

poured with a heavier hand than those given highball glasses.

Maybe it's not surprising that the college students overpoured by 30 percent, but even experienced bartenders who were told to take their time poured 20.5 percent more into the tumblers than they did into the highball glasses. So if you down two rum and cokes at a bar, chances are you have actually consumed closer to two and a half.

These findings have far-reaching consequences. Surveys of alcohol consumption, for example, fail to take into account the tumbler effect. Bar owners with an eye on the bottom line obviously would be well advised to switch to highball glasses, while parents who want their children to drink more milk should switch to tumblers. And while the authors don't make this suggestion, tipplers who want to cut back might consider sipping their next Absolut from a bud vase.

A subject for further research: the influence of stemmed versus unstemmed martini glasses on the pouring of clear spirits.



A short glass makes for a bigger pour.

SCIENCE & TECHNOLOGY

Medicine's Mirage

THE SOURCE: "Conservatives, Liberals, and Medical Progress" by Daniel Callahan, in *The New Atlantis*, Fall 2005.

REGARDLESS OF WHETHER THE health care system is market-dominated, as in the United States, or government-financed, as in Canada and Western Europe, expenditures keep increasing faster than the rate of inflation, with only small health gains the result. That suggests that both conservatives and liberals err in thinking that there's an organizational fix for rising costs, argues Daniel Callahan, cofounder of the Hastings Center, a bio-ethics think tank. It's time to look at a deeper cause: society's war against death.

Economists calculate that "progress-driven technological innovation"—both the development of new technologies and the intensified use of older ones—is responsible for up to half of the annual increase in health care expenses. Certain drugs to treat colorectal cancer, for example, can cost up to \$161,000 for a 12-week course of treatments, yet the gain can be as little as seven additional months of survival. Society is rightly reluctant to say such added months of life "aren't worth it," Callahan acknowledges. But the dollars spent on "expensive medications at the end of life" could be spent instead on "other goods and obligations, including the obligation to provide basic medical care to the poor."

New attitudes toward death can be seen in the rise of the palliative care movement, which emphasizes giving comfort to the dying and relieving their suffering, fostering an acceptance of death. But much of mainstream medicine still strives through research

to find cures for all lethal diseases, and regards death as the enemy—as, in effect, a curable disease itself.

"Much of the health care cost pressure in developed countries can be traced to the war against death," Callahan writes. The National Institutes of Health, with a budget of \$28 billion, has spent much more research money on combating lethal diseases such as cancer and heart disease than on fighting chronic diseases such as arthritis and osteoporosis, which affect many

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more people and can drastically diminish their quality of life. Because the leading lethal diseases "are primarily diseases of aging," he urges, they should have "a lower research priority."

"At the clinical level, it would seem appropriate to insist on a strong likelihood of success—a decent prospect for more years, not just months, of life in good health—before proceeding with treatment in intensive care units or the prescription of enormously expensive devices and drugs."

Meanwhile, says Callahan, there should be "more research and clinical work on the disabilities and frailties of old age," and more emphasis on long-term care. "In caring for the elderly, we should focus on quality of life, not length of life. . . . At age 75, I do not look for medicine to give me more years, but I do want my remaining years to be good years, with mind and body reasonably intact."