• involves patients and their families in both prevention and treatment and

• in general is truly economical in the sense of bringing the greatest good to the greatest number.

One set of criteria receiving increasing attention as a means of assessing priorities for health and medical investment is the concept of "years of potential life lost before age 65." It is a data class that gives greater weight to these causes of mortality that affect younger age groups. It emphasizes the human and social toll exacted by deaths in the early years. By doing so, this approach highlights the primacy of prevention and early intervention.

Using this measure, the Health Policy Project of the Carter Center at Emory University, in cooperation with the Centers for Disease Control, has estimated that nearly 65% of the years of potential life lost before age 65 are due to preventable causes, given full application of exciting scientific and technical knowledge. This is an encouraging conclusion. But it poses a challenge to medicine and public health. It tells us we could be doing much more than we are.

Enormous differences in health status exist between the well served and the poorly served in our society, and the gaps account for the major share of those premature and preventable deaths. Most minority groups in the United States have more disease, both chronic and acute, and die at earlier ages than the white majority population.

The report "Black and Minority Health," recently issued by the Department of Health and Human Services, indicated that blacks under age 45 have an overall risk of death about twice as high as that for whites. Cancer incidence is 25% higher among black males than nonminority males, and black men are ten times more likely to die of hypertension. For the black male population as a whole, the average annual age-adjusted death rate for all causes in the years 1979-1981 was 1,084.6 per 100,000 as contrasted with 736.0 for white males. For females, the corresponding figures are 611.7 for blacks and 405.0 for whites.

The Black and Minority Health Task Force report estimates an annual total of 60,000 "excess deaths" among minorities—deaths that would not occur if minorities had the same death rate as the nonminority population. Moreover, it needs to be borne in mind that this total does not include the large and rapidly growing Hispanic minority for whom figures on death rates are not available. Although not all of the factors contributing to these excess deaths can be directly acted upon by physicians, many can.

Reducing these excess deaths in our minority population—bringing their health status closer to the level we know we can achieve—would seem to be an appropriate target for American medicine in concert with society as a whole, in an era of constraints and cost-consciousness. By selecting and investing in technologies appropriate to the reduction of infant mortality, for example, we shall be adding many years to many lives rather than months to a few.

American medicine can fulfill its purpose in an era of constraint by closing the gaps between where we are and where we could be in terms of preventable morbidity, premature deaths and improved quality of life.

The Lessons of Finitude

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THE FUNDAMENTAL GOALS of medicine remain the same as long as men and women suffer. Medicine evolved as a constellation of sciences and arts aimed at diminishing, curing and preventing pain, disability and deformity, as well as postponing death. Toward these ends elaborate accounts of disease and dysfunction have been developed, and medicine's concerns with care, cure and prevention are placed within ever more scientific and technological understandings of the complaints that bring patients to physicians. Still, the words of Hippocrates ring true: "Declare the past, diagnose the present, foretell the future; practice these acts. As to diseases, make a habit of two things—to help, or at least to do no harm."[1]

What has changed is the social context of medicine. The

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passage quoted from "Epidemics" continues: "The art has three factors, the disease, the patient, the physician. The physician is the servant of the art. The patient must cooperate with the physician in combating the disease." Much more is now involved. In addition to the disease, the patient and the physician, there are organized medicine, third-party payers and complicated governmental regulations and interventions, including both malpractice suits and cost-containment rules. Things are no longer the way they appeared to the author of the Hippocratic work "Law," who observed, "medicine is the only art which our states have made subject to no penalty save that of dishonor."[2] Even if the author understated the legal restrictions of ancient Greece, the practice of medicine experienced relatively few formal societal constraints.

In looking to the future, we will have to adapt the wisdom expressed in "Epidemics" to our current circumstances. We will need to determine how both third-party payers and governments can usefully "cooperate with the physician in combating the disease." Such reflections will need to be guided by a recognition that many of our current problems spring from our past attempts to act as good physicians and good citizens. The explosion of health care expenditures is traceable in great measure to the fact that it became easier to pay for health care just as health care was becoming more technologically sophisticated and more costly. The major growth in the proportion of the gross national product devoted to health care occurred over the last 30 years, as more of the population was covered by third-party payers, including Medicare and Medicaid. In 1950 and 1955 the percentage of the gross national product devoted to health care was 4.4, rising to 5.3 in 1960, to 6.1 in 1965, to 7.3 in 1970, to 7.8 in 1975, to 9.4 in 1980 and to about 10.8 in 1983.[3] A physician's traditional role of being concerned not to overexpend the resources of patients on marginally useful treatment was seriously weakened.

Organized beneficence and distribution of risks through insurance coverage have bred budget deficits and escalating insurance costs. The solution to the problem of individual access to health care has led to national problems of containing health care expenditures. As Alasdair MacIntyre once put it, our virtues can become vices.[4] Current difficulties with diagnosis related groups[5] and other forms of cost containment suggest that we are now creating new problems as we attempt to solve the problems engendered by third-party payment for medical care (problems that arose as we addressed the problem of access to health care in the 1950s and 1960s).

In the past, our culture provided a general endorsement of the notion that this life was not the only one and that it need not be held onto at all costs. To a great extent, such views are no longer a part of our official culture. We are consequently forced to shoulder the major moral project of setting limits to the proper use of health care resources with little or conflicting guidance from reigning cultural norms. We are confronted with the unpleasant circumstance of having lost the traditional Judeo-Christian restraints on duties to treat without having recaptured the temperance of our pagan ancestors, while at the same time the issues are muddied further by right-to-life rhetoric that often glosses over the traditional limits of duties to treat.

We will need to learn how morally to commit less than all available resources to saving life while maintaining the traditional goals of caring and curing.[6] This will lead not only to rethinking Baby Doe regulations and expanding natural death acts, but to the medical profession developing indications for the use of expensive as well as routine medical technology that more explicitly incorporate cost-effectiveness considerations. We as a society attempted to solve the problems of access to health care through privately and publicly funded health insurance. Physicians can help solve the problem of rising costs by helping society prudently to limit various forms of insurance coverage. How many, for example, would want to pay for insurance for intensive care unit services in the event they should develop Alzheimer's disease? Deciding where to deploy funds has major moral dimensions and requires good medical data. It is a task to which physicians can make a special contribution so that societal constraints can better serve patients' needs. Medicine as a learned profession should instruct concerning the lessons of finitude.

(Engelhardt HT Jr: The lessons of finitude—*In* The aim of American medicine within the constraints of today's society—A forum. West J Med 1986 Aug; 145:187-188)

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