and view with alarm the prospect of legal interference. But the law can be wheeled into the most personal relationships, notably the family, in order to protect its weaker members. Carolyn Faulder insists that the medical relationship is not sacrosanct and that the patient has both rights and responsibilities concerning personal well-being.

I found a difficulty with her argument that patients be offered the opportunity to know as much or little as they require without *forcing unwanted information* on those who do not want it: 'It is, however, for the patient to decide – with the doctor's co-operation – how much information is necessary. Some patients will want to know a lot, others will be content with the bare outlines, and some will prefer to know nothing. To force undesired information on the latter is as much a violation of their autonomy as is the denial of information to those who want it.' (p39).

But how this is to be achieved is not spelled out. How can a patient make an informed decision to *reject* possessing information without first knowing what that information is? Inevitably, if, as is bound to happen, the doctor is to judge the situation, this allows the slide back into paternalism and away from autonomy. Incidentally, Carolyn Faulder refers to the patient in the feminine gender throughout and her examples are mainly drawn from studies of women patients. This strategy is used because of her stated feminist perspective: an intent which limits her arguments. Medicine is still a male-dominated profession both in numbers and, more importantly, in ideology and women patients are treated rather differently from men, as the literature on prescribing illustrates. None the less, everyone, male doctors included, is a potential patient.

Section Two takes a critical look at clinical trials, with particular emphasis on randomised controlled trials (RCTs). Carolyn Faulder points out that providing there is ethical committee approval, there is no compulsion to seek informed consent. She further argues that even where consent is sought, often it is not genuinely informed because some patients do not fully understand the implications of randomisation. Underlying the patient role is belief that if the doctor suggests treatment (or lack of it) then it is for their own good. Thus patients who take part in RCTs should only do so when they are in full possession of the facts and are then willing participants. When individuals fall into the patient role, ie the

vulnerable 'sick' role, they do not owe a duty to medical science. The first duty is to their own survival and it is unreasonable and unethical to expect altruism.

Much has been written about the doctor-patient relationship, and doubtless there will be more. Mostly though, the literature is concerned with searching for ways to improve the relationship with a view to facilitating compliance – *patient* compliance, of course. On those occasions when doctors are made to comply, it may be interpreted as 'manipulative' behaviour by the patient. Carolyn Faulder writes about the 'patient-doctor relationship' in an attempt to redress the prevailing inequality of power.

What then are the reasons preventing patients giving their informed consent? The first reason, as the author emphasises, is to do with power. Information is power, and part of the power of the professional over the lay-person comes from knowledge and restricted access to sources of knowledge. Most doctors guard their knowledge and sources of knowledge jealously. Change is in sight, and some of the ways this is happening are set out in Section III which includes a useful discussion about a Bill of Rights for Patients.

I think that other reasons why information may be held back could have been explored in more detail. Doctors do not have all the answers. This means more readiness from the doctor to say 'I do not know' and more readiness from the patient to accept this professional uncertainty. Also, and often glossed over, is the fact that doctors find it distressing to impart bad news. Withholding or disguising sad tidings may be a way to deal with the anxieties of the doctor trained to 'cure'. When cure is not possible, this can produce a sense of failure. What this book might have touched on is that there could and should be adequate social support systems to enable doctors to share these feelings with colleagues. This would surely be a positive step towards achieving the important goal of informed consent.

This book should be of interest to doctors and patients alike (which means all of us). It can be seen as health education in the very widest sense.

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Feeling Good and Doing Better: Ethics and Non-therapeutic Drug Use

Thomas H Murray, Willard Gaylin and Ruth Macklin, Editors, Clifton, NJ, 220 pages, \$17.15, \$27.50 export, Humana Press, 1984.

This is a book about non-therapeutic use of drugs, drugs for pleasure and drugs for enhancing performance, drugs like cannabis, heroin, cocaine, amphetamines and anabolic steroids. Its central theme is that our society has adopted an inconsistent, paternalistic and often unethical attitude towards drug-taking and has criminalised it in a way which contributes greatly to the harm that it does. The case is made that we should review the present situation, adopt a more humanitarian attitude, develop social rather than strictly legal controls and ultimately if need be change the law.

But this is too simple a summary, for the book is detailed in its approach and its several chapters examine a number of aspects, political, philosophical, social, legal, medical as well as purely practical, in great depth. The contributions by the twelve authors are erudite, compassionate and, I thought, beautifully presented. I particularly enjoyed the chapters by the three editors themselves, the introduction by William Gaylin which sets the scene and presents the problems, the discussion by Thomas Murray on drug use in sport and the final summary by Ruth Macklin proposing *inter alia* some new-look social attitudes. But there is also an interesting chapter by James Bakalar and Lester Grinspoon on social attitudes to risk-taking and, for medical readers, a fascinating discussion by Nancy Rhoden on the psychiatric patient's rights to refuse psychotropic medication and an analogy with the healthy individual's rights to take mind-bending drugs.

