

markets with the imperfect one of applying antidiscrimination principles in a high-cost legal system. Because labor markets are structured in ways that leave certain groups particularly vulnerable to exploitation, it would be valuable in a legally ideal world to have general rules that would apply clearly and efficiently to employers. The question becomes: Are the imperfections in the enforcement of antidiscrimination principles so profound and costly that we should forego the effort entirely?

Some economists argue that antidiscrimination laws are economically efficient because they hasten the elimination of irrational (and wasteful) discrimination from the economic system. While there is merit to this line of argument, I think it is unlikely that scholars can produce a definitive cost-benefit analysis. We cannot readily calculate the emotional cost to victims of invidious discrimination or

the cost of further racial polarization in our society that might result from abandoning antidiscrimination principles.

Epstein is most certainly right in arguing that once a society articulates antidiscrimination principles and attempts to give the principles legal effect, its legal system will face many difficult questions of values and implementation. In an adversarial legal system such as ours, the effort is costly and imperfect. The collective judgment of voters, political leaders, and the courts remains that the costs and complexities posed by laws against discrimination are worth it. The empirical evidence, although far from conclusive, tends to support the wisdom of this judgment. In his zeal to unseat conventional wisdom, Epstein stubbornly seeks to make the existing data fit his theory. Most sociologists and economists will find his vision of labor markets badly distorted.

Is Bioethics Irrelevant?

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Traditional bioethics, at least according to the latest sociological research in medical settings, is rapidly becoming irrelevant. As developed over the past thirty-five years or so by philosophers and theologians,

bioethics is dominated by an image of an individual autonomous moral agent who reaches decisions apart from social constraints. This model portrays physicians as able to contemplate complex problems free from competing demands on their time, untroubled by patients with perplexing prognoses, and unconcerned with the threat of medical malpractice suits, legal reprisals, and consequences to their own careers. (Anspach, p. 35)

In this scenario, the physician stood facing difficult dilemmas with which he (typically "he") struggled, alone in the pure air of his own conscience. Medical ethics as a philosophical discipline came to his aid, first by clarifying certain principles on which he should act (e.g., beneficence, nonmaleficence, patient autonomy, etc.) and second by providing examples of how logically to deduce solutions to dilemmas from these

Deciding Who Lives: Fateful Choices in the Intensive-Care Nursery, by **Renee R. Anspach**. Berkeley: University of California Press, 1993. 303 pp. \$25.00 cloth. ISBN: 0-520-05268-4.

All God's Mistakes: Genetic Counseling in a Pediatric Hospital, by **Charles L. Bosk**. Chicago: University of Chicago Press, 1992. 195 pp. \$24.95 cloth. ISBN: 0-226-06681-9.

Healing Powers: Alternative Medicine, Spiritual Communities, and the State, by **Fred M. Frohock**. Chicago: University of Chicago Press, 1992. 340 pp. \$29.95 cloth. ISBN: 0-226-26584-6.

principles. Of course, as lawyers, ethicists, legislatures, and families have entered the decision-making process and become, in David Rothman's (1991) term, "strangers at the bedside," the old model has become less and less realistic. Individual dilemmas have ballooned into political and legal controversies; the lone practitioner has been absorbed into the large and amorphous "health care team"; and the logical derivation of answers from principles (if it ever occurred) has

certainly given way to a mélange of standard operating procedures, stopgap measures, and tortuous political compromises. When clear-cut decisions are made, it is often unclear by whom, and when they are carried out, it will likely be by women, often nurses, certainly not by the lone male physician. The traditional model, which Renee Anspach so neatly characterizes near the beginning of her book, may once have approximated reality. But with the changes in medicine of the past twenty years, it has been reduced to an academic fantasy, now often officially appended to the margins of the modern medical center in the form of the "ethics review committee." Unfortunately, as a model of reality, it doesn't work.

