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MAKING THE ROUNDS

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Nurses and Euthanasia: Supposing It's So

David B. McCurdy

Might a bioethics community obsessed with the physician's role in assisted death be so fixated on the tall trees that it has missed the real action transpiring in the teeming understory of the forest? A widely publicized article in the May 23 *New England Journal of Medicine* suggests just such a possibility.

According to David Asch, a Philadelphia physician with the Veterans Affairs Medical Center and the University of Pennsylvania, his 1995 survey of critical-care nurses revealed that 129 (16 percent) of 852 respondents practicing in adult critical-care units had "performed" euthanasia or had assisted patients in suicide (Asch 1996). An additional 35 respondents (4 percent) had engaged in some other kind of "clandestine" action "in order to hasten a patient's death" (p. 1376). Such data raise questions about whether physicians are the only—or even the primary—practitioners whose potential role in assisted death should be a concern in clinical and policy discussions.

Asch's study has spawned not only media attention but also considerable early criticism—and numerous disclaimers—from medical, nursing, and bioethics quarters. In a companion *New England Journal* editorial, Colleen Scanlon of the American Nurses Association's Center for Ethics and Human Rights questions the validity of Asch's survey and his conclusions. She also worries that his article is "potentially damaging to the nursing pro-

fession" (Scanlon 1996). Scanlon and others who believe that the incidence of assisted death involving nurses is substantially lower than Asch suggests find significant ambiguities in the nurse-respondent accounts of participation in "euthanasia" cited by Asch (Kolata 1996).

Without question, the study has its weaknesses. Asch himself acknowledges a failure to distinguish definitionally between assisted suicide and euthanasia (p. 1377), and the survey fails to supply would-be respondents with illustrative examples of assisted suicide similar to the brief scenarios of euthanasia that are provided.

Further, by defining euthanasia as "an act with the specific intent of causing or hastening a patient's death," the survey is subject to each respondent's interpretation of "specific intent" (Scanlon 1996:1401): for example, is mere foreknowledge of a likely effect tantamount to "intending" the effect? This problem is compounded by the philosophical and legal confusions—and the moral anxiety—that seem to surface whenever involvement in "causing" death is considered (*Deciding to Forego Life-Sustaining Treatment* 1983:68–71).

Asch does attempt to distinguish, both conceptually and through examples, between euthanasia and "acts that reflect the withholding and withdrawing of life-sustaining treatment." Even so, not all respondents observed this distinction consistently, and some responses demonstrate that the complexities of clinical reality and medical technology can defeat virtually any effort to maintain a clear-cut distinction in practice.

For example, some respondents reported that they had only

Asch's 1995 survey of critical care nurses revealed that 129 (16 percent) of 852 respondents practicing in adult critical-care units had "performed" euthanasia or had assisted patients in suicide.

David B. McCurdy is co-director of the Clinical Healthcare Ethics Support Service at the Park Ridge Center.

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Unkindest cuts?

Given rising costs and shrinking reimbursement, more and more hospitals are downsizing in an effort to shrink personnel costs. In a recent survey of hospital administrators, the majority stated that they would cut staff to reduce costs before limiting capital improvements or restricting research and development. Registered nurses (RNs) as a group have been hit hard by downsizing and many experienced, qualified nurses have found themselves unemployed for the first time in their lives. Other health care administrators, in an effort to contain costs, have restructured... delivery systems by... replacing licensed professional nurses with unlicensed assistive personnel (UAP)....

The conclusion of a comprehensive survey of 1,835 nurses suggested that "the ultimate effect on the patient from the increased use of UAP can range from mere inconveniences to more serious consequences, such as medication errors, injuries resulting from frustrated patients trying to do too much on their own, failure to carry out procedures ordered by doctors, more numerous nosocomial infections, and even deaths that are perceived as having been preventable if more registered nurses had been available."...

