This is a fascinating book. It uses tuberculosis to look at the balance between individual liberty and the public good: the tensions created between personal liberty and social responsibility, a strong theme in all work in public health. The context is New York in the 1990s but as Coker states, “This book uses the lens of tuberculosis control, and in particular the detention of non-infectious individuals, to examine America’s response to its most vulnerable and marginalised citizens, and asks the question: ‘is detention of non-infectious, non-compliant individuals right from ethical, legal, and public health perspectives?’.”

The book is divided into nine chapters. It takes the reader through TB in New York City in the early 1990s through an exploration of the history of the disease, the legal ramifications, the media, the actors, and the process of how the disease was investigated and controlled. It also describes the “seeds of the disease control strategies, and indicates the importance of other approaches. “A biomedically individualised approach that pays scant attention to the social causes of TB is often more acceptable to policy makers. It appears ‘tight’ and there are no ‘loose ends’” (page 210). But as Coker argues, there are so many other ways to approach tuberculosis control, and history, in all its guises, has many lessons for us. The book is about a complex variety of subjects, but Coker makes it very readable and understandable. He uses strong research skills as well as bibliographic information to support his ideas and concepts. If you are a person who is interested in the broad issues of health and society and how health policy is created, and certainly if you are someone who works in the control of infectious diseases, I highly recommend this book to you.

**Death Foretold: Prophecy and Prognosis in Medical Care**


Many doctors these days are aware of powerful disincentives to the giving of specific prognoses. The mentioning of an estimated time, if even heavily qualified, is likely to be heard by many patients as a command such as “the doctor gave me two months to live”. The result? Patients and relatives feeling cheated if the prognosis turns out to be an overestimate, anxiety or worse if an underestimate, and colleagues critical of the doctor for having had the arrogance to predict, no matter what the actual outcome. It is not surprising therefore that doctors wishing to avoid these results are reluctant to prognosticate at all and when forced tend to make their predictions so vague as to be meaningless. For Christakis, this response simply is not good enough. In a carefully written and very well referenced book he argues cogently that prognostication is a responsibility for doctors and that “shirking the difficult questions—as most doctors tend to do—advances neither medical knowledge nor the care seriously ill patients receive”. He does so as a physician and with the backing of the results of his survey of the attitudes and self reports of 1500 American physicians. While accepting that patients might be harmed if erroneous predictions of imminent death result in the withholding of interventions that would otherwise save a life, his study convinces him that most of the time the problem is the reverse. The concept of the self fulfilling prophecy is helpfully explored and with a powerful combination of evidence, argument, and understanding is developed into the notion of “the ritualisation of optimism”. Christakis shows that, whatever is communicated to patients, physicians are terminally and patients routinely overestimate duration of survival by a factor of three or more; he suggests that it is reasonable to expect that, knowing of this bias, systematic allowance for these errors could be made in their prognostication for the group as a whole even if errors in individual cases unavoidably persist. It is hoped that, in changing their thinking, physicians might realise there is much that patients can hope for even when death is inevitable.

**Re-creating Medicine: Ethical Issues at the Frontiers of Medicine**


In essence this is a book about some of the most important and pressing problems facing medicine and the relationship of bioethics to these problems. By focusing upon issues such as organ donation, reproductive technologies, the internet, and genetics Pence ensures that this book is highly topical. It is a book that will be, for most readers, controversial. Pence seems to be on a mission to dispel commonly held misconceptions about a number of important issues. One issue that comes in for lengthy analysis, for example, is the claim that payment can “commodify” practices or persons in undesirable ways. There is an extended discussion of whether surrogacy may end up commodifying any resulting children, that is a substantial contribution to this on going debate. An area that benefits from similar treatment in the book is the claim that payment for organs and blood cannot be justified because of worries about the incentives that this would provide. On issues such as these Pence consistently challenges commonly held views. The topicality and provocative nature of this book alone are sufficient to recommend it. However, given the fact that Pence is trying to convince his reader that bioethics falls short of the mark in quite a general way it is notable that at times, the reader’s assent is gained more by rhetoric than argument. This of course is not in and of itself a bad thing; if the arguments are inadequate then a little rhetoric may aid the appreciation of the full power of an argument, but there are points where the rhetorical force of a particular point derives from a selective use of the facts and a stereotype of what is in fact a complicated phenomenon. Pence complains about “... the customary, patronizing tone of English/European writers—Oh look—what those silly crass-warmongering Americans came up with now!” (page 186). This comment plays little role in his analysis
Brain Death: Philosophical Concepts and Problems