Enter social science. While medical ethics was steadily establishing itself within the public world of health-care debate and practice, sociologists were slowly but consistently building an alternative model of medical decision making. The three books reviewed here are in this latter tradition, Bosk's most explicitly. His earlier *Forgive and Remember* (1979) is a standard in the social science literature on bioethics. The social science tradition proposes an alternative model for morality and medicine, one explicitly contradictory to the older philosophical one.

The new model differs from the old in at least four major tenets:

(1) *Decisions are made collectively, not individually.* "As I began to study life-and-death decisions [in neonatal intensive care units]," says Anspach, "it became apparent to me that the analyses ethicists provided were insufficient for studying life-and-death decisions. Whether deontological, utilitarian, or contractarian, bioethics assumes that actors reach decisions alone, apart from institutional constraints . . . [however] life-and-death decisions are not private matters, but rather take place in the context of organizations, institutions, and power relationships" (Anspach, p. 165). Both Anspach's and Bosk's books detail the organizational nature of medical work, and in a close analysis of two difficult ethics cases (involving infants with potential genetic abnormalities), Bosk notes that "no single physician claim[ed] decision-making authority in either case. Health care in America is not yet socialized; yet it certainly seems that, at least in this hospital, responsi-

bility for patients has been. . . . [It is] confusing who is in charge" (p. 103). Too, "staffing patterns . . . encourage collective responsibility" (p. 103). Individual responsibility is all but gone.

(2) *Ethical problems are caused by social structures, not cognitive errors.* Traditional bioethics, with its individualistic focus, seems to assume that ethical problems may result from inadequate reasoning. So, for Anspach, bioethics "seeks solutions in disciplined reflection rather than in changes in the social milieu" (p. 176). This style of reformism, popular among progressive physicians, leads to calls for mandatory ethics courses in medical school or "ethics rounds" in medical centers, but it doesn't touch the organizational structures in which residents routinely work thirty-six-hour shifts, rotate off services every four weeks, and may spend only five minutes a day with each patient. Bioethics, then, tends to practice a philosophical idealism in which the big problems are just that people think in the wrong way. A sociological approach, of course, rejects that.

(3) *Research should be inductive (empirical) rather than deductive (logical).* Bosk's *Forgive and Remember* was a pioneering work in the empirical study of medical decision making. In *All God's Mistakes*, he reprises the technique of close study of relatively few cases. Anspach's research is more comprehensive but remains firmly rooted in real cases. Even Frohock—whose book is rather an effort to show why liberal legal thinking cannot handle cases of alternative healing practices—provides some case studies which make the same general point: rather than look at what should be done, researchers should focus on what is done.

(4) *Solutions should be less idealistic and more realistic.* While philosophers may say, "Here's the right thing to do," one mustn't stop there. Too often, the morally "right" decision is nearly impossible to carry out, for pragmatic reasons. Nurses often feel that their major ethical problems in nursing lie not in discovering the right action to take but in gaining the cooperation or permission of others to take it. Even once we admit that ethics has its place, the major pragmatic issues of getting things done in the hospital remain serious ones.

In some measure, all three books reviewed here fall within the new paradigm. All

emphasize the social context of decisions, all are empirically based, all are somewhat critical both of conventional medicine and of conventional bioethics, all point to structural solutions to ethical problems. All, too, contribute to the growing body of empirical findings on medical ethics:

For dangerously ill newborns, it seems that the more responsible one will be for the child's care, the less likely one is to favor aggressive treatment and life-prolonging therapies. Research which supports this conclusion has been noted in earlier works such as Robert Zussman's *Intensive Care* (1992), in which nurses who care for chronically ill infants seem readier to withdraw treatment than the physicians, who spend less time in the unit. In Anspach's work, we see the same pattern. In addition, mothers—the likely care takers for a deformed infant—are less likely than fathers to favor aggressive surgery to save a life. Differences in structural location among participants have implications for ethical choices.

