

publication, such omissions are probably intentional.

The book is likely to interest mainly those working or aiming for a career in the various parts of the health information arena. It could also be read with interest by health professionals and non-ethics experts such as the reviewer, as it provides a very readable collection of quotations, a good many of which should cause some argument and debate. The review copy had a number of very small illegible patches which did not however cause any serious problem.

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Parliament and Screening: Ethical and Social Problems Arising from Testing and Screening for HIV and Genetic Disease

Edited by Wayland Kennet, London, John Libbey and Co Ltd, 1995, 351 pages, Fr168

This is a very useful book, reporting a conference in London, primarily sponsored by the EC, on social and ethical consequences of testing and screening for HIV and genetic disorders, and the roles of parliament and the news media in this. It is recommended for any study in these areas.

An overall impression arising from this book is of the bewilderment of medical, legal and social establishments when facing new crises, and of their need to learn from the past. Although lessons have been learned from prior illnesses, they are not always easily accessible when required in the midst of a crisis. This book will be very useful in reminding the administrators of future epidemics in a coherent and contained form of the lessons that have been drawn thus far from HIV.

A further lesson from this book is how quickly important lessons in the administration of the HIV pandemic in Europe were learned. As the book reveals, positions established in association with the widespread availability of HIV-antibody testing in the

mid-1980s have not been challenged to date and appear, with hindsight, to have been both prudent and highly appropriate.

For example, the opening chapter on the ethics of testing and screening for HIV constitutes a re-write of the well-established literature on the mandatory screening debate of the 1980s. It quickly focuses on the central importance of "reciprocity" in the development of public health responses. Individual civil rights are essential to HIV prevention strategies, and encourage and perhaps reinforce the engagement of the individual within the context of public health imperatives.

There is a concern that a book of ethical discussion must necessarily skate over the considerable dilemmas that challenge and – in the case of HIV – change routine procedures.

For non-lawyers, the revelation that there is no discrete body of principles in common law exclusively relevant to health law comes as something of surprise and is perhaps something that we should be worried about. For example, consent does not rely, in English law, on discussing the implications of a treatment or procedure, although there appears to be a duty of counselling in such instances. A further question is whether the implications of HIV testing, which have long been held as a justification for alterations in "routine" testing procedures, are really as bad as may have been supposed. The shock recognition for this reviewer is that there has been remarkably little empirical quantification, aside from the qualitative anecdotes of the mid to late 1980s, to support the contention that the differences in implications do merit procedures different from the "norm". There is very little evidence to illustrate just how woolly and complacent legal and professional organisational thinking has been on issues of informed consent and its potential abuses.

The opportunities for the tail of HIV care to wag the dog of establishment thinking and conventional practice in medicine is not as clearly brought out in this book as it might have been, for example in relation to the development and administration of clinical trials. However, a real value in this book lies in the comparison of parliamentary models of response to HIV across the EC states. It is extremely useful, for example, to consider how the burden of proof and informed consent in England rests

upon the opinions of health professionals, and not on the opinions of "reasonable, prudent" patients, as in Canada, for example. Developments elsewhere in medicine in this country have revealed how important it can be to consider directly the views of patients in determining the true value of clinical endeavours.

Overall, this book makes for necessary reading, and Lord Kennet and his colleagues are to be commended for laying down footprints in very difficult terrain. It is to be hoped that we can start to learn from the mistakes of the past and economise on the need for the exercise of health legislation in the future.

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Zur Verantwortung des Arztes

Urban Wiesing, Stuttgart-Bad Cannstatt, Frommann-Holzboog, 1995, 190 pages, 58.00 Deutschmarks

"What responsibilities can reasonably be ascribed to physicians?" In his recently published book *Zur Verantwortung des Arztes (On the Responsibility of the Physician)*, Urban Wiesing, a physician and philosopher, attempts to give an answer to this fundamental question. He focuses on diagnostic-therapeutic processes, since they have a normative character and are thus well suited to his investigation, which starts by examining the role of the physician and the epistemological status of modern medicine. The method employed is a so called "reconstructive approach", which starts from the present conception of the role of the physician, and then questions the extent to which this conception is plausible, consistent and applicable. The physician has the responsibility to act in specific situations in a specific manner. In doing this the physician has only limited information and is under pressure to make decisions. Furthermore the physician cannot guarantee the success of his or her actions, and does not even know whether the outcome is the result of his or her intervention or not.

Before continuing with his investigation, Wiesing examines the theory of normativity and concludes that one cannot speak of just *one* "ethic of responsibility", but that one has to speak of different concepts of ethics of responsibility in which the notion of responsibility plays an important role. He presents a brief overview of the theories of responsibility of Weber, Weischedel, Picht, Schwartländer, Jonas and Lenk, and examines these different approaches towards the notion of responsibility. Wiesing argues that a number of strands of the philosophical discussion of responsibility cannot be applied to the activities of the physician, especially ontological positions. Responsibility does not demand a predetermined action, but an engagement in reflecting about possible actions in order to accomplish those tasks which cannot be solved, if stringent duties are adopted.