T Russell. Ashgate, 2000, £40.00, pp 183. ISBN 0 7546 1210 4

It is more than thirty years since the Harvard report in the case of Irreversible Coma of twenty-five years since the UK Royal Colleges’ criteria for the diagnosis of brain death, Diagnosis of Brain Death, provoked passionate public debate. For many years now, however, the concept has been well accepted by the public and the practicalities of its use by the medical profession. According to a recent American book, however, some academic philosophers are concerned that the pragmatism of the doctors and the acceptance of the public has led too readily to acceptance of incoherent concepts and they would like to reignite controversy. The present book also argues that current concepts of brain death are conceptually inadequate and claims to present an entirely new concept of death with which it might be replaced. This is that death results from death of the organism as a whole, not of the whole organism. This concept was in fact fundamental to the original debate about brain death. What is new here, however, is the proposition that the only coherent interpretation of this is that there should be failure of control at the level of homeostasis.

Russell admits there is no hope of discovering when death occurs—it will inevitably be a matter of selecting an arbitrary point when it is agreed that it has occurred. He reviews brain stem structures, the vegetative state, and the locked-in syndrome. While some reject brain-based criteria Russell is in favour of accepting that brain death (by his new definition) should mean death.

While some reject brain-based criteria Russell is in favour of accepting that brain death (by his new definition) should mean death. The opening chapter is a useful overview of the disability rights critique of prenatal testing and the next two sections fill out the detail. Those with experience of disability set out their views and those who see prenatal testing as by no means undermining the value of the disabled state theirs. The contributors write well and put their case with logic as well as rhetoric and each chapter is well referenced. There is considerable discussion of “expressivity”, which in this context refers to the message that the offering of a prenatal test with the implied possibility of selective abortion, sends to society. Some argue that this is one that devalues the disabled community. The participants accepted a woman’s right to abortion. It is not this issue but the request for abortion of a particular fetus on grounds of one characteristic (for example trisomy), that the disabled contributors found unacceptable.

The final section of the book deals with practical matters. A lawyer voices concern that as more tests become available defensive medical practice will mean that more are offered until the medicolegal norm includes investigations that common sense would condemn. Drawing on her extensive research experience Dorothy Wertz suggests criteria on the basis of which decisions could be made for offering or not offering a test. She argues that it is important that any such criteria are not based on the seriousness of the disorder as this can be highly subjective and dependent on individual experience.

The concluding chapters come from a fetal medicine obstetrician and a genetic counseling educator and her student, who describe the personal experiences of those who have these disabilities. This message and the next two sections fill out the detail.

Here is a book that should be read by all those involved in the fields of prenatal diagnosis and genetic counselling. It is based on a two year project set up in the late 1990s by the Hastings Center in New York, in which prenatal testing and its likely future advances were discussed, from their contrasting viewpoints, by professionals providing such services and those committed to promoting disability rights. Exchanges between a group who see any form of prenatal testing for malformation as an unacceptable affront to those with disability and those who offer such testing in their daily routine will inevitably be difficult. And, reading between the lines it seems likely that the project nearly founded. One original intention was to develop guidelines concerning which anomalies might warrant prenatal diagnosis and abortion, and which were too mild for such action. The disability rights members could not agree to any such distinctions so this objective was abandoned. There was, however, firm agreement on other questions. In particular, there was agreement on the need for broader exposure to disability during training of medical students and genetic counsellors; on the need to demedicalise disability and focus less on the impairment, and more on the need for society to accept and accommodate those affected so that their disability was minimised.

A C Berry

The book spells out clearly the tension between offering parents of opportunity to avoid the birth of a child with disability and maintaining a positive attitude to those who have these disabilities. This message and the need to work towards a society where the disabled are welcomed as equals should be an ethos imparted at the training stage. The book provides an admirable resource for students, their teachers, and practitioners.

The book’s chief disadvantage is that it is based on American practice where money will buy investigations more readily than in the UK, but the ideas put forward can be applied to any local situation. The book also seems to suggest a reasonable demographic in some US states between the funding of a prenatal test and an abortion arising from its result, a pitfall to guard against.

