

demonstration of jaundiced prejudice. To others, however, ethical standards must be considered as being *sub specie aeternitatis* and hence medical procedures from all historical periods must be lambasted if thought not to have come up to scratch. In this conflict, unsurprisingly, the proverbial *via media* is not easy to define, *inter alia*, because it is difficult to know enough about the circumstances of past medical events to decide whether those involved took sufficient care of the ethical aspects of their behaviour. For example, recent historical work on ECT and psychosurgery shows that those involved in the early development and application of these treatments showed far more ethical preoccupation than hitherto has been thought to be the case, particularly by "historians" who have chosen to dub such procedures as criminal and unethical *tout court*.

A good example of this can be found in a feature article in *The Times*,¹ where quotation marks and staccato narrative are meant to make the poor reader squirm: "he was taken to a windowless room and told to get into bed. He was given a stack of male erotica magazines and a supply of Guinness, his favourite drink. A short while later, three staff came into the room and gave him an injection. Soon after he vomited. He asked for a bowl but was told to be sick in bed". Were things as simple as that? Why should one accept this particular narrative as the more plausible or constructive one? Is the intention of the writer to *understand* the event so that something similar "does not happen again" (as the current cliché goes) or is he just a *tout court* man? It would seem that the latter is the case, for the author makes little effort to contextualise the episode in order to decide whether or not the treatment in question was in keeping with the scientific, social and ethical warrants valid during the 1970s. Whether the procedure under the microscope is aversion therapy or psychosurgery, ECT, psychopharmacology, psychotherapy or "no treatment at all" (ie respecting the human right to remain ill) the bottom line will always be determined by the historian's agenda.

The book under review is unsuccessful in the solving of these problems. Indeed, the author – an academic lawyer – sometimes gives the impression that he is not aware of them at all. There is little doubt, however, that he has written a major analytic piece, bringing together the

conceptual evolution of mental health legislation since approximately 1845 and issues concerning "consent" for a number of biological treatments in psychiatry. Sixteen closely argued chapters are complemented by useful tables of statutes, cases, and notes. Historiography is linear and "internalist", ie philosophical or socio-political accounts are kept to a minimum. As *explanans* the author seems to rely on the good old concept of *Sitte* ("custom" – fashionably translated nowadays as "social practice"), developed by the great Rudolph von Ihering in the wake of Darwinian theory. By skilfully using the cross-talk method of presentation, Fennell is able to show lateral interactions between changes in legal framework, legal decisions and psychiatric practices. The strength of this book is to be found in its firm and crystalline analysis of the concepts governing the attitude of legislators and lawyers towards psychiatry, and in its important conclusion that the therapeutic boundaries within which British psychiatrists operate have since the 19th century been determined by the courts.

On the negative side, the book does not make any effort to compare British and continental ideas or to relate the conceptual status of "consent" in psychiatry with that of general medicine and surgery. This lack of contextualisation is at its worst when dealing with the role of psychiatry and the manner in which biological treatments were developed and applied. This results from both poor choice of secondary historical sources (for example Valenstein on psychosurgery may be a wonderful pamphlet in defence of human rights but is lousy history) and limited primary historical research. This is a pity, for whenever the author has undertaken the latter the results are of the highest quality as shown, for example, by chapter 5. Had Fennell brought himself to do likewise with the rest of the chapters we would now be reviewing a great historical work, a book free from claims such as the one that 19th century "psychiatrists" were entrepreneurs, avid for "professional domination" of the mental disorder market, a claim which, as should be obvious to all, is but a *Deus ex machina* that gets in the way of proper historical research into the professionalisation of psychiatry.

This book offers little in the way of

solutions. There is, of course, an obligation for the author to do so, but critical works like his impose a moral duty to suggest at least one, particularly when we are told that "users and survivors of psychiatry . . . argue for the right to be treated without drugs". If that is the case, then the author should tell to what *other treatments* he refers, and proceed to analyse them *from the point of view of consent*, with the same keenness with which he analyses the biological treatments. It may be that, as European legislation looms larger, Fennell feels that what it has to offer is good enough and that Britain ought to play ball. However, solutions by default are not always the best. We still need a coherent theoretical position to deal with what American and Continental psychiatrists are beginning to face, wit, being taken to court for not forcing treatment upon "users" of psychiatry who at the time were incapable of giving consent. Whatever the new theoretical position, it will have to start from the principle that the serious business of helping patients with "mental illness", historians, lawyers, medics and the rest of society must work together.

In conclusion, this book delivers only part of what it promises but what it does is good enough. It is excellent on the analysis of mental health legislation, adequate on the analysis of the vicissitudes of the complex notion of consent, and bad on the history of the biological treatments in psychiatry. As discussed above, this is to a large extent understandable, and should not put off prospective readers; indeed, it is the only work around trying to link these three fascinating themes.

Reference

- 1 Laurence J. How gay men were "cured". *The Times* 1996 Jul 24: 16 (col 1).

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Final Acts of Love, Families, Friends and Assisted Dying

Stephen Jamison, New York, G P
Putnam and Sons, 1995, 278 pages,
US \$23.95.