Other nursing leaders have argued that there is no evidence that nursing is responsible for rising health care costs and thus redesign of professional nursing practice is not the answer. Research by the California Nurses Association suggests that wage and benefit costs as a percentage of hospital budgets have actually fallen dramatically during the past three decades. In 1962, labor costs accounted for 67% of hospital expenditures. In 1984 the total had dropped to 56%, and by 1992, the percentage was under 54%. In contrast, administrative costs have risen 180% since 1968, and capital expenditures rose 36% in the 1980s. Taking inflation into account, RN wages increased only a total of 13% in the 1980s, whereas hospital executive compensation increased between 123% and 142%. While continuing to cry "poor," hospitals recorded record profits for 1992.

(*Nursing Outlook*, March/April 1996)

Optional death

When we provide social legitimation for the option of suicide, we may increase options, but we also effectively eliminate an option, namely, the option of staying alive without having to justify one's existence. That happens to be an option much of the Christian tradition would choose if it could, an option the Christian tradition would like to preserve and protect, for it fits the story of life as a gift, as a given.

One may choose, of course, not to be killed, but the person who makes that choice is then responsible for it, accountable for living, and can be asked to justify the choice. With this point we return to the vulnerability of the sick and suffering, for this burden of justification will be hard to bear for those who simply do not want "to be a burden."

(Allen Verhey, "Choosing Death: The Ethics of Assisted Suicide," *Christian Century*, 17-24 July 1996)

Medics and clerics sabotage Australian suicide law

Jan Culhane wants to exercise her right to die by a lethal injection of barbiturates, activated once she presses the "yes" button on a laptop computer.

But her hope of passing away without more pain faded when no Australian cancer specialist would give her the required go ahead for the act of euthanasia that the Supreme Court of Australia's Northern Territory sanctioned on Wednesday.

In this usually conservative nation, the world's first voluntary euthanasia law has run into a wall of clerical and medical indignation.

"Our doctors are a bunch of dinosaurs, and paternalism is still very much alive in Australia. Doctors still believe you have to suffer before you die," said an embittered Culhane by phone.

"It's time doctors and clerics stopped making decisions for us. I am bitterly disappointed. Now I have to wait till the cancer gets to my brain, and then I'll commit suicide on my own instead of having someone to help me," she said.

Culhane said her three children support her

decision and she has received hundreds of telegrams from all over the world supporting her decision.

"But there are also some who try to dissuade me and some who say it's a sin. But then everyone has the right to decide for themselves. And I have made my decision."

(*Chicago Tribune*, 27 July 1996)

Priest defends Clinton veto

Jesuit priest and former member of Congress Robert Drinan defended President Clinton's April veto of the bill to ban a method of late-term abortions. Alternative methods not prohibited by the bill would result in a much higher mortality rate for women, Drinan wrote.

"If Congress were serious about getting a law on the books limiting late abortions, it would include the woman's health as justification for the late-term procedure. But it seems more intent on using Mr. Clinton's veto as a political weapon."

(*In Catholic Circles: An International News Roundup*, May-June 1996)

Traditional medicine

At the Center of Mixed Health, in San Juan Chamula [Mexico], a small hamlet in the Chiapas highlands, both traditional healers and modern doctors are available for checkups. Most local residents go to the healers first, doctors there say. If that doesn't work, they then see the doctors.

"This is not a learned medicine," said healer Diego Heredia Lopez, a diminutive 58-year-old man sporting a cowboy hat and blanket-like vest, explaining his public appeal. "This is by the word of God."

Lopez, who is paid a small government stipend, treats patients free of charge, accepting whatever gifts his patients can afford. The word of God extends beyond medical education. One small room in the clinic is reserved for the healers, who chant before an altar strewn with pictures of Jesus and the Virgin Mary. The healers also preach at the Catholic Church nearby.

(*Earth Times*, 15-30 July 1996)

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(continued from page 1)

pretended to put physician-ordered vasopressors (blood pressure medications) into the intravenous solutions of ICU patients with dangerously low blood pressure. Such instances could be characterized as “withholding” a life-sustaining treatment, but it appears that awareness of their intention to cause patients’ deaths—coupled, perhaps, with uneasiness about the deception involved—led respondents to categorize these behaviors as actions performed “in order to hasten a patient’s death.”

