

There are just two articles that bear directly on problems of medical ethics. Both are successful, though in quite different ways. Helga Kuhse on euthanasia could hardly be bettered for a brief, clear, systematic and thorough introduction to the subject, leaving readers to form their own view on the basis of the possibilities that are set out. On abortion, Mary Anne Warren is less dispassionate, forcibly advancing a relatively liberal position. She argues that although persons are of special significance, in virtue of their capacity for moral reciprocity, the protection of a wider class of beings demands that full moral rights be extended to all sentient human beings, including sentient fetuses. Yet where equal rights cannot be accorded to each party in a conflict, such as to fetus and mother, personhood is again relevant and results in those of the fetus being limited. The piece lacks quite the measured clarity of Kuhse, but has the advantage of being challenging as well as informative.

Our putative students are perhaps less well served when it comes to moral theory. Interesting though Philip Pettit's article may be, I think it too difficult to be recommended as an introduction to consequentialism. Nancy Davis on deontology will also be found hard going, though here there is surely more excuse in the subject matter. Rights are given a clear treatment by Brenda Almond, although it is a pity that the analysis of claims, liberties, powers and immunities is carried out only by means of examples. This is one case, I think, where a more general account would have been more illuminating. On the last of the familiar four, virtue theory, Greg Pence does well in arguing that its role must be a limited one, but does not really show whether, and if so why, we should regard this approach as a moral theory. Since it is often proposed as an alternative to the preoccupation with ideas of consequences and right action, a more explicit discussion of how it relates to the traditional framework of the right and the good would have been useful. Whether *any* theoretical framework is needed is discussed well in an article by Dale Jamieson.

There is of course much else that might interest the student of medical ethics, and certainly I know of no other book that will so clearly inform the reader of the sheer variety of problems that are examined in moral philosophy. There is, though, a more stringent requirement if the book is to

be strongly recommended in our case: that we would select nearly all of the directly relevant articles as being especially suited to beginners. I think that it is not met.

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Genetic screening: ethical issues

Nuffield Council on Bioethics,
London, Nuffield Council on
Bioethics, 1993, 115 pages, £6.00

This report is the outcome of a Nuffield Council working party on genetic screening, its brief being (i) to report on advances in genetic screening, (ii) to review experience of the benefits and costs of genetic screening so far, (iii) to identify and discuss relevant ethical issues.

The report is a model of its kind. It is well structured, clearly written and, most important, balanced and reasonable. Those who are unfamiliar with genetics and genetic screening will find concise introductions in two chapters. Ethical issues considered are the following:

1. *Informed consent:* The report summarises the kinds of information people require in order to decide whether to participate in a screening programme. Frequently throughout the report one finds useful and practical guidance for those involved in screening programmes. Here, for example, it is suggested that information be provided both orally and in leaflet form, in language appropriate to the individual. The report stresses the importance of assurance of confidentiality, of lack of coercion, and of counselling.

2. *Confidentiality:* Again, the approach is pragmatic. The report uses everyday moral concepts which have earned a widely accepted place in our language, and does not adopt any implausible, single-principled ethical theory. It allows for rights, such as a right to privacy which extends to cover personal information. But these rights are not inviolable. If, for example, a male maliciously withholds the results of his screening test when his partner is pregnant and has herself tested positively for cystic fibrosis, a doctor may be justified in passing on the

information to the woman after attempts to persuade the man have failed. The report does not put all the onus on medical staff. It notes the responsibility of individuals to their families.

3. *Employment:* The report summarises well the conflicting interests in this area. Employers want healthy workers, while employees may in some cases justifiably wish to work rather than suffer exclusion through screening. The report concludes that exclusion should occur only where it can be shown to be absolutely necessary.

4. *Insurance:* Insurers are faced with the problem of adverse selection. A person may know that she will almost certainly develop Huntington's, for example, and an insurance company may claim that it has a right to know this fact when considering her for life insurance. The report notes that insurance companies can expect to benefit overall from screening programmes, and argues that British companies should continue with their policy of not requiring genetic screening, and also should not require disclosure of genetic data. The report allows two exceptions to the latter recommendation: (i) cases where a member of a family with a clear history of genetic disease applies for insurance; (ii) policies where large sums are involved. I believe that the report is too conservative at this point. The working party appears to accept the principle of equity, according to which those who face equal risks should pay equal premiums. But this principle is quite inconsistent with the other principle said to justify insurance schemes, that of solidarity, which requires the sharing of risks. The solidarity principle is grounded on the moral principle of fairness, *viz* that it is unfair that anyone does worse than others through no fault of her own. Genetic screening merely makes more visible the unfairness of much present insurance, and strengthens the case for radical government re-structuring, perhaps even the nationalisation, of insurance.

