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[Book Review of] *Medical Treatment of the Dying: Moral Issues*, edited by Michael D. Bayles and Dallas M. High

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group of people." Moral terms which have developed rather specific meanings, such as "passive euthanasia," are used quite loosely.

Another curious aspect of this book dealing generally with issues of medical ethics is the considerable time spent defending the historical accuracy of Scripture, as though that had some bearing on the authenticity and veracity of its moral teaching. Because it can be proven that the ancient Israelites piled 12 rocks on the bank of the Jordan on a particular occasion, it simply does not necessarily follow that the moral teachings contained in the Old Testament are true (even though that be the case). The claim is uncritically made that the Bible contains all the answers to our moral questions. The question is how it contains those answers. It is to be hoped that no one today would wage a holy war of total annihilation of God's enemies as was enjoined in the Old Testament.

Whatever Happened to the Human Race? is useful, but it has its limitations. It could best be used to acquaint the layman, and in particular the Protestant layman, with the moral questions surrounding the "life issues" and with some of the philosophies which have contributed so much to contemporary attitudes. It is also interesting to note the basis for agreement between Catholics and Evangelicals expressed in this book. However, it must be said that the book is not of great value from a scholarly point of view.

— John M. Haas
The Catholic University of America

Medical Treatment of the Dying: Moral Issues

Michael D. Bayles and Dallas M. High, Editors

G. K. Hall and Co., 70 Lincoln St., Boston, MA 02111, 1978. 168 pp., \$13.95.

Six of eight papers which compose this book were presented to faculty from the graduate and medical schools at the University of Kentucky, 1974. As with so many recent publications in the general area of bio- or medical ethics, *Medical Treatment of the Dying* is directed to a multidisciplinary audience and presupposes "no technical background in any field." However, it may be worth cautioning the reader that seven or eight authors are professors of philosophy or philosophy of medicine, and one a professor of neurology. This reliance on philosophers and the general topic of the book seem to have been the only controls on selection and organization of the content of the papers. There is no particular order or connection among the papers except that the editors do identify four themes running throughout: patient/physician relation, concepts and criteria of death and dying, the quality of life issue, and euthanasia and the termination of life-prolonging treatment. These four, of course, would emerge in any collection of articles under a similar title. Can we justify another book (hardbound at that) predicated on this shotgun approach? The oral presentations may well have stimulated "fruitful interchange" in 1974, but I question the usefulness of the published version for the professional and the educated public of the 80's.

The individual papers do touch on many significant issues. H. Tristram Engelhardt, Jr.'s paper, "Rights and Responsibilities of Patients and Physicians," is especially notable. Engelhardt traces briefly the history of Western medicine and

shows how the physician/patient relationship is rooted in the context of the community of physicians, not that of society generally. As part of the evidence, Engelhardt points to codes of ethics (or etiquette) in the 1800's which focused in large part on regulating consultations, interactions of physicians, and setting a schedule of fees. With the increasing sophistication and specialization of medical science and technology, and the growth of power in the medical profession generally, physicians' rights have become ever more dominant in the physician/patient relationship. As a consequence, paternalism among physicians is a common hazard and the rights of patients are easily compromised.

Much has changed since 1974. This book does not reflect the surge of the consumer movement in the late 70's, the appearance of George Annas's *The Rights of Hospital Patients* (1975), the rash of malpractice suits, the natural death legislation since 1976, or the current revision of the AMA's "Principles of Medical Ethics," all of which were largely motivated by greater concern for patients' rights.

One way to establish a better balance and equality between physician and patient rights and responsibilities is to acknowledge the larger society's interest and investment in the medical enterprise. As Engelhardt puts it:

The point is that, because of societal investment in the development of medical research and education, public health care programs, and individual health care (e.g., Medicare), medicine has become an element of social or civil policy. Medicine, once an enterprise of private citizens, has now become an extension of those citizens through the development of medicine within a political structure. The force of this development is that medicine as a social or political enterprise can legitimately be required to temper its interests in cure and care and make them accord with basic claims of citizens to self-determination and choice. In this sense, rights to health care and patient bills of rights are of civil rights, rights which accrue to an individual in virtue of his membership in a political structure of a certain character (p. 24).

This concept of patients' rights also implies corresponding "civil duties to participate in health maintenance, even in programs which cannot be directly in their self interest (e.g., rubella vaccinations)" (p. 25).

Engelhardt refers to treatment of the dying only in passing to illustrate his view of physician paternalism. That is, a patient's rights are most in jeopardy when he/she is vulnerable or disadvantaged because death is imminent.

Samuel Gorovitz in "Dealing with Dying," among other things, tries to clarify what it means to speak of someone as dying. He cites three conditions that must be satisfied, the last of which is "death is likely to occur soon" (p. 35). This imminence condition is a critical feature of natural death legislation patterned after the California Act of 1976. Under this Act, a patient may fill out a directive, indicating no extraordinary treatment, only after the attending physician determines that death is imminent. Prior to that, terminal condition must be confirmed by another physician, but imminence is the responsibility solely of the attending physician. This means the attending physician is the gatekeeper who finally decides when patients may exercise their rights under the Natural Death Act. The Act does not attempt to stipulate any particular time frame, e.g., two days, two years, under imminence. This is probably due to the fact there is no consensus among physicians as to an exact meaning for imminence. Gorovitz remarks that "we decide what counts as a sufficiently imminent death to qualify one as dying in part on the basis of how we want to treat and relate to people in various circumstances" (p. 36). Granted such judgments can be value-laden, what we primarily expect from physicians is their considered opinion based on discovered medical fact and the biological conditions pointing to imminence, and not a disguised

moral judgment that life-sustaining treatment should be withdrawn or withheld. Such a judgment is the prerogative of the patient (if competent).