The author is a social psychologist who was formerly the regional director of the Hemlock Society and President of the Mental Health Association of Marin County. He shares therefore the Californian culture that is, to British eyes, group-orientated, determined to find the right physician and the right counsellor, dedicated to autonomy and believing, like many of its politicians, that almost everything can be solved by open communication and good will if only everyone tries hard enough. Before I read his book I was therefore not overly prejudiced in Dr Jamison's favour.

As I am myself a former hospice physician, with over 5,000 patients dying directly or indirectly under my car, I hoped I was not unacquainted with the common problems of terminal illness. Even if I was not quite as convinced as some colleagues that hospice skills make assisted dying unnecessary and irrelevant as well as illegal, I was ready to resent any proposals for legislation that could invade crudely and simplistically the world of the last illness – one of the last emotional areas not yet submerged in a vulgar showbiz approach.

I have to say that this book's message is a world removed from that. I found the book both moving and instructive. Its raw material comes from some 160 in-depth interviews from 140 assisted deaths covering a period of several years and a broad range of age, social class, attitude and diagnosis.

The variation in the quality of assisted dying is astonishing – from the united family holding hands as their patient slips peacefully away from the dependence and suffering he was now ending, to the inadequate prescription from an unenthusiastic or ill-trained physician or the adulterated street drugs, with the opiates and the barbiturates not working even with extra alcohol and injections, and death finally achieved only with the repellent sadness of a plastic bag over the head and unforgettably awful memories for all those taking part.

It is with this in mind that Dr Jamison repeatedly emphasises the importance of communication and the sharing of motives – why does the patient really want to die, the supporter to participate, the physician to assist? Clearly these problems must be tackled, yet one is remembering the saintly English

priest who said never to investigate motivation, for it is always bad!

Neither keen supporters nor opponents of assisted dying will find too much of comfort in this book, for the author tries to let his participants speak for themselves. Since the fears and expectations of UK patients yearly come to resemble more closely those of American patients, and since family and state both face increased economic pressures, this is a well-timed book for us in the UK.

With the failure of community care and the budgetary problems of the private nursing home, we may find an increase of applications for assisted dying in the next decade. This book helps with the questions even if the ways of thinking, the guidelines and the resources listed are not always helpful to the British reader.

The core material of the case-histories goes beyond frontiers however, and the suffering, the desperation of the onlookers and the kindness of the author crosses the oceans without difficulty.

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Wrong Medicine: Doctors, Patients, and Futile Treatment

Lawrence J Schneiderman and Nancy S Jecker, Baltimore and London, The Johns Hopkins University Press, 1995, 200 pages, \$25.95 hc.

The topic of futility raises a number of undoubtedly important ethical issues. The authors argue that some treatments are futile and should not be attempted. They suggest that the goal of medicine is to provide benefit to the whole patient rather than to exert a mere effect on some body part. Doctors and society must recognise the limits both to medicine's powers and to its obligations. Quantitative futility occurs when a treatment has not worked in, say, the last one hundred cases. Whatever the precise figure chosen, they argue that "in the end we all will have to accept some empirical notion of medical futility" (page 162). Qualitative futility is summarised thus: "If a patient lacks the capacity to appreciate the benefit of a treatment, or if the treatment fails to release a patient from total

dependence on intensive medical care, that treatment should be regarded as futile" (page 17).

Given the goals of medicine, which help to define futility, the authors anticipate a consensus obligating the avoidance of futile treatment. This will be based on empirical studies with education of the public and the legislature. Declaring a treatment futile will not relieve the physician from the duty to provide good care. Indeed, they assert that good medical practice rests on a correction appreciation of the doctor-patient relationship.

The book aims to change the practice of medicine, particularly as practised (it seems) in the USA. We encounter hospital attorneys and risk managers who sometimes insist, against the advice of physicians and the wishes of the family, that futile treatment should continue; a father disconnects his child's ventilator whilst holding the hospital staff at gunpoint. Being the stuff of American drama it requires hyperbole. Hence, "Patients are almost always in motion, aggressively propelled in search of a cure . . ." (pages 3–4); a patient's heart attack requires the use of "a high-voltage cardiac defibrillator" (page 133), as if the voltage causes offence; meanwhile, "The nurses were in constant turmoil" (page 133).

And yet, these goings-on across the Atlantic recall British examples – for example Tony Bland and Child B – where the substantive ethical issues were the same. Nor can I personally forget certain patients who have not had good deaths precisely because of the medical "care" heaped upon them. Medical futility is not confined to America.

What of the concept "futility" itself? Is it actually a new and useful tool? Surely medicine has long understood that aiming at a good outcome can end in disaster, that cure is often impossible? These things were known before "futility" entered the medical ethicist's lexicon. Is it then that the concept usefully captures a common feature of disparate ethical issues? But perhaps we should be seeing the differences: here the inappropriate use of technology, there a misplaced value judgment. Any impression that "futility" simplifies may be dangerous, but the book's advocacy of an "ethic of care" is laudable.

Is it true, in any case, that "futility" could be reduced to empirical standards around which a consensus could coalesce? Does it not contain an evaluative judgment as well as a