

## Book Reviews

*Ethnic Psychiatry*, Charles B. Wilkinson, (ed.) Plenum Press, New York, 1986, 194 pages, \$25.00. *Ethnic Psychiatry* is an anthology primarily concerned with mental health issues among selected ethnic groups. The authors are psychiatrists, themselves members of the groups about which they have written. These groups include Native American Indians, black Americans, Spanish-speaking peoples, Orientals and Pacific Islanders. The choice is based on the fact that "these groups differ physiognomically (*sic*) from the majority group and towards whom exclusion from the mainstream of America has been practiced and a lower status in society has been assigned." (p.10)

The chapter dealing with black Americans discusses the problems of overdiagnosis, underdiagnosis, and maldiagnosis. An example such as autism in the young black helps the reader become aware of the complexity of mental health care and delivery to the black community. Because some clinicians are stereotyped in their thinking, they often find it difficult to believe that blacks can have a value system similar to their own. As a result, according to the authors, an inappropriate therapeutic regime is often assigned. Furthermore, the preponderance of literature dealing almost exclusively with the poor black—the disadvantaged ghetto black—points to the fact that little attention is being paid to the burgeoning middle class. Poor or middle class, blacks are often vulnerable to problems related to psychiatric and psychosomatic disorders.

The subsequent chapter on Hispanics refers primarily to Mexican-Americans, Puerto Ricans and Cubans. Cultural considerations such as language and the use *usted* and *tu*, and cultural concepts and practices such as *personalismo*, *compadres*, and *machismo* are discussed here. However, the lack of elaboration of *machismo* as well as the lack of even a mention of diseases of emotional origins such as *Mal de ojo*, *Susto*, and *Envidia*

fails to acquaint the reader with significant perspectives needed in the range of information dealing with mental health care delivery for the Chicano.

When discussing bilingualism and the level of proficiency in an adopted or learned language, the author makes a good point. Thinking in one's own language and speaking in another tends to complicate a therapeutic approach that relies mainly on talk. The use of an interpreter is still controversial since it brings to the therapeutic session the effect of the third person and the likelihood of distortion and misinterpretation.

One specific modality emphasized is that of the Spanish-speaking intermediate care program. According to the author, Hispanics recovering from severe psychiatric disorders would greatly benefit from such a program. Finally, pharmacotherapy is deemed important in the treatment of Hispanics, since they appear to be disposed to it for historic reasons. Folk healers, *curanderos (as)* are a vital aspect of the Hispanic process of healing.

The final chapter deals with Native Americans. As expected the issues of alcoholism, suicide, and violence are brought out, but the author's rightly state that these concerns are "better understood when considered in the context of overall problems and needs of American Indian people today." (p. 144)

To acquaint the reader with the many facets of the American Indian ethnic reality and its problems, the authors proceed to discuss four separate historical events for Indians. This information is both interesting and enlightening especially when the author's deal with factors such as the survival pact, religion, Shamanism, and problems in contemporary Indian life such as cultural ambivalence, depression, and low self-esteem. Under the heading of "Indian Self-Determination" the author points out that the Self-Determination Act and Indian Health Care Improvement Act "were oriented towards administrative responsibilities and did not explicitly address issues such as inclusion of traditional Indian healers in health programs." (p. 164)

Much of the information about Native Americans deals with their cultural abuse throughout history. Although very informative, this reader would have liked a greater elaboration of the Native American's cultural strengths such as traditional healing and concepts of time and harmony. However, the sections on "Integration" and "Future Directions" do emphasize the notion that "future health programs should be based on community concepts of problems and strengths." (p.181) A chronology of historical events from 1519 to 1978 as they pertain to Indians is included at the end of the chapter.

In summary, *Ethnic Psychiatry* is an attempt to acquaint Residents and Clinicians with the many and varied facets about ethnic diversity in

America. Overall, the case studies presented range from the informative to the obvious. At times psychiatric jargon tends to cloud the communication of ideas for the nonclinician. While one realizes that this work is written for psychiatrists communicating with each other or other health care deliverers, it is readable and informative, serving as a good introduction to health care deliverers or those interested in mental health issues. At the very least, *Ethnic Psychiatry* opens up the issue of mental health and the complexity of ethnic values. This is certainly a necessary first step in addressing holistic approaches to health care.

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*The dream; 4000 years of theory and practice: A critical, descriptive and encyclopedic bibliography*, Nancy Parsifal-Charles, Vol. I, II, West Cornwall, Connecticut, Locust Hill Press, 1986 (\$59.95) This two-volume reference work on imaginal activity occurring during sleep, which has historically been termed dreaming, is a valuable bibliography. Through the citations, the work is an overview of ancient, contemporary, philosophical, theoretical and research findings. By design the work limits itself to books and monographs. Journal articles and the periodical literature are not within its scope. In this sense the title is somewhat misleading. Nevertheless the two-volume set is useful for those interested in a *list* of historical and contemporary books and monographs on dreaming.

Despite the present era of the computer-accessed bibliography this printed work still provides three advantages. First, many of the older citations are not likely to be entered into computer data banks. Second, extensive descriptive summaries of many of the citations provide the reader with information not likely to be found in the computer-accessed bibliography. Third, critical analysis of many citations are presented, though many of these critiques all too clearly reflect the author's restricted orientation to dream data.

The author's orientation is clearly from the humanities and the clinician's "couch," and not from a scientific or research perspective. This orientation would be an acceptable and valid one, given that it were stated from the outset—which it is not. Since a degree of bias is usually inherent in any given work, Parsifal-Charles' bias does not crucially flaw the work—

as a bibliographic list. As an annotated reference work, however, it is frequently more than disconcerting. For example, a volume by Foulkes (Vol. I p. 155–157 1985), is critiqued not on its main thesis but on the fact that Foulkes suggests dreams have no “message” or psychological “meaning” (an issue with which this reviewer, like Parsifal-Charles, also disagrees see Haskell, 1986a, 1986b). The basic thesis and significance of Foulkes’ book, which is a complex and well-reasoned cognitive-mnemonic data-based model of dreaming, is neither addressed nor described as it should be in a work of this nature. It is certainly worth noting here that Parsifal-Charles, after suggesting in the opening pages of Vol. I (p.vi) that dreams may contain “truths” from “God,” recants some pages later and asserts that Foulkes’ research formulations are far out on “a very shaky and perhaps *illusory limb*” (p. 157, italics added).

Throughout this two-volume bibliographic work there is constant railing against a quantitative and otherwise scientific and systematic methodological approach to the dream. In discussing another work by Foulkes (1978), Parsifal-Charles again disregards the entire first half of Foulkes’ work, neither summarizing nor describing it. Instead Parsifal-Charles focuses on Foulkes’ intricate quantitative methodology for the analysis of dream data and dismisses it as “a sophisticated form of mumbo jumbo” (p. 154).

Much of the commentary within the pages of *The Dream* reflects the polarized controversy in the field of dream research. The two volumes clearly reflect an antiscience, anti-intellectual, and antischolarship ideology. In describing and critiquing what—in this reviewer’s judgement—is clearly a “popular” book by Garfield (1984), Parsifal-Charles suggests that the book is neither popular nor academic, “neither fish nor fowl,” (p.173) “running for too many pages to hold the casual reader, and providing a wealth of notes and extensive bibliography that usually discourages nonacademics”). In acknowledging and lauding Garfield’s ideas and research, Parsifal-Charles concludes, “it is a shame to have them appear . . . in what looks more like a scholarly text than a popular exposition,” (p.173).

As one reads the various annotations, the inconsistent and conflicted orientation to the subject matter becomes very disconcerting. For example, on one hand the Garfield volume is criticized for having too many references (p.173), on the other hand, Parsifal-Charles says of a citation of a volume by Evans (1983), “the reader encounters nowhere any source citations. It is impossible to verify, examine more closely, and peruse further one’s curiosity on the sources of the material presented” (p.135).

The restricted orientation of this bibliographic work toward the humanities and the clinician’s “couch” is further reflected in less evident ways. To the author’s credit, the work cites volumes which contain interest-

ing material on dreaming but which are not primarily about the subject matter of dreaming. For example, a classic volume on group psychotherapy is cited (p.157). "Secondary" sources from neurophysiological studies on sleep, however, are largely not to be found—sources such as the classic work of Drucken-Colin and McGaugh (1977). An analysis of the subject index of the two-volume set reveals no primary heading for "neurophysiology." There is only one reference to laboratory dreams versus home dreams, while the "parapsychology" and "telepathy" headings contain forty-two and twenty-nine page references, respectively. The page references found in the index under these latter headings do not simply reflect the actual volumes cited; rather they are page references to Parsifal-Charles' selective commentary on the volumes cited.

