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Books Received

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such as 'brain death' or 'heart death' should be avoided because they tend to obscure the fact that we are searching for the meaning of the death of the person as a whole." (p. 37) He analyzes such concepts as social integration and consciousness as criteria for life. "I . . . believe that death is most appropriately thought of as the irreversible loss of the embodied capacity for social interaction." (p. 42) 2) "Physicians in the states that do not authorize brain-oriented criteria for pronouncing death who take it upon themselves to use those criteria . . . in my opinion, should be . . . prosecuted." (p. 61) 3) ". . . most people writing in the field . . . are careless in distinguishing between the whole brain and the cerebrum and the functions of each." (p. 71) 4) If it is deemed that someone is in an irreversible coma and 'dead,' why do physicians feel compelled to turn off the oxygenator before pronouncing death, then turn it on again to preserve organs for transplant? 5) "When we accept active killing of the dying we are indeed stepping onto a slippery slope. We had best know very well how to get off that slope short of crashing to the depths of moral depravity." (p. 88) But he believes that "in some individual cases, active intervention may still be morally defensible." (p. 93) 6) "I would propose adding 'ordinary' and 'extraordinary' to 'euthanasia' as words that should be banned from further use. It is clearer simply to speak of morally imperative and elective means or of required and expandable means." (p. 110) He also warns against the terms 'meaningful existence' and 'death with dignity.' 7) "... the decision to allow dying patients to die or actively bring about their deaths should never be left to the individual physician." (p. 172) He believes that the physician "has no special competence for this kind of decision making." (p. 183) "Physicians, at least nonpsychiatric physicians, are not trained in determining what is in the patient's interest." (p. 217)

Although minor liabilities exist (such as the confusing Table 2) and a few debatable positions are presented, the book is an essential component of any library in medical ethics. The reader is guided through a logical sequence of steps toward a Public Policy, and is given the option of acceptance or repudiation. Whichever option is selected, one is given the necessary legal, medical, and ethical bases for decision-making.

My one reservation, and it is not a strong one, is that in his emphasis on the patient's right to choose, Veatch does not allow enough room for the fact that despondency and other temporary behavioral anomalies may induce a patient to ask for things which he does not really want. It is common for a patient to ask to die, when in fact he really means "Please assure me that it will not be painful," or "Please give me comfort and just let me talk."

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BOOKS RECEIVED

Case Studies in Medical Ethics. Robert M. Veatch. Harvard University Press, Cambridge, Mass., 1977, vii + 421 pp., $15.00.

A Christian View of Homosexuality. John W. Drakeford. Broadman Press, Nashville, Tenn., 1977, 140 pp., no price given.

Death, Dying, and Euthanasia. D. J. Horan and D. Mall, editors. University Publications of America, Washington, D.C., 1977, xxii + 821 pp., no price given.

The Homosexual Question. Marc Oraison. Harper & Row, New York, 1977, 132 pp., $4.95.

Homosexuals in History. A. L. Rowse. Macmillan Pub. Co., New York, 1977, xiii + 346 pp., $12.95.