

applied briefly to cases of abortion, suicide, and euthanasia.

This kind of approach to the morality of killing is problematic for a number of reasons. It seems to me that there are cases where a person's life may have on balance more intrinsic bads than intrinsic goods, and yet death may still be an evil for such a person. As Philippa Foot has argued (in 'Euthanasia', in her *Virtues and Vices*) (2), so long as a person has at least a bare minimum of basic goods, then that person's death may still be an evil for him. Regarding the morality of killing, Feldman says too little about what it is to *deserve* intrinsic goods (such as pleasure) to make this notion clear and plausible in this context. Indeed, when applied to abortion and suicide, justicized act utilitarianism seems to yield some rather strange conclusions. For example, Feldman tells us that where an abortion has negligible effects on others, its permissibility depends on how much life and pleasure the fetus 'deserves' (page 200).

While I have reservations about its treatment of the moral significance of death, *Confrontations with the Reaper* does provide a useful critical survey of certain views on the nature of life and death. Its clarity and accessibility make it an excellent introduction for students who are thinking about such issues.

Where *Confrontations with the Reaper* casts light on theoretical issues of death and dying, *Deathright* illuminates the background to recent changes in the American political and legislative landscape surrounding end-of-life decision-making. *Deathright* is a comprehensive overview of American public policy developments on death and dying, and provides an interesting account of some of the important political, social, and psychological influences on these policy changes. Hoefler and Kamoie analyse these developments in terms of the competing forces of 'restraint, activism, and mediation', and their analysis helps explain the increasing recognition of patient autonomy in end-of-life decision-making, in the face of a culture which seems in various ways to encourage the denial of death. *Deathright* provides insight into the practical difficulties surrounding right-to-die law reform, however, it remains primarily applicable to an American context. Nevertheless, it would serve as a useful basis for comparison with a similar analysis of such policy changes in the UK and,

particularly, Australia, with the recent legalisation of active voluntary euthanasia in the Northern Territory.

Of course, these legislative changes are not all moving in the same direction. *When Death is Sought* is a report by the New York State Task Force on Life and the Law, which defends the task force's view that assisted suicide and voluntary euthanasia ought to remain criminal offences. Despite expressing respect for the importance of patient autonomy, the task force members opposed any legislative recognition of patient autonomy in end-of-life decision-making, because of their concerns about the risks which any such legislation might pose to vulnerable members of the population. The report suggests that improving facilities for palliative care is an appropriate and ethically defensible way of dealing with patients who wish to die. *When Death is Sought* addresses some of the difficult ethical questions in this area, but I must say that I remained unconvinced by its arguments against legalising assisted suicide and voluntary euthanasia.

References

- (1) Nagel T. *Mortal questions*. Cambridge: Cambridge University Press, 1979.
- (2) Foot P. *Virtues and vices*. Berkeley: University of California Press, 1978.

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Ethical issues in nursing

Edited by Geoffrey Hunt, London and New York, Routledge, 1994, 232 pages £35.00 (hc), £12.99 (sc).

Moral dilemmas are experienced in the daily practice of nursing and rarely, if at all, solved by the random teaching of bits of moral philosophy which, so claims the editor of this book, have invaded nursing curricula up and down the land. He does not believe that yet another framework of rules or the command of a largely incomprehensible 'ethics speak' can aid an already rule-bound profession in filling the moral void which he observes, and which the maintains, not without justification, characterises the health care system.

No doubt, he is right in that and in thinking that nurses need to explore freely their own experiences and 'the

conditions which create disparities between what their ordinary moral sense tells them and what they are expected to do without question' (page 5).

Rather than trying to tell people – with or without the help of moral philosophy – what theoretically is right, there may be a need for allowing them 'to discuss what is wrong, to investigate what it is that does not allow them to do what is right or, sometimes, see what is right' (page 7).

Hunt's 'negative ethics' (page 7) is about the social and political context in which nursing has to function and be accountable. He contributes a searching chapter on nursing accountability where he observes that: 'Nursing theorists have on the whole created conceptual frameworks in a political, economic and ethical vacuum and this inevitably stamps their theories with artificiality and consigns them to irrelevance' (page 132).

This is invigorating stuff and the author's commitment is undoubtedly genuine. This brings him occasionally to the borderline of appearing polemical which, however, may well be intentional in order to gain attention for questions which while not being asked for the first time, nevertheless need to be asked again and again.

The book is divided into two parts. Part I addresses specific issues such as nursing and informed consent (Taplin), the observation of intimate aspects of care (Wainwright), choice and risk in the care of elderly people (Smith), caring for patients who cannot or will not eat (Fenton), disabled people and the ethics of nursing research (Blackburn) and a nurse's view of ethical issues in HIV/AIDS epidemiology (Kennedy).

These papers follow Hunt's precept of a negative ethics by drawing on practice experiences, offering vivid examples of individual people's problems and exploring the situational context in order to 'facilitate the emergence of various standpoints out of the honest and rigorous examination of issues posed by nurses ...' (page 7).