As a simple comprehensive *listing* of books dealing with dreaming, the bibliography is a work that is valuable. As a descriptively annotated work, it is often useful. However, as a critical commentary work, it is unacceptable by virtue of its lack of objectivity. In this reviewer's judgement, *The Dream* is a semi-popular reference work masquerading as a scholarly bibliographic research too.

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Harmon L. Smith and Larry R. Churchill, *Professional Ethics and Primary Care Medicine: Beyond Dilemmas and Decorum*, Duke University Press (Durham) 1986, 113 pp., hardcover, \$25; paper \$9.00. The essential message of this highly readable and stimulating monograph is the authors wish "to affirm the person-centered character of medical ethics," or, put another way, that medical ethics is "first and foremost about persons—what they intend, desire, and will, and especially what they value." In focusing on this interpersonal relationship of physician and patient, Smith and Churchill are critical of many traditional textbook approaches to "medical ethics," the formal systems or the focus on conventional principles and rational decision-making procedures which they dub "ethics-at-a-distance." The authors seem to be raising an important issue for both medical humanities and medical ethics, one which this reviewer has also often articulated: Is the engineering model for resolving ethical or moral conflicts in medicine adequate as a teaching and communication tool, or is something else needed—a "ministry" or pastoral care model?

Smith and Churchill do not discuss religious approaches to primary care in their study but their stress on *relationships* as a key to resolving moral issues in primary care amounts to much the same thing. But lest the reader be confused, this study is not an individualistic approach, it is rather a progressive approach culminating in a series of case studies much like those considered by Robert Veatch in his book, *A Theory of Medical Ethics*, but considered in a social justice context.

Chapter One, "Primary Care: A Moral Notion" offers definitions of ethics and primary care. In a second chapter the authors define "professionalism" and point out quite correctly that ethical thinking has been usurped by the domination of science and forces of professionalism. This is far too narrow a conception of what medical ethics is about.

The third chapter "Moral Imagination and Medicine" provides the linchpin for the argument. In a cry to go beyond the Aesculapian medical tradition, the authors call for a new focus for the moral imagination informed fully by patient experiences and social priorities for medical services. Here the authors hit the nail on the head, bringing medical morality to reality in the human experience of the medical encounter itself. The case studies then demonstrate how professional norms and values fit with patient needs, understanding and social priorities and, how all these inform the process of problem solving. The final chapter stresses how current medical ethical norms fail to address adequately the major social problems of distribution and technology faced by medicine today.

In sum, Smith and Churchill have done an admirable job of discussing an issue of major concern in a provocative and genuinely relevant

manner. This book comes highly recommended for physicians, philosophers and general readers.

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*The Coping Capacity*, Avery Weisman, M.D., Human Sciences Press, Inc. 72 Fifth Avenue, New York, N.Y. 10011, 1986, 165 pp., paperback, \$12.95. *About Mourning*, Savine Gross Weizman, Ph.D. and Phyllis Kamm, Human Sciences Press, Inc. 72 Fifth Avenue, New York, N.Y. 10011, 1987, 240 pp., paperback, \$14.95. No human being is exempt from situations of loss and grief. Such is the subliminal reminder of *The Coping Capacity: On the Nature of Being Mortal*, and *About Mourning: Support and Guidance for the Bereaved*. Both books, for which the subtitles are virtually interchangeable, offer new insights on the increasingly complex issues surrounding death, loss, grief and the mechanisms for coping.

*The Coping Capacity* is a gem. Author Avery Weisman, a renowned psychiatrist, has written a wise and subtle book which matches the brilliance of his classic text, *On Dying and Denying*. Dr. Weisman's wonderful dry humor makes skimming this slim volume an impossibility. The book is punctuated with homey witticisms and provocative observations appropriate for a broad readership. A sample: "He who tries to walk on water usually finds that he gets his feet wet and should wonder why he tried it in the first place," "Those who believe in the redemptive value of suffering are most likely to find it in someone else's suffering and sickness, not their own.," "Contenance at any age is not harmful, just difficult."

Primarily concerned with the way cancer patients come to terms with their disease and its psychosocial ramifications, *The Coping Capacity* is a practical guide for dealing with many other human problems as well. The book discusses the common coping strategies (denial, resignation, laughter) and presents an original perspective on the crises which occur in the life cycle, from sexual fulfillment to regeneration of courage and replenishment of personal morale, especially during old age. The author also offers a penetrating, un-Pollyanna view of the triumph of death, and points out the patronizing paradox of such phrases as "aging gracefully."

Not yet willing to (personally) accept the “friendship” of death, Weisman nonetheless acknowledges that death is not an unfriendly force. Death, he says, cures diseases and relieves the pain over which medicine has failed. Weisman demonstrates that our mutual “journey toward limbo” is what certifies true freedom. He states, “coming to terms with inevitability and being able to cope well enough to survive significantly are not only feasible, practical, and constructive, but in the end, liberating.”

*About Mourning* addresses specific bereavements—the death of a mate, an adult parent, a child—by interspersing vignettes of case studies with information about the funeral, support systems and the mourning process. Authors Weizman and Kamm view the family as the natural support group for mourning. Helpful not only for those struggling with loss but also for families and friends concerned about supporting the bereaved is the presentation of the range of acceptable grieving behaviors. Repetition, they emphasize, is an important aspect of the mourning process; the bereaved must be encouraged to cry unashamedly and to talk about their pain, anger and sorrow. As in *The Coping Capacity*, the reader is admonished to avoid the “three sermons too many people utter”: “Be strong; keep busy; things will get back to normal;” and expectations of a quick recovery.

Not to be overlooked is the chapter on the ethical will. Traditionally a legacy to one’s heirs equal in importance to the disposition of worldly possessions, the ethical will is a statement of values, beliefs, and directives for how one wishes to be remembered. Weizman and Kamm cite both traditional and contemporary examples—from Biblical patriarch, David’s advice to his son Solomon, to the late American humanist, Sam Levenson. For those who are no poets or great essayists, the authors offer creative variations. Quoting the Talmud, “Words that come from the heart enter the heart,” they demonstrate the priceless nature of simple statements scribbled on scraps of paper or letters written at the moment that thoughts occurred.

In this age of fast food, junk food, and pop-psychology dispensed with alarming dispatch, *The Coping Capacity* and *About Mourning* are thoughtful, carefully constructed works of rare insight and humanity.

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*Just Health Care*, Norman Daniels. Cambridge University Press, Cambridge, 1985, 245 pp., paperback (\$9.95). Why is health care “special”? Why should health care be an object of special moral concern instead of being thought of as just another consumer good? This is the question with which Daniels opens his inquiry, and it is the way in which he answers this question that yields his unique approach to addressing issues of health care justice. More precisely, the critical connection Daniels makes is between access to health care and fair equality of opportunity. He notes that health care restores, or compensates for impairments to, normal species functioning when that functioning has been disrupted by disease or accident. What is morally important about such disruptions is that they “reduce the range of opportunity open to the individual in which he may construct his ‘plan of life’ or ‘conception of the good’ ” (p.27). In other words, the opportunity range Daniels has in mind is that which is most basic to any plan of life. Losing one’s health is not like losing one’s job. Even in a poor economy one may be able to find another job, or create work for oneself. By way of contrast, loss of health means that virtually all opportunities for life plans in a normal range are lost or very severely constrained. Access to effective health care, which seems to be one of the major accomplishments of twentieth-century science, is what protects access to that normal opportunity range.

Daniels draws our attention to an important analogy between health care and education. Given that we are a science-based, information-based society, we recognize that access to formal education is essential if all our citizens are to have true equality of opportunity in competing for desirable social positions. Consequently, we provide twelve years of free primary and secondary education, and an additional eight to twelve years of greatly subsidized college and professional education. This gives everyone an opportunity to develop whatever skills and talents they have. We also devote additional resources to meeting the special educational needs of those who have remediable learning disabilities, and this as a matter of justice. I know of no one who would seriously dispute the connection between education and effective access to an indefinite range of opportunities in our society. Daniels contends that while education is basic to gaining access to opportunity, health care is even more basic since diminished health will usually mean diminished capacity to utilize educational resources.

