

Correspondence

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

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

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

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

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

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

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

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

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

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

Cost Containment and Humanizing Medicine

Dear Editors,

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

Nathan Hershey, LL.B.

Professor of Health Law
Graduate School of Public Health
University of Pittsburgh
Pittsburgh, Pennsylvania

Heart Transplantation in Massachusetts and the Prince of Denmark

Dear Editors:

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

loose! Yet must not we put the strong law on him. He's loved of the distracted multitude. . . ." (IV.iii).

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

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