J McMillan

Prenatal Testing and Disability Rights


There is agreement that pretest counselling, particularly for screening for neural tube defect or Down’s syndrome, is woefully inadequate, and that when an abnormal result is obtained there should be no opportunity provided for the potential parents to obtain first hand information on both the joys and the sorrows of parenting such a child. With decisions having to be made rapidly and emotionally charged parents are in the midst of making decisions. One original intention was to develop guidelines concerning which anomalies might warrant prenatal diagnosis and abortion, and which were too mild for such action. The disability rights members could not agree to any such distinctions so this objective was abandoned. There was, however, firm agreement on other questions. In particular, there was agreement on the need for broader exposure to disability during training of medical students and genetic counsellors; on the need to demedicalise disability and focus less on the impairment, and more on the need for society to accept and accommodate those affected so that their disability was minimised.

Discussing the necessary and sufficient conditions for life Russell argues for definitions that apply to all animals, rejecting the notion that humans are special.

Life, Russell argues, implies the capacity to transform energy, to organise life processes either in a single cell or a whole organism and to adapt to changes in the internal and external environment. Homeostasis is a necessary but not sufficient condition for life and is the only manifestation of life that can be applied universally from amoeba to man. For the amoeba this implies capacity for movement, avoiding harm, and ingesting food. For man it implies control of body temperature, blood balance and blood pressure and the passage of large amounts of urine. It is difficult if many will be persuaded by his suggestion that these should replace the whole and well- tried criteria of brain stem death, “because to use both would cause intellectual confusion”.

Stylistically, the book has several weaknesses. There is, for example, the strange use of the word “monograph”—“my proposed monograph is a robust monograph”—seeming to make it synonymous with thesis. And “any hypomonograph must be verifiable in principle” sent me fruitlessly to the dictionary. My hypomonogaph must be verifiable in principle to make it synonymous with thesis. And “any hypomonograph must be verifiable in principle”. Russell’s definition of death is entirely new concept of death with which it might be replaced. This is that death results from death of the organism as a whole, not of the whole organism.
Non Heart Beating Organ Transplantation—Medical and Ethical Issues in Procurement


The problem of the supply of organs for transplantation is a major concern in many areas of health care practice and more generally in society. The primary condition for transplantation remains the treatment of choice and in many situations this necessitates a cadaver donor. The possibility of harvesting organs from patients other than those who meet the criteria for brain death has received less publicity, but raises different ethical and legal questions, compared to the more usual situation of brain dead, ventilated patients. Given the general shortage of donor organs, however, this group of patients may represent a useful source. This report was commissioned in 1997 by the US Department of Health and Human Services and concerns “the management of cadaver donors who died a cardiopulmonary death, called non-heart-beating-donors (NHBDs)”. In these patient deaths result from “an irreversible cessation of circulatory and respiratory function”, as opposed to cessation of functions of the brain. Questions had been raised about the medical management of such donors and whether the interventions practised could be said to be in the best interests of the patient or were in fact hastening death. The question considered by the report was: “Given a potential donor in an end-of-life situation, what are the alternative medical approaches that can be used to maximise the availability of organs from that donor without violating prevailing ethical norms regarding the rights and welfare of donors? The Institute will consider the alternative approaches, including the use of anticoagulants or vasodilators, from the scientific as well as the ethical point of view.” The bulk of the report concerns a review of the protocols for NHBDs obtained from 63 organ procurement organisations in the United States. The report defines four categories of NHBDs and offers an extensive discussion of the problems of supply and demand for organ transplantation in the United States. An example given gives a useful synthesis of the report’s findings and the appendices include notes of a workshop on medical and ethical issues in maintaining the viability of organs for transplantation. The general conclusion of the report is that the use of NHBDs is “an important, medically effective, and ethically acceptable approach to reducing the gap that exists ... between the demand for, and the available supply of, organs for transplantation”. The authors conclude that the ethical questions posed by this approach “require attention, but ... are not significantly different from those that arise in cadaveric transplantation generally”. The authors summarise six principles or general approaches that apply to all cadaveric donors: 1. The societal value of enhancing organ donation; 2. Organ donors must be dead at organ removal; 3. Absolute prohibition of active euthanasia; 4. Complete openness about policies and protocols; 5. Commitment to informed consent, and 6. Respect for donor and family wishes.