The key conclusion Daniels draws from this analysis is that access to health care is not a matter of social beneficence or charity, as libertarians like Engelhardt maintain. Rather, it is a matter of justice. What follows from this is that individuals do have rights to health care, though

those rights are limited. Daniels acknowledges the intense pressures for health care cost containment in our society, and he concedes that at least some of those pressures are morally legitimate. A major advantage of his fair equality of opportunity account is that it is helpful in sorting out morally these various pressures. Thus, an anencephalic infant may have enormous health needs, but those needs do not generate any significant rights to health care because there is virtually no opportunity range at all available to that infant. We are not unjust if we simply allow such infants to die. On the other hand the uninsured who are unemployed, who may have great difficulty obtaining employment because of health problems that are remediable but unremedied, make strong moral claims for health resources because they are being denied fair equality of opportunity.

Another interesting feature of Daniels' account is its implications for the handicapped and disabled. His claim is that medical services and social support services that meet health care needs "have the same rationale and are equally important" (p.85). But as a society we have invested much more heavily in curative medical services, which Daniels suggests have more glamour and profitability attached to them, than in the supportive and rehabilitative services needed by the permanently disabled. From Daniels' perspective this is unjust.

Daniels also provides us with a useful approach for thinking about the just demands the elderly may make on our health care system. At present elderly Americans make up 11% of our population but consume 33% of health care resources in any given year. As the post-World War II "baby boom" generation ages out to comprise 18-20% of the population, and as further advances in expensive life-prolonging technology are introduced into the health care system, the potential demands of the elderly on the health care system become utterly unreasonable. How can we rationally determine when those demands are unreasonable? How can we ration the elderly's access to the health care system without being open to the charge of "ageism"?

On the face of it, we seem to have a problem of intergenerational conflict. But Daniels recasts the problem as one of prudently purchasing health care over a lifetime, for the fact is that we all hope and expect in our younger days that we will reach old age. If we agree as a society that there should be limits to what we collectively spend on health care (because there are other important social goods that need to be purchased), then it would be prudent to spend more on life-saving medical technology that would be used in earlier stages of our life in order to improve the likelihood of our reaching old age. In exchange

for that improved opportunity, we give up in old age access to many very expensive life-prolonging technologies. We accept instead more mundane forms of health care for what are the much more common needs of the elderly, e.g., for long term care and home care and other community services, exactly the sorts of services that are hardly provided at all under the current Medicare program. From the perspective of Rawlsian contract theory, which is the broad framework within which Daniels is operating, we make these trade-offs for ourselves rather than imposing rationing choices on others.

To conclude, we need to emphasize that Daniels is offering us a ground-breaking work here. He recognizes that a perfectly general theory of justice, such as that offered by Rawls, is not sufficient for addressing issues of justice and health care. For that we need a comprehensive theory of health care justice. Daniels' theory is an excellent start toward that objective. He takes us well beyond the vague rhetoric that is often associated with the assertion of a right to health care. But Daniels is the first to admit that his theory is not perfectly comprehensive. His theory does not tell us which approaches to health care financing are morally preferable, all things considered. For example, does his conception of just health care require the adoption of some form of national health insurance? And what does his conception have to say about more and less just approaches to health care cost containment? Or about whether we would have a more or less just health care system if there were more competition, or a rapid expansion of for-profit health? These are not deficiencies in his theory. They are merely indications of the research agenda that will have to shape the development of yet more comprehensive theories of health care justice.

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*The Care of Patients: Perspectives and Practices* Mack Lipkin, M.D., Yale University Press New Haven, April 1987, 235 pp. cloth \$32.50, paper \$10.95. Thirteen years have intervened between the publication of *The Care of Patients: Concepts and Tactics* and the revised edition *The Care of Patients: Perspectives and Practices*. For those swirling in the swift currents of medical change, it is reassuring to know that Mack Lipkin, M.D. continues

to serve as a steadfast beacon of light, a dedicated visionary still charged by the first edition's concluding quotation: "A man's reach should exceed his grasp; else what's a heaven for!"

In the "Foreword," David E. Rogers, M.D. advises that this book about doctoring presents a deceptively simple message:

The remarkable advances in biomedical science which have characterized the last fifty years have given doctors much more potent interventions with which to help the sick. But to apply these miraculous new technologies successfully, meticulous listening, empathic understanding, and compassionate concern for the patient have grown even more important.

Roger's brief description suggests the value of the book as a resource for medical humanities' classes, a book that medical students will find both useful and enjoyable.

Lipkin's central chapters are entitled "Etiology," "Diagnosis," and "Treatment," a division he regards as artificial since "well-trained thoughtful physicians ordinarily think of all three of the patient's troubles more or less together." These chapters are preceded by an introductory discussion of how medicine became what it is and are followed by a final chapter that attends to current problems in medical care.

A book that is so well-organized, lucid, and anecdotal produces regrets that only 235 pages separate the covers. Each section or chapter stands on its own providing important insights by the thoughtful and experienced practitioner.

The introductory chapter will be seized by many teachers as a provocative outline for students to consider. Specifically, it offers an historical overview of medicine's triumphs and failures, facts and myths, generously seasoned with commentary by figures as disparate as Henry E. Sigerest, Thomas Jefferson, and unidentified Quaker lady, Claude Bernard, and George Bernard Shaw. As Lipkin posits that vast number of illnesses fail to yield to technology and that good doctoring includes reassurance, guidance, and support, his ability to include other voices educates readers about changing values and beliefs. His review of technology, for example, leads to what Lewis Thomas calls the " 'half-way technologies,' " those skills that prolong life by way of kidney, heart, liver, etc. transplants, but fail to offer definitive treatment. These ambivalent miracles direct Lipkin to the importance of preventive technique practices that are more effective for improved health care and for the containment of costs.

The last chapter, "Some Current Problems in Medical Care," did not appear in the first edition. It addresses issues that cannot be ignored by the most caring of physicians—malpractice, economics, and personal med-

ical care—in a cursory manner that may disappoint some readers. Lipkin's book, however, is about caring; the final comments allow for a rededication to practice within the context of change. We can be grateful for Lipkin's focus; its emphasis on humanistic and practical attitudes can guide through the choppy currents ahead.

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*Jewish Values in Bioethics*, Rabbi Levi Meier, ed., New York: Human Sciences Press, Inc. 1986. 195 pp. \$29.95 cloth. As Rabbi Meier indicates in his Preface, this book brings together in twelve chapters some of the lectures which were part of "the Max Martin Salick memorial lectureship on Jewish medical ethics." An expected consequence of such a process is that the chapters will be of uneven quality with an aspect of disjointedness. Rabbi Meier's book is no exception. One of his own contributions, "Filial Responsibility to the 'Senile' Parent: A Jewish Approach" (Chapter 5) is clear in its presentation on how honor and reverence serve as the bedrock for the responsibility a child has to his or her parents, but is unclear as to how the issue fits into a discussion of bioethics per se. Similarly, Elie Wiesel's "A Singular Patient" (Chapter 7), an extremely sensitively developed contribution, far exceeds the confines of a bioethics focus. Perhaps the least helpful contribution is the first part of the paired chapters (3 & 4) on "Risks Versus Benefits in Treating the Gravely Ill Patient: Ethical and Religious Considerations." (Chapter 3) Fred Rosner does little more than raise questions, many of which go unaddressed much less answered in Rabbi J. David Bleich's response (Chapter 4). Dr. Rosner acknowledges in his conclusion that he has raised more questions than he has answered. He ranges from questions concerning particular treatment decisions to issues of micro and macroallocation. If nothing else, the complexity of the decisions which have to be made in the context of bioethics considerations is made eminently clear.

