchers, and even patients themselves.”
123 Ibid., 167. Mechanic mentions bone marrow transplants and certain breast cancer treatments that to little in improving the lives of the patient.
Moreover, Americans have placed too much faith in new medical technologies that have not been proven to work in the long run.124 This problem was also evident in the administering of new pharmaceuticals. A phenomenon of supplier-induced demand excited in the pharmaceutical industry as a result of rival drug companies trying to outmaneuver one another. Companies produced new and expensive drugs have spent more money on marketing drugs than on innovation. Mechanic argued that excessive spending on new drugs could be curbed if doctors and patients possessed a more objective view towards the administering and requesting of new medicines.125 In sum, Mechanic’s arguments focused on what value could be achieved through prudent administering of medications and medical technologies.

In order for these prescriptions to work, Mechanic argued for an “evidence based culture.” Americans, according to Mechanic, were enamored by the promise that new medical technologies and pharmaceuticals could improve their lives. However, patients received information about new medical technologies on the internet, from friends and family, and other media outlets—this information could be distorted and presented in a less than objective manner.126 Therefore, providing citizens with unbiased information about new medical procedures and drugs could reduce cost and waste. However, active participation on behalf of the patient in understanding the limits of what new and expensive medical breakthroughs was an essential component to Mechanic’s argument. Understanding the most cost effective medical treatment could thus reduce excessive health care expenditures.127

124 Ibid., 176.
125 Ibid., 170-174. Mechanic also talks about other industrialized nations and how they establish price “they will pay” for pharmaceuticals—HMOs, VA, and “state Medicare programs” do this as well.
126 Ibid., 177.
127 Ibid., 178.
Mechanic and Callahan articulated two different perspectives on how to address the problems facing health care in America. Mechanic’s empiricism stood in stark contrast to Callahan’s plaintive calls for a revolution in conciseness. Although their remedies varied both agreed that the health care system in the United States needed mending. However, one thing remains unclear; a foreseeable end to America’s health care woes. The test of any critique of a health care system is the delineation of a plausible process through which significant improvement might be achieved. Grim observations that the health care system was “toxic” might be emotionally satisfying, but they did not guarantee that political or societal acceptance of plausible solutions would occur. Both Mechanic and Callahan had done heavy lifting and the construction of historical understanding of the evolution of our nation’s health care system and this intellectual capital was necessary if an equitable and sustainable health care system was to be won.

Bibliography


Bell, Nora K. “What Setting Limits May Mean” A Feminist Critique of Daniel Callahan’s *Setting Limits*. Vol. 4 no. 2 (Summer 1989): 170-176


Callahan, Daniel  email to Jason M. Chernesky (June 27, 2007) see also or speech to President’s Council on Bioethics June 28, 2007 [http://www.bioethics.gov/transcripts/june07/session3.html](http://www.bioethics.gov/transcripts/june07/session3.html).

Callahan, Daniel. *False Hopes: Overcoming the Obstacles to a Sustainable, Affordable Medicine*. New Brunswick: Rutgers University Press, 1999


------, “How Much Medical Progress Can We Afford? Equity and the Cost of Health Care” in *Journal of Molecular Biology* vol. 319 issue 4 (June 2002)


Callahan, Daniel. 2007 Interviewed by Jason M. Chernesky by phone Manville New Jersey September 26, 2007

Dubos, Rene letter to Daniel Callahan February 25, 1969, Hastings Center Reports, Box 17 group no. 1695 folder: A-K,Yale University, Sterling Library, New Haven CT.
Fleming, Donald “Roots of the New Conservative Movement” *Perspectives in American History* Vol. 4 1972, 35-38

Fox, Daniel “History and Health Policy: An Autobiographical Note on the Decline of Historicism” found in *The Journal of Social History* Vol. 18 no. 3 (Spring 1985)


Lauritzen, Paul “Daniel Callahan & Bioethics: Where the Best Arguments Take Him” *The Commonweal* (June 2007)


Mechanic, David Email to Jason M. Chernesky (November 9, 2007)

Miller, Judith “Must Government Pull the Plug” (a debate about the ethics of setting an upper limit on the amount of health care a society obliges itself to provide for individuals.) October 10, 1974 at the Hay Adams Hotel, Hastings Center Records, Box 6, group no. 1695 folder: Robert Wood Johnson grant correspondents. Yale university Sterling Library, New Haven, CT. This information comes from an event that discussed the ethics of health care delivery.


The PBS website. “Ernst Mayr and the Evolutionary Synthesis”
The PBS website provided a brief overview of their works and biographical sketches.


Proposal to the Robert Wood Johnson Foundation July, 22 1876 from the Institute for Society, Ethics, and the Life Sciences, Hastings Center Reports, Box 6, group number 1695 Yale University Sterling Library, New Haven, CT

Report to the Robert Wood Johnson Foundation March 1, 1973-December 31, 1973 from the Institute for Society, Ethics, and the Life Sciences, Hastings Center Reports, Box 6, group number 1695 Yale University Sterling Library, New Haven, CT

Report to the Robert Wood Johnson Foundation March 1, 1974-February 28, 1973 from the Institute for Society, Ethics, and the Life Sciences, Hastings Center Reports, Box 6, group number 1695 Yale University Sterling Library, New Haven, CT

Rodgers, David. M.D. letter to Daniel Callahan December 19, 1976 Hastings Center Reports, Box 6 group no. 1695 folder: Robert Wood Johnson Reports 1974-1975 Yale University, Sterling Library, New Haven CT.


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