5. *Genetic screening and public policy:* The report takes a long term view, and advocates a programme of education in genetics, which should perhaps involve inclusion of genetics within the national curriculum. Such education will provide safeguards against abuse of genetic screening, and enable screening schemes to function better both practically and morally. The report also recommends that the

Department of Health, along with professional bodies, formulate guidelines for the introduction of genetic screening programmes.

This report will do much to facilitate the extension of screening programmes in Britain, to allay the fears of the public about such screening, and to protect individuals from violations of their rights. It is a very solid piece of work, and I recommend it highly to all interested parties.

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Standard of care – the law of American bioethics

George J Annas, New York and Oxford, Oxford University Press, 1993, 291 pages, £19.50

Here we have another elegant, thought-provoking volume from the prolific Professor Annas. Like the others, it is almost a collection of essays, in this case divided up to cover three discrete themes, with an overarching theme which allows him a forceful conclusion about the way we should think now. For Annas is one of the most powerful proponents within the United States of a medical ethics that goes beyond the purely legal. As a lawyer himself, he sees bioethical thinking as overly law-based. He sees, too, the practice of defensive medicine on the increase, of interventions performed in order not to get sued, rather than for the possible benefit of the patient, and he states categorically that such interventions are unethical.

But in this volume, more than in previous ones, he calls for a tangible change. He suggests – and we have to remember that he is first and foremost a lawyer himself – that at least one semester of the third year of law school be used for the study of health law. That would, in his view, change the way lawyers think, and reform their practice in health-care cases.

But he also argues that the United States is a country of disparate peoples of different traditions, religions and values, held together by law. In his view, an intensive study of health law would encourage law students to think creatively and humanistically about all the troubling issues of informed consent, abortion, the right to die, and organ transplantation, and, through

them, society itself would be influenced.

It is hard to know whether he is right. Undoubtedly, health law would be an important part of legal studies and would sharpen up the way bioethicists think about issues. But, if Annas is right in thinking that too many bioethicists think in terms of what is legal rather than in terms of what is right, should there not be a course of moral philosophy instead of law, aimed at getting students thinking about what people's rights ought to be in relation to a variety of issues, such as the right not to have organs harvested from a suddenly dead relative? Lawyers might have a lot to contribute, but my favoured option, after reading Annas's superbly elegant account of the questions set by the Supreme Court dramas and by private cases, discussing what standards of care ought to be, is to get medical students thinking harder about ethics. That might discourage defensive medicine, encourage discussing options with patients, and help doctors recognise where some matters are so personal – such as abortion – that it is essential that individuals be allowed to choose what treatments they want, including treatments disapproved of by some practitioners, politicians or other members of society.

But Annas makes a brave case for training lawyers, and he might be right. This is a fascinating book, with all its case-studies. The only quibble is over the indexing and proof-reading, which leave much to be desired. Ronald Dworkin, for instance, gets indexed with two references. But, in the text, one is a Ronald, one a Roger. It would help to be clear about this (my guess is both Ronald), and to have footnotes rather than end-notes, or at least chapter titles for the end-notes so the readers can find their way about. But this is minor carping in the case of an otherwise fine, readable, funny, provocative and challenging volume.

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Children's consent to surgery

Priscilla Alderson, Buckingham, Open University Press, 1993, 212 pages, hc £37.50, pb £12.99.

Discussions on consent to surgery in children have usually centred on who gives consent when the child has limited understanding and judgement, and at what stage a child has the maturity to make, or participate in making, decisions. Most difficulties surround procedures or surgical operations where the clinical issues are not clear-cut, or where results are uncertain.

This thought-provoking book considers the involvement of children themselves in decision-making about the surgery which it is proposed they should undergo. It assesses the ability of children to make informed and wise judgements about their own surgery, and also provides a lot of insights into the workings of hospitals, and into the strengths and shortcomings of hospital services for children. It also reflects on children's place in society, and the importance of children's rights in the issues surrounding consent to surgery.

The book is based on a research project carried out by the author and her co-researcher Jill Siddle, in which 120 patients aged 8–15 years were interviewed two or more times. Also interviewed were those adults parents and health care professionals who were caring for them around the time of surgery. All the patients involved in the study were having orthopaedic treatment. This forms a significant part of non-emergency major surgery carried out in the 8–15 year-old age group, and often involves multiple procedures and prolonged stays in hospital. Many of the children interviewed had already had previous experience of surgery.

Most of the children interviewed had a good understanding of their problems, and hoped that surgery would improve their condition. The main improvements the children hoped for were improved mobility, prevention of disability worsening, and pain relief. On the whole parents' hopes were similar. Surgical outcomes in many of the conditions involved in the study – scoliosis, leg-lengthening, or correcting malformations and deformities – are not always certain, but most children and parents were willing for surgery to take place.

As a group the children nearly all wanted to understand about the treatment proposed, and be involved in the decisions, and parents and professionals supported this in principle. More difficult to assess was children's competence to decide, based on understanding the treatment