The clarity and competence of the authors' discourse (among them four nurses, a health visitor and a dietician) no doubt owe something to their academic backgrounds and perhaps even to some acquaintance with moral philosophy!

In Part II five health care philosophers and a lawyer present general issues which include, besides the already mentioned paper on nursing

accountability (Hunt), discussions about the values of codes of conduct (Edgar) and about the patient's best interests (Young), an appraisal of Noddings's 'feminine-feminist' theory on caring (Hanford), observations on and analyses of medical judgment and the right to die (Maclean) and nurse time as a scarce health care resource (Dickenson).

Each contribution deserves constructive critical appraisal which would go far beyond the limits of a review.

The twelve papers are backed up by a nine-page bibliography and a useful index.

More important is that the reader will feel challenged and stimulated; one of the best reasons for investing in the purchase of this lively, sometimes controversial, but always fundamentally sound publication.

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Self-interest and universal health care: why well-insured Americans should support coverage for everyone

Larry R Churchill, London, Harvard University Press, 1994, 110 pages, \$25.95

In this slim monograph, Larry Churchill, Professor and Chair of the Department of Social Medicine at the University of North Carolina School of Medicine, sets out to 'infuse the debate about the form and financing [of health care] with the leavening of ethical analysis' and to produce an argument that will convince the American public that it should regard a health care system that ensures universal access to health care as essential. Churchill broadens the US debate about health care reform by considering the role of health care in society and argues forcefully that US health care policy should reflect not only America's familiar and dominant individual ethic with its emphasis on freedom and rights but also a strong communitarian social ethic.

A central theme of Churchill's book is his belief that health care policy should be viewed as a significant

component of a nation's social policy and that as such it is an expression of the sort of society a nation wishes to have. The purpose of health and health care policy is therefore not limited to improving the health of individuals or the population. Indeed, Churchill argues that the primary goals of health policy should be providing individuals with 'security' (ie, 'freedom to live without fear that their basic health care concerns will go unattended and freedom from financial impoverishment when seeking or receiving care') and the nation with a sense of 'solidarity' (ie, 'the sense of community that emerges from acknowledgment of shared benefits and burdens'). The more familiar aims of improving the health of individuals and the population are regarded as secondary goals of health policy.

Americans' access to adequate, life-long health insurance, even for those who are presently well insured, is precarious and the risks to physical, mental and financial well-being of not having adequate health insurance are great. Churchill argues that the goals of security and solidarity therefore reflect the enlightened self-interest of all American citizens. He draws heavily on the ethical and political philosophy of David Hume and Adam Smith to construct and support his arguments and he skilfully illustrates his points with anecdotes drawn, for instance, from his personal experience of the care offered by the British National Health Service. Churchill recognises that if the goals of personal security and solidarity are to be achieved health policy will have to reflect a communitarian and social ethic. He also recognises that as resources for health care are scarce, an equitable and just health care system that ensures universal access to care requires that society reaches broad agreement about the limits of care provided by the system, and that both users and providers of the service are 'judicious' in their demands for and use of health care resources.

I fear that Churchill's well argued views may not readily find favour in the present political climate of the United States. Nevertheless, by promoting a broader view of the role of health care in society, by drawing attention to the dangers of over-reliance on an individualistic, libertarian ethic and by appealing to enlightened self-interest, Churchill has produced a readable and valuable contribution to the health care reform debate. His views are of

relevance beyond America and his readable monograph deserves a wide international audience.

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Proper use of human tissue

Health Council of the Netherlands: Committee on Human Tissue for Special Purposes, The Hague, Health Council of the Netherlands, 1994, 141 pages, 50 DFL, publication number 1994/OIE

In 1991 the State Secretary for Welfare and Cultural Affairs of the Netherlands asked the Health Council of the Netherlands to provide information regarding current and future practices in relation to the storage and usage of human tissue with particular regard to the ethical and legal aspects. The Committee on Human Tissue for Special Purposes was convened, and its report and recommendations were published in a 140-page document in 1994.

The committee recognised that the main use of human tissue is in medical research and treatment and that the scope for its employment is rapidly expanding. Apart from the obvious uses in organ transplantation and transfusions is the use of tissue in teaching, further training, quality assurance, and the manufacture of therapeutic aids.

Whilst the moral justification of use of human tissue lies in social benefits accruing from therapeutic advances, the committee sought to address the potential moral deficits which may be associated with 'further use' of human tissue. The expression 'further use' refers to other purposes for which tissue is employed than those for which it was originally taken; for example, further research on existing tumorous material or future research on blood samples from screening programmes. Other examples would include the use of human cell cultures in biomedical science; tissue samples taken for diagnostic purposes which may lend themselves to epidemiological research. Thus new test results from old samples can generate new information about a disease. In one dramatic case in 1990 the application of new