

Book Reviews

medicine more meritorious, but may account for some otherwise surprising lapses. For example he sees Erasistratos as a stepping stone in a harmonious tradition from Hippocrates to Galen, not as the founder of a theory that Galen constantly attacked. This is a view that could hardly be taken by anyone who had read much Galen for himself. Another stumbling point is the theory of vision. He has strange remarks on “eye-spirit” and he omits some of the more ingenious ancient arguments for sight being an active process. In fact the “old medicine” (as William Harvey called it) is often more plausible than the book makes out. Hoeniger describes what people used to think very well, but is less successful at explaining why they thought it and why they were content with their orthodoxies.

One final criticism. The modern authorities cited on ancient medicine are often out of date and many eminent living scholars are not referred to at all. Consequently some matters are dealt with inadequately. Furthermore the book’s value for reference purposes is reduced. This is a pity. Nevertheless, Hoeniger’s is the most comprehensive and generally useful book that exists on the subject, and for this he deserves congratulations, not complaints.

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ALBERT R. JONSEN, *The new medicine and the old ethics*, Cambridge, Mass., and London, Harvard University Press, 1990, pp. xv, 171, £15.25 (0-674-61725-8).

Jonsen’s title is inspired by Sir William Osler’s 1919 lecture to the British Classical Association, ‘The old humanities and the new science’. Osler championed the new medical sciences in a curriculum dominated by traditional humanities, Jonsen’s 1988 Harvard Medical School Gay lectures champion the humanities (history and philosophy of medicine, medical ethics) in a medical curriculum dominated by science. The title also encapsulates Jonsen’s central theme: that new medical technology exacerbates pre-existing tensions in five “old” medical ethics: a Hippocratic ethic of beneficence, a Samaritan ethic of charity, a Lockean ethic of property right, a Percivalean ethic of *noblesse oblige*, and a Cabotean ethic of competence.

Jonsen calls his approach to history *aggadah*: “a magical rabbinic mode of thought in which myth, theology, poetry, and superstition robustly mingle” (p. 4). A description with deeper historiographic roots would be “monumentalist”. The coinage is Nietzsche’s and characterizes historians, like Jonsen, who believe that “History . . . gives moral meaning to the past; [and] moral confidence in the future . . .” (p. 157). Some might blanche at finding meaning in history; not Nietzsche—who disdained “scientific” history as a degenerate form of “critical” history and extolled monumentalism. Jonsen’s lectures are a testament to the virtues of monumentalism; e.g., his use of Locke’s labour theory of property to analyse physicians’ proprietary claims on diseases—often asserted by those ignoring the persons whose bodies lodge the diseases (p. 93).

Nietzsche warned that “whenever the monumental vision of the past *rules* . . . the past itself suffers *damage*: . . . great . . . portions . . . are forgotten and despised . . . and only single embellished facts stand out as islands. . . .”¹ Consider Jonsen’s claim that bioethics arose in the 1960s as a consequence of the “Scribner Shunt” which, by making kidney dialysis practical, generated a demand for hemodialysis that swamped the supply of dialyzers. Unfortunately, “No . . . reflection on . . . Hippocratic, Samaritanian, and Cabotean ethics could [resolve the dilemma, forcing experiments like the] Seattle [Patient Selection] Committee. . . [which] did its best without formal principles” (p. 46). Physicians confronted with the bankruptcy of their old ethics turned to “philosophers, theologians and lawyers” in search of “better” solutions—and so bioethics was born.

This version of the past “forgets” and “embellish[es]” by taking the Seattle Committee as paradigmatic. Of the 120 U.S. dialysis centres operating in the mid-1960s, only 8 followed Seattle’s example and allowed lay persons to participate in patient selection. The other 192 committees were staffed by health care professionals and selected patients according to

¹Friedrich Nietzsche, *On the advantage and disadvantage of history for life*, transl. Peter Preuss, Indianapolis, Hackett Publishing Co., 1980, p. 15.

Book Reviews

traditional medical criteria of triage. Seattle appears to have been the *only* patient selection committee to evaluate prospective patients explicitly in terms of a utilitarian standard of “social worth”; it was the only committee to have become embroiled in public controversy.² Thus the moral of the early dialysis crisis would seem to be that health professionals selecting patients according to an “old” medical principle, triage, were able to allocate scarce resources with few problems, while committees on which lay members introduced non-medical selection criteria, like “social worth”, became embroiled in controversy. It is only by forgetting about the 192 non-controversial committees, and about lay participation on the Seattle Committee, that Jonsen can tell his tale of the failure of “old” medical ethics and the concomitant search for a new bioethic.

To vex Jonsen with facts, however, is to commit what philosophers call a “category mistake”. Johnson is not aiming at academic history but *aggadah*. He isolates, juxtaposes, and embellishes to illuminate, to reveal, to inspire—and he does so brilliantly.

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DAVID J. ROTHMAN, *Strangers at the bedside: a history of how law and bioethics transformed medical decisionmaking*, New York, Basic Books, 1991, pp. xi, 303, \$24.95 (0-465-08209-2).

David Rothman, author of the *Discovery of the asylum*, has written the first social history of the bioethical revolution: how it came about that “outsiders, not doctors, defined the moral codes that were to guide physician behavior” (p. 4). The revolution was precipitated, during and after World War II, by the extensive governmental funding of hospital-based research, and the increasing social distance between hospital-based physicians and their patients. The first conflated the physician-patient with the science-subject relationship, the second tempted some physician-scientists to advance science (and their careers) by treating patients as subjects (generating scandals at Sloan-Kettering, the U.S. Public Health Service, Willowbrook and elsewhere).

Coincidentally, new medical technologies attracted public attention to the problem of excess demand for heart and, especially, kidney transplants. Traditional medical ethics offered few answers to the problem of allocating scarce organs. So, to buffer external criticism, the medical community set up lay allocation committees—and in the process, allowed outsiders into medicine. A similar buffering process occurred in medical research, where review committees (known as IRBs) were set up to protect “patients” rights in the aftermath of scandals. Allowing select professional outsiders, the bioethicists (lawyers, philosophers, and theologians concerned with medical ethics), to serve on oversight committees was thus the price the medical profession willingly paid to secure public and government financing, while shielding its practices from more pervasive public and particularly political scrutiny.

Rothman’s focus is on persons and events. Thus “change”, that is the bioethical revolution, “began with a whistle-blower and a scandal” (p. 15). The scandal, using patients as unconsenting guinea pigs; the whistle-blower, Harvard anaesthesiologist, Henry Beecher—whose 1966 *New England Journal of Medicine* article described twenty-two cases of published research in which human subjects were abused. Why did Beecher “blow the whistle”? Rothman emphasizes Beecher’s fear that “bad ethics would undercut the pursuit of good science” (p. 72). He barely mentions the world-wide debate over codes of experimentation engendered by the 1949 Nuremberg trial of Nazi physicians and the subsequent 1954 and 1964 codes of the World Medical Association—or Beecher’s adamant opposition to the 1963 Harvard regulations on research.

²A. H. Katz, and D. M. Proctor, *Social-psychological characteristics of patients receiving hemodialysis treatment for chronic renal failure*, Public Health Service, Kidney Disease Program, Washington D. C., July 1969; quoted in Renee Fox and Judith Swazey, *The courage to fail: a social view of organ transplants and dialysis*, 2nd ed., University of Chicago Press, 1978, p. 228 ff.