Other respondents said they administered “large doses of sedatives or opiates” to patients from whom a respirator was being withdrawn. Here the context was clearly the withdrawal of a life-sustaining treatment, with death expected to follow. Thus a question can be raised: Were respondents who cited such instances implying that the dosage of the drug they gave in conjunction with the ventilator withdrawal exceeded approved limits, predictably “caused” respiratory cessation, and was “intended” to hasten death?

Or, at least in some instances, did the large dose nevertheless fall within the upper limits of the approved range, and did the nurse intend to alleviate physical discomfort and anxiety—rather than “cause” death more quickly? In such a scenario, the term *euthanasia* seems out of place. The nurse’s behavior would fall under the moral umbrella of the well-known Roman Catholic principle of double effect, since the patient’s death was neither intended nor directly induced and death was not the direct means to the good of symptom relief (Ashley and O’Rourke 1994:40).

A majority of the study’s 553 reported instances of euthanasia or assisted suicide occurred “at the request of” the patient or a family member or other surrogate (p. 1376). Asch speculates that “tacit consent” may have been present in other instances. He also reports that most instances involved a request by a physician, and he supposes that other instances may have occurred with a physician’s knowledge and tacit consent.

Asch’s way of presenting his “request” data raises more questions than it answers. What constituted a request for nurse-assisted death by a patient or surrogate—or by a physician? When no explicit “request” was made, did respondents usually assume tacit consent, or were they acting compassionately to serve what they considered the patient’s best interests? Unfortunately, the few narratives that Asch includes shed little light on these questions. It is also not clear how physician requests influenced respondents’ decisions to act to hasten death. It is hard to know whether to be more troubled by the fact that a high percentage of acts were carried out at a physician’s request or by the fact that a small but significant number of such acts were initiated without a physician’s request or knowledge.

In the end, however, only so much can be made of the crit-

icisms of Asch’s survey and his interpretation of its meaning. Even though the survey has multiple shortcomings and some respondents’ self-reported instances of euthanasia admit of other interpretations, the fact remains that a significant minority of critical-care nurses surveyed reported participation in behaviors that fit within common definitions of active euthanasia. And even if the actual incidence of nurse administration of euthanasia or assistance in suicide was, say, only half that found by Asch, would not the fact that 8 to 10 percent of respondents reported such participation represent a substantial—indeed sobering—level of involvement?

The fact that members of the medical and nursing communities have tended to minimize the validity of the study and the significance of its findings is understandable (Kolata 1996). Few health care professionals want to believe that Asch’s figures can possibly be representative. Not only do participation in euthanasia and assistance in suicide violate nursing’s ethos as summarized in codes of ethics and recent professional organization position statements (Scanlon 1996:1401) but also a wide-

spread perception that such activity is common could undermine the public’s trust and patients’ sense of security when receiving care from nurses (Kolata 1996).

Should the public, including seriously ill patients and their families who enter hospital ICUs, begin watching nurses with a wary eye? Even among the instances reported in Asch’s study, initiatives to hasten death in the absence of some form of request or consent from the patient were certainly an exception. The study supplies little basis for diminished trust of nurses in general or crit-

ical-care nurses in particular.

Nevertheless, the study does raise a number of questions that invite and even demand follow-up investigation and, where indicated, appropriate response. Most obviously, better constructed studies of nurses’ actual understandings and behavior concerning euthanasia and assisted suicide are in order. Studies should explore how nurses construe the terms *euthanasia* and *assisted suicide*, which in Asch’s study were subject to a variety of interpretations. In particular, nurses’ perceptions of the meanings and moral implications of “intending” and “causing” or “hastening” death deserve closer examination, as does the perceived relationship of euthanasia and suicide to the provision of palliative care.

Further studies may demonstrate that, as one nurse put it, “there is a lot of confusion among nurses about what is euthanasia and what is palliative care and when does causing death actually cross that line” (Kolata 1996). If so, educational interventions to dispel such confusion may serve not only to clarify nurses’ thinking and perceptions but also to relieve unduly burdened consciences. Nessa Coyle has supplied a helpful list of nursing behaviors that may be confused with euthanasia but which are, in fact, commonly accepted under such prin-

It is clearly imperative that the ongoing discussion of physician-assisted death take the actual and potential role of the nurse into account—and give nurses a prominent voice in the public-policy discussion.

ciples as double effect and respect for autonomy (Coyle 1992:45).

