Dismiss this thought, or accept it, Sulmasy certainly makes us examine ourselves, and what we do, and how we do it, and keeps the spiritual dimension of health care a live issue!

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The Health Care Ethics Committee Experience

Edited by Stuart F Spicker, Malabar, Kreiger Publishing Company, 1998, 452 pages, US\$ 59.50.

This book comprises a selection of papers originally published in the journal *Healthcare Ethics Committee Forum* (HEC Forum). Its stated aim is to provide a coherent introduction to the everyday work and problems faced by healthcare ethics committees (HECs). With the emergence of a small number of hospital ethics committees in the UK and Europe, and the likelihood of more developing, this publication is timely. The book is divided into ten sections although issues tend to overlap between sections. The initial sections focus on general considerations in setting up a committee and differing visions of HECs. The concept of the healing dimension of an HEC in providing a forum for dialogue and mutual respect together with an ability to articulate moral values, thus allowing resolution of ethical conflict, is specifically addressed here but is a recurring theme throughout the book. A paper by Sichel argues that the ethics of care espoused by Gilligan and Noddings may be a better basis for HEC deliberations than the traditional ethical theories of rights and justice. Cushman argues that the HEC's role is to ensure that clinical decision making is congruent with generally accepted bioethical principles, offering a more formulaic approach than that suggested by the other writers in this section. Blake proposes that the hospital should be viewed as a moral community with the HEC being responsible for "exploring and articulating those boundaries of conduct that define the moral character of the hospital".

The education and case review functions of HECs are considered in separate sections. Papers in the education section focus on the role of HECs

in self-education for committee members and education of hospital staff. A role for the committee in education of the wider community is also considered. Practical suggestions for developing education programmes based on the experiences of several HECs are offered. Rawlins and Bradley present their findings of a clear difference between physicians and nurses in their perceptions of an HEC's role and their preferred method of ethics education, an important, if not entirely surprising, factor that will need to be addressed by any HEC education strategy. Case review by HECs is allotted two sections. Is this a reflection of its perceived importance? Ross argues that by using a committee to review ethically difficult cases the hospital communicates its commitment to the creation of an ethical community. Loewy suggests a role for both ethics committee and ethics consultant in case reviews, illustrated by his personal experience as an ethics consultant and member of an ethics committee. Glaser and Miller suggest that the goal of HECs should be to enable all professionals in the hospital to shoulder their ethical responsibilities and resolve ethical dilemmas by effective case conferencing. Case review by the committee would then be used to influence policy development and not to resolve individual cases. A number of issues pertinent to case review by HECs are discussed, including the role of patients and family members and whether a committee should make binding decisions.

Individual members of HECs discuss their roles in one section. The comments of the community member on the frustration of dealing with the effect of institutional dynamics on implementation of HEC policy guidelines are illuminating. The legal aspects of HECs are considered. A discussion on whether HECs should ever provide advice contrary to the law is in the form of two papers, one arguing for and one arguing against the motion, a format which is used effectively in several sections of the book.

The later sections consider the extension of the HEC's role into new areas such as hospital administration, long term care facilities and the community. Should HECs consider the ethics of business decisions taken by the hospital managers or contribute to management policy? Other models of addressing the issue of ethical concerns in the administration of the hospital are considered, including devel-

oping a separate corporate ethics committee. How are HECs developing outside hospitals? Alternative models for the structure and functioning of HECs in different environments are considered. Meece describes a cooperative model which draws members from all long term care institutions in Sonoma County, California and which has been able to develop guidelines on "Do Not Resuscitate" orders and informed consent which have been implemented across the county. Wilson describes a community bioethics committee which is separate from health care institutions and open to all citizens for support and information on bioethics issues.

The final section looks to the future. The effect on HEC deliberations of the need for cost containment in health care is considered, with the suggestion that this will entail a shift in priority from the principle of autonomy to that of justice. The possible role of HECs in setting legally recognised standards of medical practice and influencing legislation is also raised.

This collection of papers provides a thought-provoking and useful overview of the development of HECs in the US. Many of the authors use examples of cases to illustrate their argument, which adds interest. Only one paper mentions the need for evaluation of HECs and there is no debate on the intrinsic value of HECs. Some of the discussion may not be relevant to readers outside the US but I would recommend this book as essential reading for anyone considering setting up a healthcare ethics committee and for those interested in the practicalities of incorporating theoretical medical ethics into clinical care.

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Ethics, Computing and Medicine: Informatics and the Transformation of Health Care

Edited by Kenneth W Goodman, Cambridge, Cambridge University Press, 1998, 180 pages, £15.95 (sc) (US\$24.95), £45.00 (hb) (US\$64.95).

