Book reviews

The virtues in medical practice

Edmund D Pellegrino and David C Thomasma, Oxford, Oxford University Press, 1993, 205 pages, £25.00

The book arises out of the authors' strong conviction that virtue is an irreducible element in medical ethics because of the special relationship between the doctor and the patient. The essence of this relationship lies in the doctor's commitment to curing, and caring for, the patient, which constitutes the very goal of medicine.

The authors argue that what they refer to as 'principle-based ethics', although valuable, does not take sufficient account of the moral character of the agent so that 'virtue ethics' is needed to supplement and enrich it. The character of the doctor is vitally important in medical practice since possessing virtue influences his or her moral deliberation. To a 'virtuous' person certain options in moral choices are simply ruled out. The largest part of the book is an examination of the virtues that, the authors maintain, a doctor should possess: fidelity to trust, compassion, prudence, justice, temperance, integrity and self-effacement.

To what extent do doctors today possess these virtues? The authors' answer (which is based mainly on their appraisal of American experience) is rather alarmist. They talk about 'the moral malaise of the professions' or the 'erosion of virtue'. One wonders to what extent they are right in stating that 'The medical profession today is afflicted by a siege mentality' (page 39), where the attacking hostile forces are mainly economic self-interest and competitiveness, which turn physicians into businessmen and entrepreneurs and often lead to morally questionable practices that compromise the good of the patients.

'Never has there been more confusion about who and what it is to be a physician' (page 154), the authors conclude.

The main message of the book is its call for the resuscitation of virtue and the restoration of the moral force of the medical community. 'Despite significant evidence of the breakdown of Western civilization, sufficient pockets of decency still remain to encourage us to promote the ideals of virtue' (page 115). Those ideals will be promoted if there is more emphasis on the moral (as distinct from purely technical) education of health care professionals. In reference to a famous ancient debate about whether virtue can be taught, the authors argue that it can and ought to be taught. This is best done by the example that a 'virtuous' physician provides to those around him. But teaching ethics as a separate subject is also essential and the authors are strongly in favour of making ethics a regular part of the curriculum in medical schools.

'Virtuous' physicians – the authors believe – will oppose cheating, neglect, dishonesty, and scientific fraud. 'They will refuse to "dump" the patient who cannot pay; they will refuse to discharge the patient before he is ready; they will refuse to act as society's fiscal agent; they will refuse to be seduced by the profits of investments and ownership of health facilities or bonuses for denying or delaying needed care ...' (page 157). They will exclude from their community those who violate the principles of professional morality.

But will they know what stand to take on such complex issues as euthanasia, abortion or the new reproductive techniques? Here the authors emphasize that 'virtue ethics' does not tell us how to resolve specific moral dilemmas. Its main aim is to increase moral sensitivity and responsibility or, as they might like to say, to enlarge 'pockets of decency'.

JOANNA PASEK
Centre for Social and Economic Research into the Global Environment,
University College,
London

The troubled dream of life: living with mortality

Daniel Callahan, New York, Simon and Schuster, 1993, 255 pages, $21.00

'"The patients would see that the doctor gave them up", a Confederate [field hospital] steward recalled [after the American Civil War], "and would ask me about it. I would tell them the truth. I told one man that and he asked 'How long?' I said 'Not over twenty minutes'. He did not show any fear. They never do. He put his hand up so and closed his eyes with his own fingers and he stretched himself out and crossed his arms over his breast. 'Now fix me', he said. I pinned the toes of his stockings together. That was the way we lay corpses out, and he died in a few minutes. His face looked as pleasant as if he was asleep. And many is the time the boys have fixed themselves that way before they died".'

Daniel Callahan's *The Troubled Dream of Life* asks how have we come to lose that 'tameness' in death, as Philippe Aries termed it, and whether we have been disappointed in our efforts to substitute more modern forms of control over our way of dying, such as advance directives. '[We] chose "choice" about death ... as the new, supposedly liberating focus. That was, at the time, a perfectly reasonable response. Many people were in fact being denied a right to have treatment terminated, and a corrective was needed.'

But recent large-scale research such as the SUPPORT project, run at

Dartmouth Medical School by Joanne Lynd and Joan Teno, has suggested that widespread use of advance directives, in the wake of the Patient Self-Determination Act, has had little effect on patient satisfaction or clinical practice. The only statistically significant difference found so far is that advance directives are more likely to be recorded in patient notes. And fewer than fifteen per cent of Americans have signed advance directives. Many physicians actually find it more difficult to stop prolonged treatment than they did twenty years ago, despite the advent of advance directives. Doctors have more options and may fear malpractice suits if they fail to make full use of available technologies – or they may simply be uncertain about when to invoke the advance directive. When is the patient with a chronic disease actually *dying*?