Another set of questions suggested by Asch's study might be gathered and explored under the broad heading "the 'situation' of the nurse in critical care." For example, what support people or systems were available—or perceived as available—to the 129 nurses who reported engaging in euthanasia or assisted suicide? While the existence of "requests" from physicians and other nurses (p. 1376) for assistance in hastening death suggests some sort of collaboration or consultation, the general (and sad) impression left by the few brief narratives that Asch shares is of isolated caregivers who confront patients' pain and suffering with little companionship. Were chaplains or social workers, nurse colleagues, support groups, or hospital ethics committees available to share the burden, offer an additional perspective on people and issues, and provide emotional and spiritual support?

Moreover, what education or training, if any, had been provided to prepare these critical-care nurses for the predictable likelihood that some of their patients and families would request assistance in dying? Again, the nurses whose narratives appear in Asch's report gave little evidence that they had received specific education in responding to requests for assistance in dying or in recognizing and responding preventively to situations in which such requests might emerge. If further study reveals a dearth of relevant educational resources in critical-care nursing, perhaps approaches developed in other specialties, such as oncology nursing, can help to fill the void (Coyle 1992).

Another aspect of the critical-care nurse's situation worthy of further study and appropriate intervention is her mediating role in the care of the patient. In practice, as Scanlon observes, this role often translates into being "caught in the middle" between competing obligations, such as complying with physician directives and advocating for the patient (Scanlon 1996:1402). The nurse is subject to the well-known catch-22 of having responsibility without holding authority. For several of Asch's respondents, finding themselves in this difficult position seemed an ingredient in decisions to act to hasten death (pp. 1377–78). Sometimes, perhaps often, the nurse may feel the need to offer the patient a form of care that compensates for the failure of medicine to provide the care she believes is truly needed. It is clearly imperative that the ongoing discussion of physician-assisted death take the actual and potential role of the nurse into account—and give nurses a prominent voice in the public-policy discussion.

Last, but hardly least, it is important to remember that, like the physician, the nurse is a citizen of—and a person formed by—the surrounding culture. That culture currently desires the legal and practical availability of euthanasia and assisted suicide for those who suffer or wish to avoid an undignified death. Moreover, among the cultural values supporting the availability of these options are compassion and the sense of a duty to

relieve suffering—values at the heart of nursing. These values are also central to Christianity and Judaism, which continue to influence both cultural and personal values. In light of this, perhaps it should be little wonder that some nurses are moved to the practices of euthanasia and assisted suicide. In certain difficult cases, they may seem to offer nurses the best possibility of remaining true to the deeply felt values that brought them into health care in the first place.

Despite working where the outsider might believe that the caregiving options are most plentiful, critical-care nurses—like their patients—often experience an actual poverty of available medical and caregiving options. Even in the supposed era of hospice care and a dawning age of improved palliative care, too often the medically available options in critical care boil down to two extremes: "do everything" or "there's nothing more we can do." In society at large, this poverty of options has made Jack Keivorkian a hero and *Final Exit* a best-seller. Perhaps it led some nurses in Asch's study to create their own third option in the constricted ICU arena.

The real practical challenge goes far beyond addressing "the role of critical care nurses in euthanasia and assisted suicide." It is the continuing challenge of forming the health care system and its practitioners to be more responsive to the real needs of suffering people. Beneath this practical challenge lies a deeper, profoundly spiritual one: that of developing (or reclaiming) resources in religion and culture that enable us, nurses included, to acknowledge and respond to the realities of suffering and death

without being overwhelmed by them—or driven to contrive unilateral responses that place everyone involved at needless risk. □

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Assisted Suicide in Practice

Arthur W. Frank

Lonny Shavelson, *A Chosen Death: The Dying Confront Assisted Suicide* (New York: Simon and Schuster, 1995), 240 pp.