This collection of eight articles, the majority of which are published here

for the first time, is a timely contribution to the identification of, and debate around, the fields of ethics and health informatics. As befits the multidisciplinary nature of its subject matter, standing as it does at the intersections of health care, computing and ethics, its contributors include specialists in public policy, social research, nursing, computing, ethics, and law. While at times making for a less than entirely cohesive tone, this approach has the advantage that important areas are addressed rather than ignored.

The editor is at pains to inform the reader that the collection aims at going beyond mere identification of already recognised problems, and seeks both to re-map the landscape, highlighting hitherto unrecognised areas of ethical concern, and also to suggest answers to some of the problems. He is benignly dismissive of the question-raising that for him characterises much contemporary bioethical debate: "To write, 'Lo, an ethical issue' is doubtless to make a contribution, often an important one. But it is inadequate" (page 3).

A multi-authored collection, the book exhibits both the strengths and the weaknesses of such a collaborative enterprise. Two important themes emerge, one of which is highlighted by the editor in his opening chapter, but there is also significant disagreement between the contributors around a central issue in the field. Depending on one's own perspective, of course, this might be seen as a creative tension that reflects a dynamism of thought at the leading edge of research: or not.

Goodman's central theme, which he describes as emerging, is the adoption of a stance that he labels as "progressive caution". This *via media* seeks to steer a middle ground between the Scylla of reactionary Ludditism and the Charybdis of an unreflective embrace of the next big technological thing. James Anderson and Carolyn Aydin's chapter on system evaluation, for instance, argues that developments in health informatics should be seen as analogous to progress in other areas of health care provision, and that there is a corresponding duty to evaluate information systems in practice before the practice becomes too firmly rooted to be overturned. This suggestion fits well with the doctrine of *primum non nocere* (first do no harm), although whether the already hard-pressed members of local research ethics committees (LRECs) would be pleased at the prospect of all new health infor-

matics systems coming under their remit is at best an open question.

A second theme of the collection, particularly of the chapters on "Medical informatics and human values", "Outcomes, futility, and health policy research" and "Meta-analysis: conceptual, ethical and policy issues" is the idea that while there are no individual tasks of medicine that should be ring-fenced for humans only to perform - for instance certain operations might be performed less well by a fallible human than a machine - none the less the second-level questions and tasks, such as determining the goals of medicine, and evaluating the worth or futility of a particular intervention are matters that can be considered properly only by humans. Goodman's conclusion that we should be wary of being "so enthralled by the medium that we get the wrong message" (page 161) might be taken as the motto of the whole collection, holding that as tools, information systems and machines may be useful, but that there is a conceptual limit to their application, and we should greet each new possibility with scepticism and look for the harm that it could do rather than the novelty it provides.

The contributors, however, cannot agree so easily on the slippery if central issue of the moral status of medical information systems. John Snapper argues that expert systems should be held to be morally accountable because they are potentially legally liable for their decisions. This view is challenged by Randolph Miller and Kenneth Goodman, who implicitly reject the idea that medical decision-support systems (MDSSs) can be seen as morally accountable, and instead locate moral responsibility with the personnel operating the systems. While not every reader will share Snapper's intuitions that morality ought to follow behind legal principle, the disagreement is clearly important, and is set to become central to the area of both ethics and law if, as Goodman predicts in his opening sentence, "the future of the health professions is computational" (page 1).

Ultimately, the collection's failure always to live up to its promise of providing answers rather than questions should perhaps be seen as a strength rather than a weakness, reflecting the ongoing uncertainty around not just the new area of health informatics, but also around such issues in the underlying ethics as privacy, confidentiality, non-maleficence and the review of

research. Goodman's achievement in bringing together specialists from each of the areas at the interface of the ethics of health informatics lies not in solutions adduced but in consciousness raised and methodology explored.

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Managing Death. The First Guide for Patients, Family Members, and Care Providers on Forgoing Treatment at the End of Life

James M Hoefler, Oxford, Westview Press, 1997, 206 pages, £16.95.

I found this book, which has been promoted as "the first guide for patients, family members, and care providers on forgoing treatment at the end of life", interesting, well-presented and readable.

The author deals with this very difficult emotive subject with both sensitivity and warmth. The preface leads you nicely to the introduction and sets out a USA consensus of four principles which apply as death approaches: (1) Patients should be able to make any decisions they choose about what medical technology they will accept or refuse (whether they are terminally ill or not); (2) If the patient is unable to make decisions for him or herself, surrogates - family members or close friends - should be fully empowered to step in and make decisions based on what they think the patient would want or what they believe would be in the patient's best interests; (3) There should be no distinction between withholding and withdrawing treatment; it should be just as acceptable to stop treatment once started as it is not to start treatment in the first place; and (4) Artificially provided nutrition and hydration - tube-feeding - should be thought of as a medical procedure that patients or their surrogates can decide to accept or forgo like any other medical treatment.

The decision-making principles above were agreed by bioethicists, medical clinicians, legal experts and religious leaders.