These minor criticisms aside, various contributors present what Rabbi Meier describes as the "quintessential lesson of Jewish medical ethics: life has infinite value" (p. 32). This theme threads through most of the chapters and is the vantage point from which a number of bioethical issues are addressed. Although many contemporary discussions of the issues of with-

holding and withdrawing therapy focus on deliberations of "quality of life" and "death with dignity," the Jewish perspective precludes such discussion. With its emphasis on the infinite value of life, and life integrated in the sense of "engagement" (p. 32), Jewish orthodoxy has no room for accepting or seeking death with dignity. Death is to be fought against rather than sought after; held off rather than held close. Considerations of the "right to die" issue often discussed in bioethics texts is out of place in a religious tradition which holds, as Rabbi Meier says, "mercy killing is considered an unwarranted intervention in an area which must be governed only by God" (Code and No Code: A psychological Analysis and the Viewpoint of Jewish Law, Chap. 2, p.44). In addition, Rabbi Bleich states: "Judaism teaches man has no proprietary interest either in his life or in his body. The proprietor of all of human life is none other than God Himself" (Chap. 4, p. 66). There are other topics covered in the canonical bioethics literature of the 60s and 70s which are given a different twist by the orthodox tradition represented in this book. Truthtelling was one of the early issues under discussion. The shift from Oken<sup>1</sup> to Novack<sup>2</sup> represents the swing from withholding information to full disclosure. The emphasis on patient autonomy gave a higher priority to disclosure than to the possible harm which might result from disclosure. Placing emphasis on the infinite value of life diminishes the importance of full disclosure. Similarly, by giving primary consideration to the physical welfare of patients, the major focus of the doctor-patient relationship according to Sir Immanuel Jakobovits ("Ethical Problems Regarding the Termination of Life," Chap. 6), the role of truthtelling diminishes. If knowledge of a patient's condition would diminish the length of his natural life by one day, "then under no circumstances are you ethically entitled to tell the full truth to the patient" (p. 86). An analogous conclusion with respect to informed consent can be drawn from the mandate to seek available and beneficial therapy. Rabbi Bleich points out: "Jewish law, unlike common law, does not at all demand that a patient consent to a procedure designed to restore health or prolong life. . . . The physician is under divine mandate to treat and the patient is under equal obligation to accept treatment, provided that the treatment itself is not hazardous in nature" (p. 73). These are just some examples of the responses made by a representative set of Jewish theologians. Of equal importance to the responses is the method by which the responses were derived. The various contributors appeal to the *Bible*, to the *Halakhah*, and to revered rabbinic responses for solutions to the particular issues being addressed. Each in their own way they try to hold in tension obligation to universal moral law and its application to a constantly changing world. The area of medicine presents the greatest challenge. As Rabbi Bleich says:

It turns out, however, that a major exception to the formalism which is the hallmark of Jewish law lies in the area of medicine and bioethics. Here we find problems which lend themselves to multiple answers, situations in which there is room for discretion. These are situations in which the answer is not automatically yes or no, but in which the answer can be yes, no, or maybe, and all three answers may conceivably be correct. (Chapter 4, p. 70)

The complexity of bioethical issues and the richness of Jewish law to address them, is central to Rabbi Rockman's contribution, "Jewish Medical Ethics and Law" (Chapter 10). He begins with: "In Jewish medical ethics there are very few black and white answers; there are mostly gray ones" (p. 150). He goes on to "demythologize" the law, concentrating on the *halakhic* process rather than on the *halakhah* alone. This chapter offers the reader a superb insight into the way in which the richness of Jewish thought and tradition are brought to bear on an exceedingly complex subject.

An apt conclusion for this review, although not of the book, looks at Rabbi Greenberg's, "Toward a Covenantal Ethics of Medicine" (Chapter 9). The rapid advances in medical technology are creating an atmosphere where physicians are acquiring tremendous power. "In this age, human beings are attempting to take control of their own destiny. Nowhere is this more dramatically demonstrated than in the extraordinary explosion of power within medicine, which now begins to tackle the issues of DNA and genetic engineering and the most fundamental structures that control life itself" (p. 124). The acquisition of such power places physicians at the human center of the process of human development. For the first time, technological advances enable humans in general, and physicians in particular, to help shape that process. The possession of power allows a person to fulfill one aspect of what it means to be created in the image of God. From such a view follows Rabbi Greenberg's claim: "Properly understood, every moment spent in medicine is a moment of religious calling and of ethical responsibility, because it is part of that process of perfecting human life" (p. 132–33). The empowered physician does not act alone, however, for to do so leaves open the possibility of abuse. In the covenant established between physician and patient, the power of medicine is countered by a recognition of the patient's status. "The very act of human healing, which is in a sense acting like God, involves the recognition of the image of God in others. This is the doctor's covenantal commitment" (p. 140). Rabbi Greenberg presents a powerful image of the nature of modern medicine and the role of the medical healer as derived from theological reflection upon one of the cornerstones of Judaism.

Despite the uneven quality of the chapters and the discontinuity

among the presentations, Rabbi Meier's collection of essays is informative and thought provoking for Jew and Gentile, patient and physician.

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*After Barney Clark: Reflections on the Utah Heart Program* Edited by Margery W. Shaw, University of Texas Press, 1984 ix + 221 + Appendices, \$22.00. Barney Clark, a dentist from Seattle, was the first recipient of a permanent artificial heart; implanted on December 2, 1982. Dr. Clark lived for 112 days, dying on March 23, 1983. Seven months after his death, the University of Utah Medical Center in cooperation with the University of Texas Health Science Center at Houston sponsored a three-day conference in Salt Lake City for 30 local participants and 15 outside consultants to explore ethical, governmental, sociological, legal, economic, historical and public relations issues associated with the "Barney Clark" experience. The proceedings of the conference, edited by Margery W. Shaw, comprise the contents of this book.

As a tribute to Barney Clark, the book's overall impact reminds us about the human aspects of this medical venture. It could best serve as a primary historical description for future researchers, capturing the personalities of the central persons involved: Dr. Clark and his family, Dr. DeVries and Dr. Robert Jarvik, and discussing the intricate relationships—both personal and professional of these people; while also addressing specific issues such as consent (a copy of the seven page consent form is included in the appendix), privacy and the development of the artificial device. As a descriptive collection of essays, the book is a fitting tribute to the subject who pioneered the experiment.

Because the book is a collection of talks presented at the conference, however, it reflects the range of preparedness of the speakers. Many



of the selections are brief and focus on particular clinical or public relations issues. Those that do tackle the larger issues are still not polished papers. Alex Capron, Professor of Law, Ethics, and Public Policy at Georgetown University, spoke of some of the conference shortcomings. He lamented that larger issues such as . . .

“When does it become justifiable in the process of developing a device as an artificial heart to use it in human subjects?” or “How, once we pass the few patients like Dr. Barney Clark with severe cardiomyopathy, are treatment decisions going to be made about the 250,000 Americans who die of myocardial infarctions each year in hospitals and might thus be candidates for an artificial heart?”

were not addressed. In keeping with his own assigned task and those of other participants, he centered on a few particular issues of the case which had legal components: termination of treatment; surrogate decisionmaking; and privacy. Also, before proceeding with his discussion he cautioned that his remarks were “tentative” for even after 24 hours of immersion in the Utah Science Center, he was still unclear about aspects of it.

After reading through the book, one cannot help but conclude that it would be best to consider most of the remarks “tentative.” The essays address a potpourri of ideas and in so doing effectively capture the intellectual climate of the conference. Because broader questions are not posed, it is difficult to integrate the materials in some overall fashion, even though each major section has a summary discussion.

There were, however, several provocative themes in the book. The one of most interest to this reviewer was a foreword by Renée Fox, the pioneering 1950s sociologist in medical innovations in the 1950s on Ward F-Second where cancer therapy was experimentally performed. In the early 1960s Fox and Judith Swazey researched their book, *The Courage to Fail*, a study of transplantation surgeons, and interrelated questions concerning patients, research and experimentation. Her comments on the artificial heart program compared it to these earlier efforts and centered on the theme “The same, but different.” It is from this essay that some general perspective can be gleaned from Barney Clark’s experiences; but even here, remarks seemed more probing than conclusive. How was it similar to other innovative procedures? The “special” nature of Barney Clark, his relationship with his clinical colleagues, collaborators, and the pioneering qualities of the Utah team were all reminiscent of earlier innovative work. So too were the experiments in which all participated and the “unfailing cooperation” displayed by participants as they were carried out. Innovative procedures then and now are “bold, uncertain and often dangerous.” Charisma played a part in the earlier

work and in this adventure there were four charismatic leaders, each playing a different role: Drs. Willem J. Kolff, William C. DeVries, Robert Jarvis, and Chase Peterson. As in many innovative procedures, there was a priority dispute. This time, it emerged concerning the name of the artificial heart—Jarvik-7. The project was riddled with the symbolic quality of the heart, which, Fox's interviews revealed, is still viewed as seat of the soul or spirit, a source or repository of love, courage and other most human emotions. These observations were understood and accepted by conference attendees: both academicians and clinicians.