The majority of Gorovitz's article is occupied with a discussion of the variety of ways in which physicians and their associates can relate to dying persons (diagnostic, medical intervention to forestall death, facilitating the ending, intervening to terminate life, after-death responsibilities), and a sampling of related moral dilemmas.

In his concluding remarks, Gorovitz states, "The difficulty of solving specific moral problems without a generally accepted and complete theory of morality, combined with the apparent unavailability of any such theory, leads to skepticism about whether moral philosophy can shed any useful light on the problems faced in clinical practice" (p. 44). Gorovitz contributes to this skepticism by his relatively superficial account of the moral dilemmas in the area of death and dying and by the absence of any reference to the wealth of old and new moral theorizing applicable to the clinical setting.

Robert P. Hudson contributes to skepticism in a different fashion. He contends that "the current burgeoning of interest in death and dying will result in a period of relative anarchy. Until the field clarifies itself and lines of responsibility can be drawn, it is vulnerable to overzealousness on the part of the public and its institutions, of which the healing profession is one" (p. 82). Going to extremes does seem to characterize the glamorization of suicide and knee-jerk legislation on death and dying in recent years. But one can object to the implication that no existing discipline(s) is yet adequate to the task of taking charge of ethical issues in the area of death and dying. It is true that "bioethics" is a new development, but the appearance of the *Encyclopedia of Bioethics* in 1978 attests to the serious thinking, scholarship and wealth of resources available now (and in 1974) in death and dying and other areas, not to mention the fact that medical ethics has a long history in the Roman Catholic tradition and other religions as well. Hudson indirectly refers to sources of religious ethics when he cautions, "There appears to be a recurrent need to emphasize the unpredictable nature of biologic and medical variations that will always thwart those who seek a single metaphysical system to cover all clinical situations, while providing the Linus' blanket of absolute internal consistency" (p. 71). If, as Hudson suggests, the only alternatives are situational and contextual ethics, then I suppose religious ethics, certainly Roman Catholic, are guilty of gravitating toward the single metaphysical system approach.

Several other authors analyze elements in Catholic ethics in particular, but superficially and unsympathetically. I don't fault the secularist tone of the book as a whole. There is certainly room for enlightenment from whatever quarter. But I suspect that facile disparagement of traditions of religious ethics simply deprives the larger society of one valuable resource for combatting general moral skepticism.

James F. Toole, the neurologist, deals with the concept of brain death. (The inclusion of this paper and the fact that other authors touch on the same topic would justify a more accurate title for this book, such as *Death and Dying: Moral Issues*.) Toole ignores basic philosophical concepts of definitions of death and discusses the physiological standards and methods for determining the fulfillment of standards based on the 1968 Harvard report. His primary concern seems to be that while total loss of all brain function is currently required before declaring a person dead because of brain death, in the future, he predicts, the line will be drawn short of total loss, in which case a new dimension will be added to the physician's role. Then "the neurologist will be called to the bedside not only to cure but to kill" (p. 56). In several other papers, the slippery slope argument in general is dismissed out of hand, and none but Toole rely on it.

Robert M. Veatch analyzes the concept of natural death and its implications for public policy. Veatch argues that human responsibility in building of community

includes the goods of prolonging life and combatting of natural death. Theoretical issues aside, I fear Veatch's position will be read by industrialized countries as further justification for expending every more resources in the area of extending life and defeating death — for the benefit of the affluent. In his concluding statement, Veatch acknowledges that an allocation of resources question is involved, and that in a sequel to this paper he intends to defend the distributional principle that medical resources should go first to those least well off. Such a discussion, for me, would give an entirely different perspective to his natural death paper. I wish the sequel had been included here or that he had reserved an entire section at least to sketch the main lines of such a thesis.

Two articles concentrate on euthanasia — John Ladd's "Positive and Negative Euthanasia" and Michael D. Bayles's "Euthanasia and the Quality of Life." Both cover what is by now well-trodden ground. They seem to be in basic agreement on major issues. For example, both contend that there is no moral difference between killing and permitting a patient to die by ceasing life-prolonging treatment. Adequate representation of the opposite view would have added to the usefulness of this book.

Overall, I do not recommend *Medical Treatment of the Dying*. For better balance and general coverage of issues in this area, for useful organization of the material with introductions and bibliographies for each section, I recommend the paperback *Ethical Issues in Death and Dying*, edited by Beauchamp and Perlin (Prentice-Hall, 1978).

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Current Literature

Material appearing below is thought to be of particular interest to Linacre Quarterly readers because of its moral, religious, or philosophic content. The medical literature constitutes the primary, but not the sole source of such material. In general, abstracts are intended to reflect the substance of the original article. Contributions and comments from readers are invited. (E. G. Laforet, M.D., 2000 Washington St., Newton Lower Falls, MA 02162)

Position statement on medical participation in capital punishment. *Am J Psychiat* 137:1487 Nov 1980.

The American Psychiatric Association "strongly opposes any participation by psychiatrists in capital punishment, that is, in activities leading directly or indirectly to the death of a condemned person as a legitimate medical procedure."

Koryagin A: Unwilling patients. *Lancet* 821-824 11 April 1981.

In the Soviet Union the diagnosis of psychopathy may often be based on

political criteria, and dissenters may be committed to mental institutions for punitive purposes. These individuals receive no psychiatric treatment while institutionalized. (Cf. Chapman article following.)

Siegler M: A physician's perspective on a right to health care. *JAMA* 244:1591-1596 3 Oct 1980.

The claim of a right to health care is, in the first place, ambiguous. Confusing a right to health care with a right to health may result in an inappropriate emphasis on health care