Once while in a fit of bioethical overload, I realized that every argument for or against assisted suicide could be turned around and used by the other side. Even worse, all the reverse arguments were good arguments. What then is the difference, I began to wonder, between a good argument and a compelling argument? *Good* arguments have, at minimum, coherence with complementary beliefs, a place in some moral tradition, and some degree of empirical support. *Compelling* arguments cause us to change our minds and even our lives. Charles Taylor (1989:73) describes a compelling argument: "You will only convince me by changing my reading of my moral experience, and in particular my reading of my life story, of the transitions I have lived through—or perhaps refused to live through."

To find compelling arguments, we have to go to the moral experience of people's lives. We must not only hear their stories, we must let these stories affect what Taylor calls our readings of our own moral experience. Lonny Shavelson is an emergency room physician and medical journalist. He understands the medical nuances of the cases he describes, but he avoids ever playing the expert. His success at insinuating himself into people's lives suggests that Shavelson must project a genuine compassion. Compassion is the singular strength of this book.

A Chosen Death tells the stories of how five people die. Two women with cancer and one disabled man plan and effect their own deaths, though in no case does death happen as planned. A man who has AIDS plans to end his life but then dies a natural death. In the most disturbing story, a person plans his death, solicits assistance, and possibly changes his mind once those plans are in progress. No physicians are involved in these deaths, unless one counts Shavelson in that role.

Shavelson teases out the fullest social, psychological, and moral complexities of these stories. Except in his concluding plea for the right-to-die movement and the hospice movement to recognize their common interests, Shavelson makes little pretense of advancing any new arguments about euthanasia. Instead he frees us from the circularity of argument and reorients us to experience: what actually *happens* as dying people mobilize their resources and negotiate various options. As Shavelson's subtitle implies, the dying confront not only death but also the different kinds of assistance in dying. Contemporary

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dying confronts both the single inevitability of death and the sequence of choices that dying has become. Part of the messy complexity of dying is that the parameters of the decisions keep changing.

Two themes pervade Shavelson's account of people's struggles. The first is *responsibility*. Not only do people seek a good death for themselves, they seek a moral good for those they leave behind. A woman who is dying of cancer says, "I still have some responsibilities ahead. My mom taught me about dying, and it's my turn to pass it on to my kids" (p. 165). This discourse of responsibility is not limited to those who are dying themselves. Another woman speaks of a man dying of AIDS and his duty to their daughter: "I can respect Pierre's desire to die now, but he has responsibilities for Alexa's feelings as well. And he's not taking care of those" (p. 45). Soon after she says this, Pierre fulfills the responsibility she sets for him.

The other theme is *contingency*. The most harrowing moments described in *A Chosen Death* occur when bodies do not act as they are supposed to: just as medications do not relieve pain as physicians expect, bodies do not die as advice manuals like *Final Exit* assure readers they will. If Shavelson works these moments for their fullest dramatic impact, he is nevertheless making a point that is too often neglected: "choosing" death is always an illusion. Not only are bodies unpredictable, so are emotions. One woman summarizes the contingency of emotions with remarkable candor: "I know from experience that I often formulate elaborate plans, and then when the time comes I do something entirely different" (p. 178).

In the cancer deaths and the AIDS-related death, responsibilities do seem fulfilled and contingencies are overcome. Becoming acquainted with these people not as "cases" known by their diseases but as distinct individuals—Renée Sahm, who has worked as an emergency disaster planner, Mary Hall, a much-published mystery writer, and Pierre Nadeau, a trapeze artist—I ceased wondering whether to be for or against some euthanasia policy and instead tried to imagine how these people could possibly have acted "better" than they did. If in those three life stories I was left feeling that each had done her or his best, two other cases left me disturbed and ambivalent.

Gene Robbins has had several strokes and fears his next stroke may leave him fully disabled. He solicits the help of a volunteer from the Hemlock Society who, against that organization's explicit policies, is only too willing to help him die. What results may well cross the line between assisted suicide and murder. I cannot imagine a reader not being shocked, but how to respond to this shock is less clear. Some will argue that since people will continue to seek and receive assistance in dying, legalization of assisted suicide is needed to end the euthanasia equivalents of back-alley abortions. Others will read the story as a clear example of why any hastening of death entails legal and moral disaster.