Fox introduced another theme, however, which seems to have been controversial at the conference: the influence of Mormonism on the entire project. Barney Clark, with DeVries, and many members of the heart team were Mormon. Moreover, the University of Utah, its medical center and heart teams are embedded in a community that has a distinctive culture and a shared body of ideological beliefs. For Fox, Mormonism was a central aspect.

Those familiar with Fox's writings will recognize that this is a variation on a somewhat abstract theme recurrent in medical sociology. To present it at a conference focused mainly on concrete, specific events highlighted the two prominent perspectives represented at the conference. Fox was reminded of this when she had to defend her observations to those who took her remarks too literally; i.e., that she was *not* referring to the personal beliefs of those members of heart team who were Mormon and in turn, not impugning the objectivity concerning the selection of Dr. Clark as a patient. Such diversities of viewpoints evident in the conference are typical of the gap that exists between the clinic and academia. To the extent that this conference raised issues that alerted clinicians and scholars to this gap, its proceedings can serve as a reminder of the need to close it.

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*Should the Baby Live?* Peter Singer and Helga Kuhse, Oxford University Press, 1986, 280 pp., \$17.95. The book *Should the Baby Live?* by H. Kuhse and P. Singer adds to the veritable deluge of books on the topic named in the subtitle: *The Problem of Handicapped Infants* (published by Oxford University

Press, Oxford and New York, 1985, 228 pp., \$17.95 in cloth, also available in paperback). Kuhse and Singer have helped us in several important ways. Their book reads especially well. The language is clear and the arguments carefully laid out. We do not have to struggle with unnecessarily technical biomedical or philosophical language. The book contains adequate references to important historical events and the contributions of others who have considered the topic, but the authors do not overwhelm us with exhaustive accounts of either. What Kuhse and Singer have provided is more accessible than most of the other work in this area and will certainly be useful beyond the small world of the "professional" ethicist. For all of this we must thank the authors.

The authors begin by clarifying one of the most annoying mystifications in all the talk about handicapped babies. They reveal, largely through an analysis of the Baby Doe regulations and legislation in the United States, that decisions about these unfortunate infants are essentially value decisions. Many, including government administrators and legislators, maintain the fiction that decision making in these cases is medical-technical. When the Baby Doe Law (the Child Abuse Amendments of 1984) permits doctors and families to withdraw treatment of permanently unconscious infants, it admits a basic moral stance. The legislation acknowledges that at least some lives seem not worth living.

We find the central thesis of the book in Chapter 6: "What's wrong with the sanctity of life doctrine?" It begins with a brash claim: "The argument we shall present is so clear-cut that henceforth the onus will be on those who invoke the sanctity of life principle to show where our refutation goes wrong." Indeed, one is hard pressed to fault their criticism of the sanctity of life notion without acceptance of faith-based theological perspective.

Kuhse and Singer ground their own position on the concept of personhood and do not entirely succeed. Joining Tooley and others, the authors use the development of certain characteristics, including self-consciousness, rationality, a sense of continuity in time, etc., to demarcate "undeniable moral significance." They state that species membership has no ethical significance.

This brief review does not permit extensive commentary on these points. But some discussion of each must be undertaken. The argument from personhood suggests that even healthy newborns do not enjoy protection from ethical proscriptions on killing. They have not yet become persons. Without saying so directly, the authors seem to recognize that this view is unsettlingly counterintuitive, violating ordinary good judgment about what is right. The main difficulty with this rests with the question of when these somewhat arbitrary characteristics of personhood develop and our difficulty

in determining this. It is all very fuzzy. What constitutes self-awareness, or perhaps more to the point, enough self-awareness? Each passing day brings news of further child development research revealing the marvelous complexity of healthy newborns' capacities. We have learned that babies perceive and respond to their environment in ways far more sophisticated than anyone imagined even since "current" texts on human neurodevelopment were published. Perhaps we should not be so confident about fixing any particular time when babies gain entitlement to the label "person."

Kuhse and Singer have not conclusively answered the problem of whether species membership, rather than individual characteristics, has moral weight. They equate species-based decisions to racism and sexism. They ignore the fact that genetic makeup permits the qualities of persons to be expressed. A crucial link exists between the chromosomal information that *allows* humans to be and to reproduce and the characteristics of "humanhood" that deserve moral recognition. As a class, members of the species *homo sapiens* have these characteristics more consistently and in a more highly developed form than any other group.

In addition, Kopelman has argued that profoundly retarded humans are part of our community and that "Biological and social relationship creates unique attachments and felt obligations."<sup>1</sup> These ties, as illustrated by the way we behave in families and in friendship, transcend reliance on "some minimal level of intelligence or functioning. . . ."<sup>2</sup> Group membership and common human behavior should count for something in our moral reckoning on the troubled waters of deciding how to treat handicapped infants.

Kuhse and Singer should not have to bear the entire burden of failing to solve these problems definitively. This reviewer offers no solution here, either. The book deserves study and is recommended because of its clarity and the comprehensiveness of its considerations of the relevant ethical issues.

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*For the Welfare of Mankind: The Commonwealth Fund and American Medicine*, A. McGehee Harvey and Susan L. Abrams, Johns Hopkins University Press, 1986, 688 pp., cloth, \$32.50. Occasionally, one encounters a book that is more interesting for what it omits than for what it includes. *For the Welfare of Mankind: The Commonwealth Fund and American Medicine* is just such a book.

It is the biography of a fund started in the beginning of the twentieth century to work "for the benefit of mankind" and choosing to carry out this lofty goal through massive contributions to medical research, medical education, and health care delivery. The book's voluminous pages record the endless millions of dollars flowing into the world of American medicine through the decades. The philanthropic effort is well-documented. What is less clear is just what the fund has accomplished, particularly, with reference to medical education and health care delivery. Perhaps this is a strange point to pose, given the amounts of money that have been poured into the medical enterprise. Yet, this chronicle of one of the great American philanthropic foundations tells us very little about the evaluation of outcomes for patients and for the American health care system.

The Commonwealth Fund was created by the fortune that Stephen Harkness made, along with John D. Rockefeller, in the Standard Oil Company in the late 1800s. As Stephen Harkness' wealth grew, and philanthropic giving became possible, he and his heirs followed Rockefeller's advice to concentrate their charity on medicine, "a field in which there can be no controversy." Today, this statement seems charmingly naive. Medicine today is filled with conflict and controversy. One wonders what role the Harkness millions plays in that controversy. At the best, it has been a significant factor in developing the powerful academic medical centers which have become the symbols of emphasis on biomedical research and a style of medical education emphasizing specialists, subspecialists and high technology medical care. This is a style of medical practice much criticized today for being fragmented, costly, and removed from the ordinary problems of the average consumer.

The Commonwealth Fund has supported a wide range of medical enterprise. These include psychiatric fellowship, advanced medical fellows working in a wide variety of subspecialties, "creative" scholarships in basic research in the leading medical institutions of the western world, extensive grants for medical education programs in twenty-six medical schools as well as capital grants to a number of medical schools. The listing of the amounts given by the Fund since its inception is staggering. One gets the impression that a number of America's leading biomedical scientists and many of the elite medical schools owe a good deal of their existence to the Commonwealth Fund. One problem is that this book is primarily descrip-

tive and provides little analysis of what the giving means sociologically, economically, and ethically to the medical enterprise and to the American public.

A recent issue of *Daedalus* (Winter 1987) explores in detail the subject of "Philanthropy, Patronage, Politics." One of the most interesting essays, by Karl and Katz raises a number of intriguing points about foundations like the Commonwealth Fund. They discuss the political and ideological climate at the turn of the century when many of the great foundations were started. They discuss the accumulation of wealth and its excesses; questions of taxation and avoiding government control; questions of the more hidden motives of the original donors and their advisors. They suggest that foundations have usually served "conservative" ends, using their resources to recruit scholars and intellectuals to these ends. They also note that foundations are quickly taken over by bureaucracies never intended by the original donors. One of the most interesting questions they raise is whether tax-exempt status is legitimate for activities that, in essence, create public policy.

The Commonwealth Fund has been a key factor in reshaping American medical education and in influencing the pattern of biomedical research. This descriptive book is only a limited portrait of the Commonwealth Fund. A second volume is needed which ought to be a sociological study of patterns of funding, evaluation of outcomes for how doctors have been educated, what outcomes have been achieved for populations of patients, and the political and policy implications of Commonwealth Fund giving. The Fund would be an excellent subject for some modern evaluation research along these lines.

