

movement as well as both the *Glucksberg* and *Quill* Supreme Court cases, corrects common misrepresentations of two controversial cases in Oregon, drawing on his experience as a clinician at the bedside and in the case of these patients. Barbara Coombs Lee, a nurse and a lawyer and the executive director of the Compassion of Dying. Johannes van Delden, Jaap Visser and Els Borst-Eilers review 20 years' experience in the Netherlands, including three major nationwide studies and an account of the distortion of this data by Hendin and other American authors. Herman van der Kloot Meijburg, former director of bioethics for the Dutch Hospital Association, as already discussed, provides a vivid personal account of his father's death in a country in which active voluntary euthanasia and physician assistance in suicide are legal.

Part 4 of *The Case Against Assisted Suicide* addresses the question, "If assisted suicide is not the answer, how can we improve the care and reduce the suffering of those who are seriously and terminally ill?" (iii). Cicely Saunders, founder of the modern hospice movement, discusses the evolution and development of hospice and its integration into medical practice. The volume editor, Foley, defines palliative care and describes how the major barriers—physician related, patient related, and institutional—that prevent patients and families from receiving appropriate human care at the end of life.

I have used both the *Physician-Assisted Dying* and *The Case Against Assisted Suicide* volumes in introductory ethics

courses in both the sacred (Christian conservative evangelical) and secular university environments and, overwhelmingly, my students found an invaluable resource in this definitive collection of 35 essays from 43 men and women representing diverse backgrounds and stances on the issues of physician-assisted dying, patient choice, and palliative care. As one reviewer of *The Case Against Assisted Suicide* volume aptly noted, detractors of works of this sort might attempt to criticize it for being what it is not. It is not a detailed analysis of the principles and ethics of palliative care and it is not an attempt to present wholly new arguments regarding the case for or against physician-assisted suicide. It is also not a scientific treatise in the form of a logical analysis on whether or not any particular argument presented in either volume lacks deductive or inductive merit.

Having dismissed the allure of the potential these volumes "might have" held but, alas, did not approach, the question once asked still persists: "Could assembling points of contention as a point-counterpoint collection of essays serve any good intention?" My students who resiliently continue to enjoy the books in ways that still surprise me would offer a resounding, "Yes!" Their ongoing interest makes the case for the obvious ability of these volumes to offer necessary guidance in, to quote Vivian Bearing from the movie *Wit*, "overcoming the seemingly insuperable barriers separating life, death and eternal life" without sacrificing their fear of such a task to "hysterical punctuation."

Review of Ian Dowbiggin, *A Concise History of Euthanasia: Life, Death, God, and Medicine*¹ and Neal Nicol and Harry Wylie, *Between the Dying and the Dead: Dr. Jack Kevorkian's Life and the Battle to Legalize Euthanasia*²

Reviewed by Sandra Woien, Arizona State University

Euthanasia and physician-assisted suicide raise a myriad of ethical issues. While these two books explore some of the cultural and historical controversies of euthanasia and physician-assisted suicide, the books fail to unpack the ethical issues and thereby fail to advance ethical inquiry. Their

strengths lie elsewhere. Both these books deal with their subjects in chronological order, and illustrate that the opposition to such practices usually stems from certain metaphysical and religious worldviews, but their similarities end there.

1. Lanham, MD: Rowman & Littlefield Publishers, 2005. 163 pp. \$22.95, hardcover.

2. Madison, WI: The University of Wisconsin Press, 2006. 273 pp. \$27.95, hardcover.

The authorized autobiography of Dr. Jack Kevorkian, *Between the Dying and the Dead*, was written by Kevorkian's friends Nicole and Wylie, and is timely with Kevorkian's recent release from prison after eight years. It is written for a wide readership, and is recommended for anyone who wants to know more about Kevorkian's life. The book reveals illuminating and interesting personal facts about its subject. Kevorkian, known as Murad to his mother, as Joe to his father, and as Jack to others, was the son of Armenian refugees who immigrated to the United States to escape the Armenian genocide in Turkey. His family's background engendered in Kevorkian an early skepticism of authority. Moreover, when Kevorkian was a young man, his mother, Satenig, was diagnosed with abdominal cancer. The prognosis was grim as the cancer had spread to her bones. Motivated to assuage their mother's pain, Kevorkian and his sisters tried to persuade the physicians to increase the amount of morphine. Yet, their efforts were futile. Watching his mother die in pain impacted the young Kevorkian, and undoubtedly motivated him later to help others end their lives. The book also portrays Kevorkian as a man with diverse and sometimes peculiar tastes. Kevorkian is an artist: he plays the flute, he is interested in classical music, he produced a movie and he creates paintings. He also has a penchant for white bread and for burnt food.