Equally troubling is the story of Kelly Niles, a quadriplegic who decides that his life is no longer worth living and after great suffering—he attempts to starve himself—brings about his own death. As a

Arthur W. Frank, professor of sociology at the University of Calgary, Calgary, Alberta, Canada, is author of *The Wounded Storyteller: Body, Illness, and Ethics* (1995).

child Kelly was hit on the head in a schoolyard scuffle and then misdiagnosed in an emergency room. Brain injuries leave him unable to speak or control his body, but the medical malpractice settlement leaves him with a personal fortune. Kelly has all the care he can want, from both family and paid attendants.

Kelly's story mixes euthanasia controversies with the politics of disability, but Kelly's Promethean character rises above the arguments about the morality of certain acts and the rights of certain types of persons. As I finished his story, I felt awed by the conjunction of sameness and difference: Kelly's problems are my problems, and I will never have the slightest idea what it is like to be Kelly.

Among Kelly's other resources is a friendship with the spiritual teacher Ram Dass, who counsels him neither for nor against dying. "Look, Kelly," he tells him, "you're given a certain set of stuff; everybody's got stuff. Your stuff is that you can't move and can't talk. And I've got my own problems and stuff. You could work with your stuff to sainthood, use it to become a great teacher. Or you could look at your stuff and choose to die. So is your stuff an asset or liability? I don't know. Who are we to judge? Only you know how much you can take" (p. 151).

In Kelly's story, as in all five stories, we find literal instances of what Taylor, in the quotation above, calls "transitions I have lived through—or perhaps refused to live through." Dying is the last transition. If having assistance to hasten death is, by definition, a refusal of further dimensions of this transition, this refusal will not be the first that most of us make, and we may look back on previous refusals as

sound judgments that enhanced our lives. Kelly Niles does not choose nothingness in his death; he chooses "crossing over," which is his own complex belief in an afterlife.

When is refusal all right, and who judges what is all right for someone else? Is Ram Dass's "Who are we to judge?" a New Age evasion, or does it reintroduce qualities of humility and charity that so much ethical discourse lacks? Ram Dass's caution against judging others has a good precedent; suspending judgment is not always a moral evasion.

Good arguments about euthanasia will go on being debated. Shavelson reminds us that the compelling arguments—the arguments that will guide our own choices in dying and what we offer our family and friends in dying—are not going to come out of these debates. At worst, debating principles is another way to deny the eventuality of our own decisions about how much we can take and more frightening still, how to help friends and loved ones decide how much they can take. How *do* we use our stuff? Which principles we invoke, and how we interpret their relevance, will be based on how we read the moral experience found in our life stories. Fortunately these life stories are not ours individually but are fragments of a moral experience that we share collectively. The compassion of *A Chosen Death* is to help suffering, confused individuals toward a shared story of dying.

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Setting our moral compass

Charles Dougherty, *Back to Reform: Values, Markets, and the Health Care System* (New York: Oxford University Press, 1996), 179 pp.

Dougherty's book is a thoughtful and necessary antidote to contemporary discussions about health policy reform, which often lack a moral compass. His explicit goal is to turn attention to moral values in order to "begin a conversation" about the right direction for health care reform. His method is to identify key moral values, uncover their roots, draw out their implications for health care reform, and use these values to critique current trends. Dougherty opens by likening America's health care system to a jet plane flying at great speed through a storm with none of its directional equipment functioning, "making great time" to nowhere in particular. While not entirely without direction—for example, cost containment and maximizing return on investment are surely ends—the health care system's marketplace goals seemingly overwhelm all other ends. Dougherty describes these other ends as core moral values. They include access, dignity, care, quality, protection of the least well off, responsibility, excellence, and the common good. He devotes a chapter to each of these values and also considers the inevitability of both rationing and cost containment and the need to address these concerns with one's moral compass intact.