Perhaps surprisingly, in view of the overall conclusion of the report, the authors are reluctant to set out clear criteria for the various procedures involved, but rely heavily on case-by-case decisions (for example, for the use of anticoagulants and vasodilators, and vascular cannulation in preparation for organ perfusion) and “informed family consent” when interventions are required to facilitate organ harvesting, which are not intended for the treatment of the patient at the medical condition. The legal framework is specific to the American situation, and the report talks of consent being obtained either from the competent patient or from “surrogate decision maker(s) for the incompetent patient”.

The ethical focus of the report is the way in which designation as a potential organ donor may lead to changes in the care of the patient in ways that clearly have no therapeutic value for that patient, but which have great potential value for the recipients of any harvested organs. The extent of these changes in care is illustrated by reference to a study of beating heart cadaver donors, which found that almost half the average hospital-stay cost was related to care that was considered futile for the donor patient “in favour of improved organ procurement rates”. The discussion of these issues is organised under the headings of Policies and oversight; Medical interventions and ethics; Conflicts of interest; Determination of function; and Families. The general view seems to be that, with adequate safeguards, the interventions necessary to improve organ retrieval from NHBDs, although not offering any benefits to the donor patient, can be justified by the greater social good derived from transplantation.

The report, while very much oriented to the American experience, is a useful resource for anyone working in transplantations. However, it raises, by inference, one or two troubling questions that do not receive any discussion. One concerns the problem of supply and demand. In 1996 the total number of cadaver donors in the USA was 5416. This number represented a 33% increase over a nine-year period. The transplantation waiting list on the last day of 1996 stood at 50,047 people, an increase of 14% on the previous year and of 212% over the previous 10 years. These figures are discussed in more detail in the report, but the conclusion is that demand is growing faster than supply. The only discussion of possible reductions in demand concerns narrowing the criteria for eligibility for transplantation. It would appear, however, that a more productive approach might be to look for ways of reducing the number of organ failures, by preventive measures and by more effective early treatment of the conditions that lead to failure. At 1996 levels a 5% increase in cadaver donors will provide an increase of 14% on the previous year and of 212% over the previous 10 years. These figures are discussed in more detail in the report, but the conclusion is that demand is growing faster than supply. The only discussion of possible reductions in demand concerns narrowing the criteria for eligibility for transplantation. It would appear, however, that a more productive approach might be to look for ways of reducing the number of organ failures, by preventive measures and by more effective early treatment of the conditions that lead to failure. At 1996 levels a 5% increase in cadaver donors will provide an increase of 14% on the previous year and of 212% over the previous 10 years. These figures are discussed in more detail in the report, but the conclusion is that demand is growing faster than supply. The only discussion of possible reductions in demand concerns narrowing the criteria for eligibility for transplantation. It would appear, however, that a more productive approach might be to look for ways of reducing the number of organ failures, by preventive measures and by more effective early treatment of the conditions that lead to failure. At 1996 levels a 5% increase in cadaver donors will provide an increase of 14% on the previous year and of 212% over the previous 10 years.
faced with difficult choices over health care reform and how to set priorities for health care spending. The Hastings Center has conducted an international study on the goals of medicine and the executive summary of the resulting report is included in this section. The report starts from the premise that it is the ends of medicine not only the means used to reach these ends that are at stake: “too often it seems taken for granted that the goals of medicine are well understood and self-evident, needing only sensible implementation. Our conviction, however, is that a fresh examination of those goals is now necessary”. The report identifies and defends four main goals that medicine should aim to achieve: the prevention of disease and injury and the maintenance of health; the relief of pain and suffering; the care and cure of those with a malady, and the avoidance of a premature death. They argue that such a clarification of the goals of medicine is imperative as without such reflection, “the various reform efforts going on throughout the world may fail altogether or not achieve their full potential”. This report and the articles included in this section are a useful consideration of the often neglected area of public health ethics and include the important article by Daniels and Sabin on palliative therapies and managed care. The second edition also includes a new section on the cloning of human beings. This includes a useful summary of the National Bioethics Advisory Commission’s report on human cloning and responses to this by James Childress, a member of commission, and Susan Wolf on why the NBAC is wrong. In terms of the discussions of health policy this could be improved by being more closely concerned with what is happening in the USA, but this does not detract from its wider usefulness as the principles and the moral underpinnings of such policies are extensively debated.