The book also discusses Kevorkian's research interests, which some readers may find fascinating. As a resident, Kevorkian was given the nickname 'Dr. Death' that stuck with him throughout his career. While some may think this moniker came from his activities of assisting others to end their lives, this moniker initially came from his researching the contraction and dilation of the retina of near death patients. His research interests also included transfusing blood from cadavers and instituting certain monetary incentives to relieve the organ shortage. As one could imagine, his research interests were never supported by established medicine, which kept him on its fringes.

The media portrayals of Kevorkian, in his later years, often show him as acting independently. Yet, the authors reveal that Kevorkian had assistance in carrying out physician-assisted suicide. Margo, his older sister, acted as a liaison between Kevorkian and his patients; she often screened the requests for physician-assisted suicide, comforted both the patients and their families, and videotaped the procedure. She was also instrumental in initiating the relationship between Kevorkian and Geoffrey Fieger, who represented Kevorkian successfully in many trials. Later, Janet Good filled Margo's role, and one of the authors of the book, Neal Nicole, also assisted Kevorkian. When Kevorkian thought it might be helpful for his patients' family members to meet, his assistants hosted a dinner, and a support group, called 'the survivors' was formed.

The book ends with Kevorkian's last trial. The authors reveal the grave mistake Kevorkian made when—estranged from Fieger—he decided to represent himself in court. This mistake, along with others such as his con-

frontational approach and his failure to follow his own standards for assessing decisional capacity, led not only to widespread criticism of his methods, but also to his being sentenced to ten to 25 years in the Michigan prison system.

Dowbiggin's aptly titled book, *A Concise History of Euthanasia*, is an historical account of euthanasia in Western civilizations, and many monumental historical events and players warrant only a couple of succinct pages. The book contains some interesting historical facts. For instance, from its discussion of suicide in the 1700s, the reader learns that bodies of those who committed suicide were dragged through the streets, that stakes were driven through the cadavers' hearts, and that the suicide's property was confiscated. The book also introduces some issues that may be new to readers, such as the recent case of George Exoo, who assisted in the suicide of Rosemary Toole-Gilhooley; as a result, Ireland is seeking his extradition. The author also cogently shows that public opinions about euthanasia are influenced by religious and other prevalent social beliefs, and reveals the long-standing clash between religious and secular ideologies.

Yet, from the beginning, the reader gets the idea that the historical account portrayed in this book is coming from a somewhat biased perspective. Starting in the introduction, Dowbiggin makes the conceptual and practical connection between euthanasia and eugenics. The reader is pummeled with this thesis throughout the book, from the opening discussions of the Romans, through the Nazis, to the end with ethicist Peter Singer. Dowbiggin tries to demonstrate that deviations from common Christian morality lead to both eugenics and euthanasia. While he accepts this as a conceptual truth, the connection appears to be more a matter of contingency than of necessity as the example of Kevorkian demonstrates.

Dowbiggin conflates many important ethical, conceptual and practical distinctions into one. The introduction casts the debate over euthanasia as two-sided; on one side, we have the argument for beneficence, and the other side we have the argument for personal autonomy, human rights, and other considerations. Yet throughout the book, both types of ethical justifications are conflated while the connection between eugenics and euthanasia is overemphasized. Furthermore, Dowbiggin accepts a broad definition of euthanasia; for him, the term *euthanasia* includes active and passive euthanasia, voluntary and nonvoluntary euthanasia, and physician-assisted suicide. As he writes in the introduction, "History demonstrates that euthanasia has meant different things to people at different times throughout the past" (2). Dowbiggin tries to capture all the different conceptions of the term, but at the same time, muddies important conceptual and practical distinctions. For instance, the conceptualization of withdrawal or refusal of certain treatments as euthanasia distorts not only conceptual distinctions but also historical facts. In discussing the address of Pope Pius XII in 1957, in which he made the distinction between ordinary and extraordinary treatments, Dowbiggin

writes, “for millions around the world, his comments redefined euthanasia as a process whereby it was morally permissible to withhold unwanted, unnecessary treatment” (116). Surely, Pius’s intention was not to redefine euthanasia, nor to my knowledge, has the Catholic Church ever supported euthanasia; rather, his intention was surely to show that withdrawing or refusing extraordinary care was *not* euthanasia.