Such evaluation research might take as its starting point something Edward Harkness, scion of the family, said in 1910: "What is needed is study for research to establish whether the end of medicine has been successful in helping to 'prevent' disease."

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*By No Extraordinary Means.* Edited by Joanne Lynn, Indiana University Press, Bloomington & Indianapolis 1986 ix-272. Clothbound, \$25.00. This work grew out of a conference sponsored by the Society for Health and Human Values in Philadelphia in 1984 regarding the legitimacy of withdrawing food and water from patients who cannot or will not eat or drink. The conference was prompted by three court cases in 1982 and 1983. One concerned an infant

with Down's Syndrome, esophageal atresia and tracheoesophageal fistula.<sup>1</sup> The second involved the criminal prosecution of two physicians for discontinuing intravenous fluids in a patient with profound anoxic brain damage.<sup>2</sup> The third, the Conroy case, resulted from the petition of the nephew of an elderly nursing home resident to withdraw nasogastric alimentation, although the patient could eat on her own.<sup>3</sup>

The book presents a well balanced account of the arguments surrounding this issue. The volume is divided into five sections, each with several chapters of variable quality. This character is best conveyed by summarizing the salient arguments. In the first section, Alexander Capron discusses how the court system has come to confirm the rights of privacy in patient care and in the dying process. He outlines the general legal and ethical ramifications of withdrawing nourishment including discussion of whether this constitutes homicide; whether it fulfills the minimal expression of human caring; and whether there is room for a quality of life decision concluding that the burdens of nutrition outweigh its benefits.

Kenneth Micetech, Patricia Steinecher and David Thomasma contend that intravenous therapy and artificial alimentation should be seen as medical treatments like any other, subject to modification or withdrawal in accordance with specific criteria.

In the second section, "Considerations in Formulating a Moral Response," Joanne Lynn and James Childress argue that there is no *intrinsic* objection to withdrawing food and water. For most patients nutrition should be provided at all times. For some patients, it may be withdrawn either when a competent patient states that this is his will, or when it becomes evident that the procedures for feeding are futile, that improving or maintaining the state of nutrition and hydration is of no avail, and when the burdens of treatment outweigh their benefits.

Daniel Callahan disagrees. In "Public Policy and the Cessation of Nutrition," he points out that the symbolism of feeding cannot be so easily dismissed. The repugnance towards withholding food is strongly rooted. Should the practice of withholding food become widespread, it would likely change from an optional course of management in some cases to mandated behavior under certain circumstances. This position is contested by Childress, who suggests that Callahan has invented a "sentiment" or "symbol" utilitarianism. Ronald Carson sides with Callahan with respect to the symbolism of feeding, but proposes that when food is rejected, this symbolism can be replaced by other acts of caring.

Dan W. Brock examines the more fundamental question of whether withdrawing food and water constitutes "killing" or "letting die." He finds no significant moral difference between these two acts, and con-

cludes that there is no special moral prohibition referable to withdrawing food and water.

The Catholic and Jewish traditions are represented by Edward Bayer, and Michael Nevins respectively. Alan J. Weisbard and Mark Siegler's chapter, "On Killing Patients with Kindness: An Appeal for Caution," is perhaps the single most important chapter in the book because it considers the explicit significance of withdrawing nutrition: "for an increasing number of incompetent patients, the benefits of continued life are perceived as insufficient to justify the burden and the cost of care; . . . death is viewed as the desired outcome; and . . . the role of the health care professional is to participate in bringing this about."<sup>4</sup> Additionally, it stipulates the dangers of reverting to this policy as a means of cost containment.

Part III, "Perspectives on the Law," contains three chapters relating recent legal decisions to policy issues. Ron Landsman's discussion of emerging legal rules contains an excellent summary of advanced directives and living wills. Part IV, "Special Considerations for Particular Populations," reviews the special problems of elderly residents in nursing homes, newborns, patients in persistent vegetative states, competent patients refusing food and water, and the effects of decisions to forgo nutrition on health care providers. Part V, presents several detailed analyses of the Conroy case.

Lynn is not correct in suggesting that the withdrawal of food and water is a *new* moral dilemma: indeed, if there is any significant oversight in this book it is the lack of an historical perspective. Historically, the same four basic justifications for withdrawing food and water that are discussed in this volume have been debated in other contexts. These are: 1) nourishment is refused; 2) nourishment is harmful; 3) the means of nourishment are objectionable; 4) it is desirable to hasten death. Some important philosophical distinctions are not represented in this book. There are important moral and religious differences, for example, between 1) proffering nourishment that is refused, 2) forcibly administering nourishment, and 3) withdrawing nourishment. In the Talmudic tradition, for example, two separate obligations must be considered: the patient's obligation to eat in order to preserve life, and the caretaker's obligation to set nourishment before the patient (even if it is refused). In addition, the act of eating has sacramental significance in many traditions. The consensus that food can be denied because it has no physiological benefit does not address the issue of moral benefit for the consumer or the provider. The moral significance is not necessarily restricted to mere symbolism.

Certainly, where food is refused by a competent patient there is no moral obligation to force feed. But there are at least *three* models for the incompetent patient who will not eat: the anorexic adolescent who



chooses starvation as a mode of self-destruction; the demented adult who refuses food and removes all intravenous lines; and the abulic patient incapable of eating but equally indifferent to the implementation or the withdrawal of parenteral nutrition.

While the anorexic is not the subject of Lynn's book, this problem should still be considered in any discussion of the right to privacy and patient autonomy. For unlike other patients who refuse nutrition, the refusal of food in the anorexic may be the primary sign of emotional illness, and constitute a treatable condition. This brings up another issue that was not considered: does one always take anorexia at face value or does one pursue the treatable cause of loss of appetite? Once treatable anorexia has been excluded, there are few situations that call for obligatory artificial alimentation, but unless one really desires the death of a patient, there is an obligation to consider anorexia as a clinical sign, and diagnose its cause.

The real problem is the abulic patient who has left no instructions. But the "burdens" of nutrition that are so often mentioned in the text are not readily apparent in this setting. Is it acceptable to withdraw alimentation from the patient who lingers in a vegetative state without any apparent distress?

To do so becomes an act of euthanasia. Historically, the administration of poison has been less acceptable than nonintervention in time of crisis ("killing v. letting die"). Now, the withdrawal of food and water is proposed as an intermediate step: less offensive than administering poison, less passive than noninterference.

The arguments in this book do not prove that the techniques of parenteral nutrition are necessarily burdensome. They do illustrate that these techniques may be *perceived* to be burdensome by the patient, when they may be legitimately refused and withdrawn. The real problem lies with the unresponsive patient. I fear that parenteral nutrition has been adopted as a metaphor and a euphemism for continued life. With the exception of patients who willfully indicate their objection to oral and parenteral nutrition, and those whose systems literally cannot absorb or metabolize liquids or solids however supplied, the intention behind the withdrawal of nutritional support is to hasten dying. The court in the Conroy decision ruled that this was permissible so long as physicians stipulated death would occur within one year, regardless of treatment. One year thus becomes the arbitrary legal measure of the dying process.

Although this book is about food and water, it is really concerned with two basic questions: do we wish to embark on a policy of hastening the dying process in abulic patients, using substituted and objective criteria to justify our decisions? Shall food and water be the instruments of hasten-

ing? McIntyre, Weisbard, and Siegler address these questions directly, Brock, Callahan, Lynn and Childress indirectly, and others parenthetically, if at all. As the first collection to deal with these questions in detail, *By No Extraordinary Means* has delineated the areas that require further study. Joanne Lynn has performed a great service in bringing these issues to the attention of ethicists, physicians, and medical humanists.

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*Hospitals, Health and People*, Albert W. Snoke, New Haven, Yale University Press, 1987, xiii + 213pp. In this memoir of half a century in medicine and hospital administration, Dr. Snoke recalls the values and priorities of a world we have lost. His reminiscences and judgments make plain how much has changed in health affairs in recent years, even in the decade and a half since Snoke left his last full-time administrative position.