Callahan is adamant about the need for legal procedures to curb long drawn-out deaths at the mercy of interventionist technology. But he urges us not to stop there. 'The old question was: when is a patient dying, and thus a candidate for the abatement of lifesaving treatment? The new question should be: at what point, or within what range, should lifesaving treatment be abated to enhance the likelihood of a good death?'

As in his controversial *Setting Limits*, which put forward some unpopular propositions about rationing health care for the elderly, Callahan's calm style masks what is a radical proposition in the American context, although perhaps not in the British hospice movement. This is that the correct aim of care for the terminally ill should be to ensure a positively 'good death', not merely to avoid a bad one. Medicine needs to work *backward* from the ideal of death at the right time and right circumstances, rather than in its characteristic forward-only mode towards cure. 'Active treatment to cure disease and prevent death would stop well *short* of its technical possibilities, at the point where a peaceful death could be most assured and best managed. The worry that a patient might die *sooner* than technologically necessary would be effectively balanced by anxiety that a patient might die *later* than was compatible with a peaceful death.'

This is what the patient needs, Callahan argues; what the physician needs is a corresponding lightening of obligation. Withdrawing care does not equate to killing the patient, because it

is 'the inexorable forces of nature' which kill. To think otherwise is to fall victim to '"technological monism": 'the tendency to erase the difference between human action as a cause of what happens in the world, and independent, natural biological processes, those old-fashioned causes of disease and death. It is nothing less than an ingenious way of blaming the victim, as if death itself were now our fault, the result of human choices, not the independent workings of nature.'

A *caveat* is in order here. Unlike some of the more starry-eyed 'natural death' advocates, Callahan is careful not to romanticise old ways of dying. 'Death is not, and should not become, a glorious event to be sought and embraced. It is an evil. It ruptures the solidarity of the human community. It forces the dying person out of the lives of those around her, a loss both to her and to others. The source of the evil is the "savagery of nature", a nature to be accepted but not romanticized.' Nor can we ever recapture whatever it was that allowed the Confederate soldier to die so well. Reviving defunct rituals is a sort of *mauvaise foi.* 'Since no one else can give us, as if it were our own, a meaning to our dying and death, we must find that for ourselves; some of us will never find it.'

Whether death *is* bad, let alone evil, may be a matter for scepticism. In the ancients' view, the final nothingness was neutral. But these passages demonstrate the enticing combination of fervour and sensitivity which pervades the whole of *The Troubled Dream of Life.* Avoiding portentousness and pretentiousness, Callahan writes for the lay person, assuming no philosophical knowledge and little clinical background. Yet in a field which invites home-spun philosophising and high-flown cliché, his thought and prose remain beautifully spare and clean.

Callahan's sensitive and careful analysis is most apposite to rights-minded American society, where technology gallops ahead and the establishment of hospices proceeds in more tortoise-like fashion. There is a risk that UK readers may seize on Callahan's second thoughts about choice and control for dying people as evidence that the Americans have finally seen the error of their litigious ways. Such complacency would be small-minded and misguided. Callahan's wise book could enable this country to achieve a compromise which is something other than fudge.

DONNA DICKENSON
Senior Lecturer,
Department of Health and Social
Welfare,
The Open University,
Milton Keynes

Living with AIDS: experiencing ethical problems

This book is based on the author's doctoral study in which she interviewed people with AIDS and their significant others. In most of it, with sections for each of the major ethical issues, she sets out verbatim the views of these very diverse people, with a few context-setting comments. She concludes each section with her own comments and analysis. The book is framed by chapters setting out her approach to ethics and the problems raised by AIDS. A particularly thoughtful section outlines the ethical dilemmas she herself faced and resolved during the course of the work.

The author somewhat self-consciously sets out her stall for an approach based in descriptive ethics, contrasting this with other more familiar and perhaps more detached systems. The issues covered in the various chapters include substance misuse, chronic disease, death, discrimination, money, health care, personhood, relationships and sexuality. The book is lightly peppered with some rather distracting and generally unhelpful figures, either comprising histograms showing the variety of her subjects or some curious diagrams, laden with words, to illustrate ethical issues in a structural way.

Despite the familiarity of the issues, the voices of those affected come through very strongly in a way that ensures that the book's approach to ethics is deeply rooted in the real world of ordinary, and at the same time extraordinary, people. The author's commentaries at the end of each chapter are rather variable: they mingle some very insightful comments with some surprisingly banal interpretations and trite, sometimes frankly unrealistic, solutions. Perhaps she should have had more confidence in the ability of the voices to convey the problems and the difficulty of

The troubled dream of life: living with mortality

Donna Dickenson

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