In summary, both books fill certain niches. The Nicole and Wylie book is invaluable to anyone who wants to know

more about Kevorkian’s personal history, and as long as the reader is aware of its limitations, Dowbiggin’s book may be useful in understanding the historical context of euthanasia. The authors come to opposite conclusions about the role of religion in medicine. Kevorkian insists that medicine and religion should be kept separate, while Dowbiggin tries to show that any time medicine is divorced from religion, euthanasia and eugenics result. Nonetheless, both books agree that the debate over euthanasia and physician-assisted suicide is not yet over. ■

Review of David H. Brendel, *Healing Psychiatry—Bridging the Science/Humanism Divide*¹

Reviewed by Nada Gligorov, CUNY Graduate Center and Mount Sinai School of Medicine

In *Healing Psychiatry—Bridging the Science/Humanism Divide*, David H. Brendel promises to bridge the science/humanism divide in psychiatry in both theory and practice. The divide is between psychiatrists who attempt to cure mental illness by relying on pharmacology and neuroscience, and psychiatrists who rely on more humanistic approaches. The divide is a result of distinct theoretical views on the nature of human psychology. On one side, there are physicians who endorse reductive materialism, and believe that all psychological states are reducible to brain states. On the other side, humanistic physicians separate psychology from brain states and endorse the view that psychological states cannot be entirely explained with advances in natural science. Each psychiatrist is forced to choose between the two approaches.

Brendel explains the contrast between the two approaches to psychology as follows: “The major conceptual divide that now confronts psychiatry is between a respect for human complexity (which we can attempt to describe but cannot fully systematize) and the commitments of the behavioral sciences (which aim to categorize, explain, and predict human behavior empirically)” (9). He goes on to explain that the appeal of the reductive approach is obvious because psychiatry is continuous with medical science, which is committed to rigorous scientific explanation and prediction. Reductivism is also necessary for the idea of consilience in which all the natural sciences would ultimately be subsumed into a unitary groundwork of knowledge. As a result of this view the social sciences, such as

sociology, psychology, economic and others, would eventually be incorporated into the natural sciences. Thus, mental states would become part of this unitary system through their reduction to brain states. Brendel points out that both approaches, psychopharmacological as well as humanistic, have therapeutic benefits. As a result, in chapter two Brendel proposes that the best way to treat patients is to blend both approaches. He suggests pragmatism as the solution because it focuses on the treatment that best works for the patient.

Brendel holds that pragmatism impacts psychiatry in four ways, which he calls the four *p*’s of pragmatism. The first *p* is that the psychiatrist should be committed to *practical explanations*, which are true if they promote beneficial results for the patient. In this way, pragmatism is neutral in its theoretical commitments to either reductivism or humanism. The second *p* is the commitment to *pluralism*: the psychiatrist must “retain a multiplicity of clinically useful explanatory models” incorporating methods from both science and humanism. The third *p* emphasizes the importance of the *patient participation* in the treatment plan. The fourth *p* underscores the idea that all psychiatric treatment is *provisional*. The psychiatrist should remain open-minded and accept the idea that new treatments may become available.

In the third chapter, Brendel describes cases in which he adopts the pragmatic approach in treatment. In one of the cases, Brendel treats the patient by prescribing antidepressants and by scheduling sessions that explore the patient’s

1. Cambridge, MA: MIT Press, 2006. 178 pp. \$26.00, hardcover.

Copyright of *American Journal of Bioethics* is the property of Routledge and its content may not be copied or emailed to multiple sites or posted to a listserv without the copyright holder's express written permission. However, users may print, download, or email articles for individual use.