Twenty years ago, Albert Jonsen observed that the task of social

ethics was to "measure social policy and social phenomena against articulated and critically assessed moral values" ("Principles for an Ethics of Health Services," in *Social Policy, Ethics, and the Aging Society*, ed. Bernice Neugarten and Robert Havinghurst, 97–104 [Washington, D.C.: National Science Foundation, 1976], 97). By proposing the moral values he believes should be the yardstick against which reform is evaluated and supporting this choice of values, Dougherty performs an invaluable service that will help each of us undertake the task Jonsen proposed.

Dougherty's meticulous analysis is instructive and generous; it is also a call to engagement. While forthrightly proposing normative values grounded in Western religious traditions and in Enlightenment thinking, he also invites discussion of his premises and arguments, acknowledging that the prevalence of moral values that Americans hold dear does not grant them moral validity. Moral validity would rest upon intersubjective agreement, a process that demands the serious conversation now lacking in the health care debate.

What *Back to Reform* lacks in elegance, it more than compensates for with its thoroughness, care, and deeply rooted commitment to the most compassionate dimensions of the Jewish and Christian traditions. Dougherty's background in Catholic moral theology is particularly evident. He is also astute. He faces directly, for example, the possible charge of moral relativism. He answers thusly: "Pluralism is the acknowledgment that a human life can be

lived well on the bases of many differing values... but pluralism loses its significance without the implied objectivity of the standard of a human life well lived, of the sense of human thriving toward which values aim. It is this objective norm... that provides the justification for the metavalue of toleration, and grounds for rejecting the nihilism of extreme relativism, and the basis of hope that moral progress is possible" (p. 28). Herein lies Dougherty's generosity and wisdom.

Martha B. Holstein
Research Scholar

Perceptions of mental illness

Lynn Gamwell and Nancy Tomes, *Madness in America: Cultural and Medical Perceptions of Mental Illness before 1914* (Ithaca, N.Y.: Cornell University Press, 1995), 182 pp.

This "study of the evolution of American perceptions of mental illness" features scores of pictures, some in color, depicting conceptions of "madness," insanity, and mental illness in the American past. Not surprisingly, the authors find that bias and ignorance characterized majoritarian attitudes toward such illness, especially in the cases where it was manifested among women or among Indians, blacks, and other minorities.

One is likely to shudder, perhaps to weep, certainly to want to hurry past some pages and almost as certainly to linger on others as the coauthors present illustrated examples of cruel and inhumane treatment. Phrenology, "American nervousness," "hysteria," over-ready Christian theological judgments about "demoniac possession," and more—all receive their critical due. But markedly absent is the all-too-frequent tone in contemporary accounts that judges those who went before as villains and fools. Gamwell and Tomes know how little we know today about madness, how little citizens in our time understand mental illness or what to do with its victims, so they are measured in their critiques of those who went before. "There are striking improvements today," they say, while recognizing "how misguided one's suppositions about sanity and madness can be" and wondering how future historians will regard even the most benign and forward-looking in our time. Such a conclusion on the last page is the best recommendation for the 181 pages that precede it.

Martin E. Marty

Health care in an aging society

Daniel Callahan, Ruud H. J. Ter Meulen, and Eva Topinkova, eds., *A World Growing Old: The Coming Health Care Challenges* (Washington, D.C.: Georgetown University Press, 1995), 175 pp.

This collection of essays takes a cross-national, interdisciplinary approach to a number of issues emerging from the perceived crisis associated with an aging society. The volume presents papers written in tandem with an international project jointly organized by the Hastings Center and the Institute for Bioethics in Maastricht, the Netherlands. Representatives from eight countries participated: Sweden, Belgium, Germany, the United Kingdom, the Czech

Republic, Hungary, the Netherlands, and the U.S. Each chapter addresses one topical issue raised during the project. Papers presented in the first part of the book examine a set of five key issues from a philosophical, or at least holistic, perspective. These issues include the meaning and significance of old age; the goals of medicine and health care for the elderly; balancing the needs of the young and old; resource allocation and social priorities; and families, society, and long-term care. Each remaining chapter targets at least one of these topics, examining the problems presented from the point of view of a single national example.