Albert Snoke has had a distinguished career in health affairs. After medical school at Stanford and a residency in pediatrics at Strong Memorial Hospital in Rochester, New York, he chose a career in hospital administration. From the mid-1930s to 1946 he was assistant director—for a time, acting director—of Strong Memorial Hospital. From 1946 to 1969 he was the director of Grace (later Yale)—New Haven Hospital. For the next four years, he was coordinator of health services for the governor of Illinois. Since then, he has been a consultant and teacher. During most of these years, he was active in state and national hospital affairs serving, for example, as president of the American Hospital Association and a member of many federal committees.

The book is arranged thematically. In thirteen chapters, Snoke sets forth his experience with and current opinions about the major issues in health policy and hospital administration. His tone is warmly rational; Snoke is easy to like, even when his views are controversial. Moreover, his nostalgia for the past is never cloying. Snoke seems to be saying, on almost every page, that people were nicer to each other in hospitals in the past, even though some patients had terrible experiences because they were poor or were treated stupidly or insensitively, or because little could be done to help them.

We are far from the world of health affairs that Albert Snoke knew in his prime. Most hospital chief executive officers (few are simply directors now) talk the language and assert the values of industrial corporations even when they work for voluntary or public institutions. The hospital industry, as it now unselfconsciously calls itself, worries about patient care because it brings a price in a competitive market. "Voluntary" and "nonprofit" are technical terms to describe tax status, corporate organization, and the format of balance sheets; they no longer automatically imply charity or community responsibility.

Although Snoke struggles to comprehend this world, his distaste for it is evident on almost every page. The conciliatory habits of a lifetime prevent him from condemning its moral inadequacies except by implication. Moreover, he probably knows, or at least suspects, that many hospital administrators struggle to prevent or at least alleviate the results of the commodification of care.

This book will not be widely read. Most hospital administrators, like most people in health affairs, are impatient with the past. A few eccentric teachers might, however, assign chapters from Snoke's memoirs as part of an effort to recreate what it was like to be a patient or a health professional in a hospital just a few years ago.

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*For-Profit Enterprise in Health Care*, Bradford H. Gray, editor, Washington, D.C.: National Academy Press, 1986, 556 pp. This very important and carefully researched book is divided into two sections; the report of the Institute of

Medicine's Study Committee on the role of for-profit institutions in health care comprises about 40%, with the remainder accounted for by a collection of papers prepared for consideration of the Study Committee.

The book begins by presenting informative background material on for-profit enterprises, including the observation that for-profits were quite prominent in the early 1900s. Also, the report emphasizes an important characteristic of a nonprofit, that it cannot distribute any surplus, and the use of mergers as the primary mechanism for the growth of for-profits.

Chapter 4 is particularly useful in showing that both for-profits and nonprofits rely to a great extent on debt finance, though for-profit can also utilize equity finance. An implication is that both types of organizations have to satisfy capital market suppliers, so that, after the decline in Hill-Burton grants which had provisions concerning charity care, nonprofits and for-profits are found to act similarly.

The book presents much empirical information on the performance and operation of for-profits and nonprofits. For example, there are comparative studies of prices, costs, occupancy rates, medicare patient outcomes, and compliance with accreditation requirements. In general these studies do not indicate important differences in quality aspects like mortality rates. They do, however, suggest that prices and expenses are higher in for-profits than in non-profits. The results also suggest that for-profits are more responsive to economic incentives. A hospital in the cost-based reimbursement environment had little to gain by low prices. Under the DRG regime one would expect for-profits to be highly cost conscious.

The book considers the important issues resulting from the growth of for-profit enterprises, including the impacts on physicians, other health care providers, and patients. One example is the impact of for-profits on the provision of uncompensated (including charity) care. The report presents national data which show that for-profits and non-profits do not provide very different rates of uncompensated care. However, the report also notes that data for states with large numbers of for-profit hospitals (which may be the more important data) do show more substantial differences. The studies used data obtained from a period before prospective reimbursement. Moreover, price sensitive payers like insurance companies may no longer be willing to subsidize care for the indigent. Accordingly, it is unclear whether such subsidization could be practiced now, even absent the growth of for-profit enterprises. In any case, the report does not draw definitive conclusions about the impact of the for-profits on the ability of non-profits to subsidize care for the indigent, a basic question.

The issue of the desirability and appropriateness of cross-subsidization is addressed in chapter 2 of Part II on ethics issues, one of

the best chapters in the book. Hospitals seemingly have an obligation to provide medical care for the indigent, but as the chapter suggests, no similar societal obligation is imposed on food stores for the indigent/hungry. In effect, a hidden tax is placed on other payors to cover the cost of caring for the indigent. Increasing competition and the inability to cross-subsidize will force society to face the issue of indigent care. It is not at all clear why the "rich" sick or those covered by insurance ought to pay for the care of the indigent. Moreover, eliminating cross subsidies through greater competition will mean consumers will pay for the costs they impose, leading to greater efficiency in the use of resources.

The majority of the Committee concluded that the evidence was not adequate for it to support or oppose for-profits; they merely recommended that society carefully monitor the developments. A statement by a minority of the Committee noted that there were few benefits from the expansion of for-profits in terms of prices and costs of care; the minority also saw some possible problems including a reduced ability to cross-subsidize. Therefore this group stressed concern about the possible domination of health care by for-profits.

This reviewer finds that for-profit providers of care, including physicians, dentists, and others, play important roles in the industry. General concern about incentive effects seems to be more important in the case of hospitals than for these other providers. In fact, incentive effects are important for all providers. Moreover, concerns are sometimes expressed that division of surplus among HMO physicians could lead to undertreatment of patients. However, the still dominant fee-for-service system presents the possibility of overtreatment. An important ethical and economic issue implicit within the book is whether to err on the side of over or undertreatment. Indeed, what constitutes appropriate treatment is itself a difficult issue.

The Committee report and the associated studies are essential reading for anyone concerned with our health care systems, but the report raises some questions which require further analysis. For example, one might question why there is entry by for-profits into an industry with substantial excess capacity. Are the for-profits entering in areas not adequately served by existing nonprofit hospitals? If so, why haven't the nonprofits expanded into these areas? Moreover, economic theory of competitive markets suggests that losses ought to occur in an industry with persistent excess capacity to cause resources to move to other industries where they are more highly valued. Why is this not occurring? How can for-profits be earning profits with their especially low occupancy rates? What does this suggest about the level of prices in the industry? These questions suggest that insufficient competition exists in the industry, a subject that is given too little attention in

the volume. One advantage of having both for-profit and nonprofit forms in the industry may be more competition, which ultimately will produce greater efficiency in the industry. Also, for-profit and nonprofit hospitals may each offer society certain advantages. For example, nonprofits may be willing to conduct more basic research, while for-profits may be especially adept at tapping new market demands. It is quite possible that both types of institutions should coexist. Indeed, one could argue that public subsidy for indigent care is necessary to ensure fair competition.

There should be more research on a micro economic level, like the interview study of three local markets reported in the book. This is especially important because the hospital industry is essentially a local industry. To understand the impact of for-profits, more in-depth case studies would be important complements to the kinds of studies reported in this volume.

This book is a most important contribution to the literature which should be read by any student of the health care industry. It is well researched, well written and thought provoking.

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*William Hunter and the Eighteenth Century Medical World* W.F. Bynum and Roy Porter Cambridge: Cambridge University Press, 1985, 425 pp., \$49.50, Hardback. This is a collection of essays based on papers delivered at an international symposium marking the 200th anniversary of the death of William Hunter and held at the Wellcome Institute. Surprisingly, Hunter, who has received less attention from historians than one might expect given his eminence during his own time and his lasting scientific achievements, is not the major focus of attention of this volume, its title notwithstanding. Only three chapters explicitly center on his life and career, while three others feature him as only one of a number of major figures. The remaining eight chapters examine a variety of topics on eighteenth century medical thought and practice. In short, Hunter as presented here is but a partial base upon which the content of this work rests. The justification for the inclusion of these eight other contributions seems to lie in the editors' view that one reason why William Hunter has been neglected is that eighteenth century medicine as a whole has not been well understood. Given the relatively ex-

tensive attention given to other notable physicians including William's brother John in other sources, this argument seems rather weak.

Though some chapters have clear connections with others, these are often not explicit or clear. It would have certainly been possible to have greater dialogue among the contributors, particularly, as this is a work where the author had an opportunity to hear the other presentations before submitting final written drafts. However, only one author Keel—manages to do this. Nevertheless, it should be emphasized that many of the chapters, taken individually, are excellent. Although a few seem exclusively geared to the specialist in this time period, most contain sufficient contextual background to allow them to be read with profit by other historians of medicine as well as general readers.

