The 'euthanasia' programme led to the killing of wounded or insane returning servicemen, of foreign workers who were no longer fit for work, of racial minorities in conquered territories – especially the USSR, and finally, to the mass slaughter in the concentration camps.

After the end of World War II, many of the psychiatrists and laymen responsible were known and a few were tried and condemned, but large numbers escaped punishment. The medical profession of their generation does not come out of the story well, since the perpetrators had no difficulty in finding colleagues to certify them 'unfit for trial'.

Burleigh has trawled the massive archive which records the rise of the programme with meticulous scholarship. The quotations from the many participants, particularly from the victims and their relatives, give a clear picture of the atmosphere at the time as well as of the reactions to the ethical arguments, usually clothed in pseudo-scientific or utilitarian jargon. He writes in tones of barely concealed fury at the brazen duplicity of those responsible for a deliberate policy of murder.

The euthanasia debate which is still alive today and, hopefully, being conducted in a more ethical way, will benefit from another look at the German experience, which this book so vividly recaptures. It is a gripping read.

DUNCAN FORREST
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Doctors, dilemmas, decisions

Ben Essex, London, BMJ Publishing Group, 1994, 301 pages, £22.95.

This book sets out to analyse decision-making in general practice. It is not, as the jacket claims, the first book on the subject. It is, however, an entirely new concept, based on over 200 case histories from the author's experience which pose dilemmas. From these are drawn some 900 'rules' which the author has devised to help in reaching decisions.

The format of the book initially is somewhat daunting and rigid with boxed and tabulated information on every page. However, the case histories, which represent the whole range of physical, psychological and social pathology of general practice make such compelling reading and provide so vivid a picture of the immense variety that is general practice that the reader is led on despite the complexity of layout. Thus initial reservations about the style of the book are quickly dispelled.

One's first reaction is surprise at being asked to review this book for the *Journal of Medical Ethics* since it seemed to deal more with management and clinical decision-making than with conventional ethical problems. Later, however, the book deals with HIV/AIDS, with confidentiality, compliance, patient autonomy and consent so that ethical dilemma, which is present in even the simplest of cases if it is looked for, was plentiful. Where such problems were spelled out they tended to be dealt with in terms of law and guidelines from bodies such as the Royal College of General Practitioners (RCGP) and the British Medical Association (BMA) rather than from the standpoint of moral philosophy. This was a deficiency and reference to any of the many texts on ethics was noticeably deficient. Indeed, references as a whole were few, with many chapters without any and only that on 'protocols and policies' with any amount. The 'rules', the author claims, were tested through teaching and research, and would be more acceptable had they been called guidelines, for 'rule' implies a rigidity which is rarely applicable to the ever-changing, infinitely variable problems of general practice. Again, with increasing familiarity with the author's reasoning these reservations eased so that on finishing the book I felt I wanted to start reading it all over again.

The author claims justly that this is a book for everyone. Certainly this retired academic found much to be nostalgic about while reading it; for medical teachers preparing for their classes of trainees or students, and above all for those preparing for membership of the RCGP, this book is an excellent method of studying and revising general practice. Originality, almost to the point of idiosyncrasy, makes thought-provoking reading. Well done, Dr Essex and thank you for a very stimulating view of what you rightly describe as 'one of the most intellectually demanding specialities in medicine'.

ROBIN HULL
Retired Professor of General Practice

Procuring organs by transplant: the debate over non-heart-beating cadaver protocols

Edited by Robert M Arnold, Stuart J Youngner, Renie Schapiro and Carol Mason Spicer, Baltimore and London, Johns Hopkins University Press, 1995, 249 pages, pb.

The nineteen papers in this volume address ethical issues surrounding the procurement of organs from 'non-heart-beating cadaver donors' (NHBCDs). These are patients who have been declared dead by cardiopulmonary criteria rather than neurologic criteria. The main impetus for NHBCD procurement stems from the University of Pittsburgh Medical Center's Protocol of 1993, whose move towards cardiocentric criteria for death was in response to increasing pressure for more organs. The papers in this collection, by doctors and bioethicists who support the protocol, stress benefits associated with increased procurement rates; critics raise ethical questions concerning the motives for shifting the boundary between life and death and raise further doubts concerning psychological and social policy consequences of the move towards cardiocentric criteria for death.

Prior to the widespread acceptance of neurologic criteria for death NHBCDs were the primary source of 'cadaveric' donation. But this method fell into disrepute with the establishment of irreversible loss of brain function as the boundary between life and death. The revival of NHBCDs as organ sources in the late 1980s is bound up with improvements in techniques for the preservation of organs following cardiopulmonary cessation and protocols for 'controlled donation' which allow patients and their families to donate organs after a decision has been implemented to forego life-sustaining treatment. A typical example would involve cessation of heart-beat during an operation, where a prior directive to forego resuscitation was in force, followed by *in situ* cooling of the kidneys and removal of transplantable organs. Protocols which authorise organ removal following cardiac arrest do not address the issue of brain death, and represent an alternative concept of death based on