While each chapter has a significant point to make, and most are highly readable, the book as a whole lacks impact, for several reasons. First, each essay is fairly brief and thus provides only an overview of the issues, without depth or exploration of the substantive content. While this approach offers general readers a quick "tour" of the problems, more experienced scholars will soon realize that they have already heard or read much of what is presented here. Second, the essays are presented as "stand-alone" chapters, without a unifying commentary or discussion following. No attempt is made to follow the individual threads of argument through one chapter to another or to demonstrate how the papers fit into the context of the project from which they evolved. In fact, we do not know if the papers were developed as definitional or summary to the project process. In addition, there is some unnecessary redundancy. For example, many chapters begin by reiterating the demographics of an aging society. These well-known statistics could have been presented once, in the introduction, and then edited out of the remaining chapters, thereby allowing authors more space to address the substantive issues. Finally, the project report is presented last. This chapter, however, provides the best overview of the total effort and if presented first might well have provided the structure needed to unite the individual contributions.

If this volume is intended as the dissemination piece of a major project, it seems necessary to ask the impertinent question, "So what?" As the authors of the project report note, they present here a set of very complex problems: difficult to isolate, difficult to describe, and extraordinarily difficult to resolve. Their goal is to steer discussion in the policy arena, not to offer solutions. It is not clear, however, what next steps should be taken to move the issues from the identification and discussion stage to that of solution. How do we create a national and international forum for debate on the meaning of old age? How do we shift from our current focus on the medicalization of old age to a more integrated perspective that recognizes the interface between acute and chronic care, that recognizes old age as both a physical state and a spiritual stage of life? Some precise recommendations for implementation of the recommendations would have made this volume a very valuable resource. Instead, although the essays presented here make a worthwhile contribution to our understanding of the issues as a whole, they do not lead us many steps further along the path toward a new order.

Madelyn Iris, *Scholar-in-Residence for the Study of Ethics, Values, and the Meaning of Aging, The Park Ridge Center, and Associate Director, The Buehler Center on Aging, Northwestern University, Chicago, Illinois*

In this issue: Nurses and Euthanasia—A Closer Look at the Asch Survey

(BOOKS *continued*)

Suffering in the first person

Suffering, ed. Betty Rolling Ferrell (Sudbury, Mass.: Jones and Bartlett, 1996), 238 pp.

Ferrell's book is a welcome addition to the growing body of clinical, psychological, and theological reflection on the nature of human suffering in the clinical setting.

Its central strength is its constant recognition that suffering happens to people. Therefore, the only adequate response is a personal one. That is, when we encounter suffering, we encounter first and foremost a person who is suffering. Not surprisingly, then, this volume takes a decidedly holistic approach to understanding the elusive phenomenon of suffering and to designing ways to "manage" it.

A critical, though certainly not novel, premise for this approach is the recognition that, although pain is one of the most likely causes of suffering, the two are not to be confused. People in pain are not necessarily suffering; similarly, people suffering are not necessarily in pain. Any clinician who overlooks this fact might assume that, having

brought a person's pain under control, he or she has dealt with whatever suffering might exist.

A less-noticed consequence of this important distinction, however, is that, given the close connection between pain and suffering, if we do not treat pain properly, then inevitably we permit a high incidence of suffering in vulnerable patients.

In separate chapters that explore suffering from such perspectives as research, children and their families, the physician as person and professional, the interpersonal role of the nurse, the many faces of suffering are profiled. Another chapter captures, in the words of the sufferers themselves, the almost ineffable poignancy of their experience. Yet another chapter shows how religious faith can respond intellectually, ethically, and experientially to the experience of suffering.

The book closes with a justifiable admonition. "Those who care for persons with cancer and other life-threatening illnesses face erosion of the human spirit no less destructive than a decubitus ulcer, yet perhaps less visible." We are, as a consequence, complicit in a moral outrage when we fail to respond to suffering.

T. Patrick Hill

Research Scholar and Associate Editor of Making the Rounds