The first two chapters are those most focused on William Hunter. Roy Porter looks at the social context which allowed Hunter to rise in prominence. Noting that he “had his start in the wrong country, in the wrong religion, matriculated at the wrong university, destined for the wrong profession [ministry],” he paints Hunter as an entrepreneur and an opportunist subscribing to Georgian values. His work as a male-midwife was “testimony to his nose for rich pickings and for access to the boudoirs of the great.” His privatization of scientific knowledge through his anatomy school was in keeping with the tradition of practitioners keeping “trade secrets.” Helen Brock's narrative of Hunter's rise and career on the other hand seems more balanced as she seeks to understand his idiosyncracies less in macrosocial terms and more with respect to his direct life experiences.

In Chapter 3, Joan Lane provides a very useful and well-written overview of the apprenticeship system in the 18th century. She examines the mutual role obligations, the process of training, and the shift which takes place in the learning experiences of surgeon-apothecaries who increasingly looked to the hospital and the private medical school for supplemental practical and theoretical instruction. W.F. Bynum follows with a discussion of the career patterns manifested by several hundred physicians who attained hospital appointments, how they utilized the institution for their own ends, and how surgeons forged a different relationship with hospitals. Toby Gelfand then looks at the system of private surgical teaching at English and French hospitals explaining how the British system, which was less hierarchical and authoritarian, provided students with an unrivaled opportunity to determine the range of their learning experiences.

In Chapter 6, Christopher Lawrence examines changes in medical teaching at the University of Edinburgh through much of the 18th century. This is followed by Johanna Geyer-Kordesch's portrait of German medical education where she examines the role of religion—Lutheran pietism—as shaping both the orientation and values at Halle. Othmar Keel in Chapter

8 challenges the accepted thesis that clinical medicine was not “constituted” until after the French Revolution, and argues that the system in France was largely modeled upon clinical training models which had evolved in Italy, Austria, Germany, Denmark, and Britain in the last two decades of the 18th century.

The next two contributions were the most problematic. Francois Duchesneau looks at the important issue of vitalism and seeks to understand the various manifestations of this doctrine in their proper historical context, challenging modern writers’ contention that vitalist explanations “hinder attempts to analyze phenomena down to their determining physicochemical conditions.” He chooses to examine, without explaining the basis of his choice, the vitalistic constructs of Barthez, Blumenbach, and John Hunter. While he offers a good synthesis of each, he does not satisfactorily relate these constructs to the issues set forward at the beginning of his paper: what use do these theoretical physiological constructs serve? How well do they order data and correspond to the evidence and do they promote research? The premise of Ian Wolfe’s chapter on William Hunter and the Great Chain, on the other hand, is simply baffling. Wolfe illustrates the concept of the Great Chain of Being using William Hunter’s natural history collection showing that the collection pointed up inconsistencies in the doctrine although noting that Hunter did not necessarily regard his collection in this light—nor was he perhaps even directly aware of the “Great Chain.”

The last four chapters are perhaps the most unified of the set. In a nicely written piece, Angus McLaren looks at how early modern British men and women perceived sexuality. He reviews popular works of the period, explores the consequences of the epigenetic and preformation theories of embryonic development to ideas about the relationship to pleasurable sex and procreation. Adrian Wilson explores the varieties of male-midwife role, identifying eight paths to childbirth, noting that the type of case male-midwives were likely to see shaped attitudes towards the use of the forceps and helps explain the differences towards their use by Smellie and William Hunter. Edward Shorter then examines the relative popularity of other forms of intervention which he calls “fiddling and meddling,” noting how the enlightenment with its positive orientation towards “nature” played a pivotal role in shaping attitudes on whether to intervene in childbirth. Finally, L.J. Jordanova looks at Hunter’s magnum opus, *The Anatomy of the Human Gravid Uterus*, discussing the meaning of their graphic plates which had “the startling effect of combining realism with butchery” comparing them with other illustrated texts, and revealing William Hunter’s emphasis on accurate rather than idealistic representations as a means of extending knowledge.

In sum, this book, though it does not constitute an organic co-



herent whole, has much in individual parts to recommend it to the reader interested in expanding knowledge about eighteenth century medicine.

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*Ethical Dilemmas in Modern Medicine.* Loewy, Erich H., Lewiston, New York: Edwin Mellen Press, 1986. This book, by a practicing physician, is a series of essays on a wide variety of topics in medical ethics, beginning with some general reflections on clinical uncertainty, moral pluralism, and paternalism. These are followed by essays on particular topics including AIDS, using physicians in executions, organ procurement and donation, abortion, age as a factor in medical decision making, sustaining the permanently acognitive patient, dementia, disagreements between patients, their families, and physicians, who decides to write a DNR order and nutritional support for the hopelessly ill. Some of the essays have appeared in print, others, apparently, have been written for this volume. The essays are directed to the general reader, both physician and patient, without much background in the ever growing, perhaps increasingly complex, field of medical ethics.

The book can be of help to the general reader as an introduction to an excellent range of issues in medical ethics as seen by someone who deals with them daily in the delivery of patient care, but one of the book's problems is the lack of a consistent theme which holds the essays together. The author claims to have a set of "core issues" which occur throughout the essays but they are difficult to make out. He says, "among the core issues within this collection, the issue of what it is that causes us to have legitimate moral concern for objects and the issue of the agent, the community and their reciprocal relationship predominates." (p. 14) One might understand this to mean something about when it is appropriate to have a moral, as opposed to a nonmoral, concern about something but that is hardly what these essays are about. Since all of the essays are about issues in medical ethics, some moral values, and thereby concerns, must be a part of the discussion. Or perhaps this refers to the kinds of objects, and their characteristics, about which we can have legitimate moral concern. This is the issue in the essay on abortion but it does not seem to figure very heavily in the other essays.

The second of the core issues in the quote is a more pervasive, but also more frustrating, factor in the essays. The author claims that ethical decisions in medicine involve an interplay between the history of those issues, the patient, perhaps the family, the physician, and the community. But that is often where the essays end, i.e., with a statement that there are many factors to be considered and no definite answers are available. Take, for example, the end of the chapter on treating the acognitive patient (p. 230). The author states that there is neither a moral imperative to support life nor to discontinue it. Although there is a presumption in favor of discontinuing it, "judgements in individual cases depend upon the texture of the individual context." One can easily grant that such decisions are both difficult and complex but that is obvious. Readers would be better served by at least a comprehensive list, possibly with some discussion of priorities, of the factors involved in such decisions, or perhaps an interesting case could illuminate the author's concerns, but instead we are left with what could only be labeled as a kind of moral intuitionism.

In fact, the ethical stance of the book is difficult to make out. There is the puzzling statement (p. 30) that "moral virtue resides more in making a decision and in the agony of making it than it does in the potentially fallible decision itself." One would have thought that moral virtue was a habit or state of character based on the acceptance of principles from which decisions about particular cases flow. How can moral virtue "reside" more in making a decision than in the decision itself? This may be a convoluted way of saying that principles are more important than consequences, that intentions are more important than outcomes, but we are never given a clear statement of what the relevant principles might be.

And there are many other ambiguous statements. Take, for example, the discussion on autonomy and paternalism (Section II, chapter 3). There is a confusion between autonomy as a condition of action, i.e., being in control of one's self, being rational, being free from external constraints, and autonomy as a value, the grounds for our treating others in certain ways, i.e., acting so as to respect or enhance their autonomy. Although these senses of autonomy are related, they need to be treated separately, particularly in a discussion which tries to find some limited justification for paternalism.

Limitations of space prevent raising many other questions about the book, but let me add some stylistic concerns. The book has many repetitions of points and discussions, perhaps inevitable in a collection of pieces some of which have appeared previously, but some editorial smoothing out would have helped the flow of the text. There are quite a few spelling and grammatical errors which indicates less than careful proofreading. But most frustrating is the practice, in this reviewer's estimation increasingly all too common these days in writing on medical ethics, of citing entire books or

articles when only a particular sentence or paragraph within the works is intended. Whatever happened to the requirement that citations be as specific as possible so that readers can follow those citations as accurately as possible?

In spite of the above problems it is very heartening to see a practicing physician grapple with some of the most important topics in medical ethics. That clinical perspective is rare and important and can serve as a valuable counterpoint to the more abstracted reaches of discussions in medical ethics.

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