The physician – in his or her relation with the patient – has a threefold responsibility: first, an explicit mode of behaviour, such as non-maleficence, confidentiality, the duty to disclose, and respect for the autonomy of the patient. These modes of conduct can easily be identified at the theoretical level, but in practice they are dependent on the situation. Second, the physician is obliged to act according to the current state of the art and third, despite the uncertainty of the outcome, he or she is obliged to act conscientiously. These three levels are all necessary and not interchangeable. Furthermore the responsibility of the physician should be limited in that the patient must be the primary concern of the physician; social considerations should not influence or interfere with this relationship.

These traditional responsibilities of physicians apply equally to modern medicine. In cases such as euthanasia, abortion or gene therapy, society has the responsibility to decide, *whether* these means should be implemented, but physicians have the responsibility to determine *how* they should be implemented.

Wiesing's book is well and consistently structured and written with great clarity. It makes comprehensible and intelligible reading even for the non-philosopher, and would be useful for those interested in their role as physicians.

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Bringing the Hospital Home: Ethical and Social Implications of High-tech Home Care

Edited by John D Arras, Baltimore,
Johns Hopkins University Press,
1995, 250 pages plus index, £33.00

"Home is the place where, when you have to go there./They have to take you in". So said Robert Frost, the outstanding American poet and his view still prevails, though the cost of the exercise has only recently been appreciated. There is a strong belief in the UK that in America they do things differently but that in due course the same events appear here. If this be so there are grounds for considerable anxiety, for two strands, one technical, the other managerial, have joined to produce a frightening prospect. For example, the use of central lines to administer total parenteral nutrition and systemic antibiotics has made it possible for those who, a short while ago, would have had a tenuous existence in a sophisticated hospital, to come home and for the care of the line to be delegated to nurses and relatives. Again, miniaturisation of complex technology has reduced the enormity of the iron lung to a suitcase pack. Secondly, the changes in medical management have led to a "sicker and quicker" approach to discharge by hospital managers demanding rapid turnover of beds in order to obtain maximal funding.

In 1992 a group began a study of the issues delineated in the title of this volume. Sixteen papers represent their opinions on a wide variety of topics, from children to geriatrics, from terminal cancer to lifetime support, from psychological, social and ethical issues to the problems of high-technology, from the moral to the economic. That the group managed to produce so splendid a text in so short a time leads one to think that there had been much previous heart-searching; indeed the depth of the approach speaks profoundly of the pain that has been experienced by these carers, both professional and lay. Perhaps the most startling part of the text comes from the specific American experience of health care. There the high-tech providers appear to be promoting market forces – a frank exploitation among the sick and dying to a degree that demands Senate investigation. British doctors have learned to their

cost in the last few years that the National Health Service (NHS) is not immune to market forces and the demand for high-tech medicine is likely to be as strong here as over there.

This being so it behoves us to study the American experience in the light of our own particular situation. Each person in the UK has a personal physician who is able, if not always willing, to visit at home, and in this area there has long been an interchange between the local hospice and the home in the care of the terminally ill. Again, many local areas have had the good sense to maintain the war memorial cottage hospital, albeit updated as a community hospital, for conditions requiring less than the full blown high-tech approach. Staffed by GPs these serve a locality, providing respite care which enables carers to obtain relief from the constant burden of care. Finally, the primary health care team centred on the health centre provides a focus for care between the major hospital and the home. The importance of these features is apparent in view of the American situation where there appears to be no halfway house between the major high-tech institution and the home. Area managers would do well to think hard before closing that inefficient, old-fashioned, ex-workhouse, horrid though it may well be in the light of the stainless steel and flashing diodes of the major centre, for people live and die at the periphery as well as expeditiously in intensive care. Unless it be that with thoughts of their own mortality they rebuild at the periphery, as Oxfordshire has so well achieved.

The immorality of the early discharge and the arrival of high-tech demands on the family are well illustrated by case studies, one of which demonstrates clearly the cruelty of forcing an untrained wife to manage, 24 hours a day, seven days a week, a respirator that is her husband's sole lifeline, waiting day and night for the bleep that indicates a mechanical – or worse an electronic – failure that she is untrained to manage. If the marriage be a good one it will be stretched to cope, if it be average it is severely at risk. Much of the problem arises from the belief that if there is an answer to a problem then the answer must be supplied – life at any cost. Whilst this approach may be right in the relatively young it cannot sensibly be applied to the elderly or the terminally ill. There the requirement is for the best