It is always useful to be able to direct students to collections of original articles that they might otherwise have access to and this collection gathers together pieces by some of the finest authors writing on ethics today. At the end of each article the editors have included some questions for consideration and these will be helpful for both teachers and study groups, as they can form the basis of discussion and enable students to critically evaluate the articles. The collection will be useful for students seeking a broad introduction to the subject and researchers who might not have subscribed to the Hastings Center Report over the years. It will be a valuable addition to university libraries, especially those who do not subscribe to the journal itself.

L Frith

**Practical Nursing Philosophy: the Universal Ethical Code**


This book is clearly written and well laid out. The short summary at the beginning of each chapter is a useful guide to the reader and also serves as a valuable summary of key issues for revision purposes. The author offers a number of case scenarios for the reader to work through and provides many practical examples of situational analysis and possible steps to ethical decision making. Seedhouse accurately claims that in nursing, as elsewhere, philosophical analysis is useful in helping to clarify ideas. Unfortunately, as he also accurately points out, to date much of what has been described as nursing philosophy has not in fact led to the clarification of ideas but rather to a greater mystification.

The author poses two significant challenges to nursing through the pages of his book: (i) use some of the tools of analytical philosophy to reconceptualise concepts central to nursing practice, and (ii) take a lead in developing a more humane approach to health care ethics. Chapters two to five deal with the first of these two challenges. They offer a significant and necessary challenge to nursing academics and practitioners alike. Seedhouse accurately points to the many examples of inadequate conceptualisation of the so-called core concepts of nursing. He also makes lots of mileage out of what he refers to as nursing big ideas. I have to admit to being almost entirely in sympathy with the author’s self appointed task. I suggest that of the four chapters considering concepts that have gained nursing academics’ favour as being “central” to nursing, Seedhouse most successfully deals with the notion of advocacy and the nurse as potential patient advocate. Seedhouse’s analysis is one of the most comprehensive I have come across.

In terms of his second challenge regarding leading the way in a more humane approach to health care ethics, the author also provides interesting insights into some of the tensions, inconsistencies, and incompatibilities in nursing, particularly in mental health nursing. Seedhouse raises some important questions for practitioners to consider. For example, he asks if it is possible to promote the mental health of patients within the current structures of mental health service delivery—and if so how? Is it possible to balance care and control? In their defence, some practitioners might argue that Seedhouse has a somewhat antiquated view of the mental health service and indeed to many, mental health nursing is seen as a rather by the book profession. The least compelling section of this interesting book is the final chapter. Two difficulties emerge here. Firstly, the focus on the individual practitioner, and his or her perception of the ethical, belies the significant influence of organisational structure and culture on accurate perception of the ethical. It also, by default, ignores the impact of professional socialisation. Secondly, while it may be accurate to suggest that “Ethics is a pervasive phenomenon of human life—every human action that can affect one or more of us has ethical content”, it is not very helpful. The usual difficulty remains: perceiving and forming judgments regarding those actions or situations where there is significant ethical content. I suggest that the failure to do the latter may either trivialise the moral domain of clinical practice or lead to a state of moral paralysis in the thoughtful practitioner.

None the less this is a useful introductory text that offers effective conceptual analysis of a number of important concepts in nursing. Seedhouse also raises some significant questions regarding the function and purpose of nurses and nursing practice.

P Anne Scott

**Interests in Abortion: a New Perspective on Foetal Potential and the Abortion Debate**

T Martin, Avebury, 2000, £40.00, pp 113. ISBN 07546-1146-9

This is an interesting attempt to tackle that most emotional of all subjects—the abortion debate. Taking as her basis Tooley’s well known discussion on abortion, Martin sets out to provide an account of the intrinsic morality of abortion which, she says, takes a moderate approach to the subject. Unlike many writers on this subject, there is nothing obviously partisan about Martin’s approach. The book is written in a somewhat dense manner, but this may simply reflect the complexity of the issue itself.

Unusually, Martin seeks to use evidence about fetal pain as one plank of her argument that even in early pregnancy terminations, account should be taken of evidence which suggests that fetuses can experience pain. Moreover, as part of the continuum of development, she argues that there are circumstances in which it is not intrinsically wrong to terminate a pregnancy. She concludes that after 24 weeks the fetus is possessed of certain characteristics which render it equivalent to the person to be born, thus justifying restrictions on abortion, save in rare and extreme cases.

This is a thoughtful and interesting contribution to the debate.

S McLean

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