Many questions remain to be answered. Why, for example, do we take the unswerving view that drug-taking for pleasure or enhancement is wrong and must be prevented? Is it because of the dangers involved? Not solely, because inherently more dangerous pursuits like riding motorcycles are condoned and some, like climbing Mount Everest

encouraged. In sport, is it because we regard the use of drugs as cheating? Surely not, for other 'cheating' manoeuvres such as blood-doping and training visits to training centres at high altitude, for those who can afford to go, are acceptable. Is it because it advances no social value? In a liberal society every individual has a right to privacy – it is formulated in the American constitution and its amendments – which might be seen, at least within limits, to deny the compulsion for such advancement. These and many other matters are discussed in this book.

Some features of the present situation urgently need our attention. We maintain an unacceptable two-faced political attitude to drug-taking. On the one hand we allow and profit from consumption of alcohol and tobacco; on the other we prohibit cannabis, heroin and the rest. Morally as well as ethically this is both illogical and lamentable. Even now in the throes of an epidemic of narcotic abuse still the harm done by socially acceptable drugs prevails. Certainly social attitudes are changing and there are some signs that the prevalence of the smoking habit will decline. Can we afford to be more liberal in our attitude to the remainder? I believe we must reject the simple pragmatic solution offered by one of the authors; namely that the State cannot effectively control the drug scene, therefore it should give up trying, make appropriate allowances and thereby free the police for more worthwhile pursuits. The fact is that drug-taking is inherently coercive to others, not only to athletes as asserted by Thomas Murray in his chapter, but to us all and especially to the very young, to the ill-informed and to the mentally incapable. To this extent drug abuse is a communicable disease.

There are obviously no straightforward legal solutions. Social attitudes must change: in the final words of Ruth Macklin '... it would be a decidedly rational step in a more socially desirable and morally acceptable direction.' This is a book to be read, enjoyed and contemplated.

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What is to be Done about Illness and Health? – Crisis In The Eighties

Jeannette Mitchell, Harmondsworth, 300 pages, £2.95, Penguin Books, 1984

This is a book which will excite strong emotions in its medical if not its lay readers.

The first section looks at the social causes of disease. A series of interviews provide a moving image of the health problems of ordinary people in the inner city. The strains of working where productivity matters more than people; the feelings of powerlessness which arise when confronting massive bureaucracies, including the health service; and the complex interactions of poor housing, exploitative jobs and poverty are vividly portrayed.

This human aspect is underpinned by a brief presentation of the epidemiological data linking poverty with ill health. The result is a blending of *Inside the Inner City* and the Black report, which makes its point strongly and uncompromisingly. Better health is not merely a matter of more money for the National Health Service (NHS); it requires a questioning of how people are forced to live and of placing profits before people.

Unfortunately, the second and third sections of the book, which consider the present role of the health service and how thing could be organised better, fail to maintain the same high standard. The dehumanisation when hospital patients are treated as cases and not as people; the irony of running a hospital as a 'health-care factory' which exploits its workers and promotes their ill-health just as any other profit-oriented factory; and the contrast between the glamour of high technology medicine and the real human needs of the chronically sick and disabled are important points. The discussion of what medicine can and cannot offer society is sane and well balanced. However, though many important criticisms of the way in which the health service operates are made, and the limitations of medicine pointed out, there is a lack of factual support or logical argument for the criticisms made. The use of individual cases to make points, rather than to illustrate points supported by data, gives those who wish to the chance to dismiss the case cited as unrepresentative of the general situation. An irritation is the use of a nebulous 'we' without any clear antecedent in many unsupported assertions, which creates a tone of

peevish aggressive moral superiority. 'We were told we were entering the era of unproblematical contraception' Who was? By whom?

As a general practitioner, I felt the treatment of primary care was far too superficial and sketchy. Perhaps because I am a white male doctor I thought the decision to place all the blame for medical hubris on doctors was simplistic. I would have welcomed discussion of why society colludes in attributing to doctors powers they do not have, and in seeking miracle cures where there are none. The role of the media in this process, and people's need to control problems by medicalisation are ignored. The doctor-blaming also meant that the oppression of junior hospital doctors, with their 104-hour week and its implications for patient care, was ignored. I found the assumption that there exists an angry, working-class, health-care consciousness in anything other than an inchoate form unconvincing, and would have welcomed more consideration of how such a consciousness could be helped to develop and organise.

The concluding consideration of possible better systems of care is rather sketchy and uncritical. The alternative ways of working which are being tried are hinted at rather than discussed, and in the final chapter an apocalyptic vision of a possible socialist health centre is extremely thinly drawn.

This book approaches questions which are vital for anyone who is unhappy with the present state of society and of the health service – which surely all thoughtful people are. In spite of its dogmatic assertions and some lack of factual support, the validity of its basic case should not be dismissed.

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On the Uses of the Humanities: Vision and Application

A report by the Hastings Center on a project on applied humanities and public policy. Project co-directors: Daniel Callahan, Arthur Caplan, Bruce Jennings, 74 pages, New York, \$8.00 The Hastings Center, 1984
The Hastings Center was established in 1969 to address ethical problems of medicine, biology and the behavioural sciences. In this report three co-directors of a project provide help for the teacher who recognises the need for the