In major medical centers, “informed consent” represents at best a polite fiction. Bosk finds that physicians acting as genetic counselors present even the most obviously “scientific” information in ways that subtly shape parents’ decisions. Anspach outlines the process in which “only *after* the staff have reached a consensual decision to terminate life support or withhold treatment are the parents consulted. . . . The parents’ consent is not required to *continue* treating a baby” (Anspach, p. 92). Staff members decide when, and to what, parents or patients may “consent.”

Staff and outsiders (patients and their families) inhabit different worlds, with radically different visions of reality. This is the central message of Frohock's book, in which he explores the different—and basically incompatible—worldviews of religious healers, leukemia patients, and physicians, among others. Bosk describes the gap between the scientific world of the physicians, with statistical probabilities and survival rates, and the “family living” dreams of parents, for whom a damaged child is a total tragedy. Anspach's argument is still more nuanced, as she details (for instance) how the use of “folk psychology” among staff re-creates the separation, making parents and others into quasi-patients incapable of making their own

decisions: “Psychologizing allows professionals to *neutralize* dissent—that is, to preserve their own worldviews—while faulting or discounting parental judgments” (Anspach, p. 148). The miracle is that staff and outsiders, so separated, ever agree on decisions.

Substantive findings like these are only half the subject of these books. The other is the difficulties of doing fieldwork in medical settings. To become a hospital insider, doctors and nurses must routinize the terrible events which occur there and provisionally treat suffering and death as normal parts of everyday life. But sociologists are not permitted such a defense, and they pay for it. For Bosk especially, parent of a child born during his research, the anguish was especially trying: “I was not comfortable listening to the details of [parents'] pain. When the study began, I did not have children; I was deaf to the meaning of the parents' stories. When I became a parent, I tuned out the parents. It was simply too terrifying for me” (p. 169). Indeed, this kind of trouble, and Bosk's more general dismay over the ethics of doing ethnographic research in morally challenging settings, really are the heart of his book, more than his substantive findings on genetic counseling. Bosk sometimes excused himself from his research on these grounds, skipping conferences, for example, to preserve his emotional well-being. Anspach (perhaps being newer to the field?) was more consistent in her work, and her appendix on fieldwork, a model for doing conscientious fieldwork, closes with the considered warning that “all field researchers make decisions guided not only by canons of methodological adequacy but by considerations of politics, pragmatism, ethics and etiquette” (p. 217).

In making an argument for the social science paradigm in bioethics, Anspach's work is first-rate: coherent in its presentation, well organized and flawlessly written, clear in its details yet broad in conception. Her earlier work, for instance an article on language patterns in medical case presentation, was far narrower in scope than this book. In *Deciding Who Lives*, she speaks to the larger issues of decision making and health policy, of organizational structure and moral life, and she emerges as one of the finest theoretically ambitious field-workers in medical sociology

today. Bosk's work, a bit in contrast, all but announces his retirement from ethnographic research. His book is really two books, one on genetic counseling, the other on the personal difficulties of doing ethnography in medical settings. While it certainly contains any number of his usual sharp insights, the tone is decidedly pessimistic, as if to cry out, "Vanity, vanity, all is vanity" in fieldwork. And Bosk himself volunteers that "the new theoretical freight—the real contribution—is modest. . . . There is not much new in this" (pp. 145–46). It's an astonishing confession from a gifted intellectual, and perhaps overwrought. Finally, Frohock's book is a rather disjointed sequence of vignettes, some brilliantly conceived and written, others all but incomprehensible. I even found myself scribbling "huh?" in the margins. Frohock sets out no fewer than three distinct goals for his book in the early pages, and perhaps the lack of coherence follows from his enthusi-

asm to say too much in a single work. Still, his book does contain some wonderful interviews with practitioners of faith healing, and all three books make their distinctive contributions. Slowly but steadily then, a small group of sociologists around the country are doing the groundwork, and with Anspach's book—a bit less functionalist, a bit more critical of medicine than earlier work, certainly more theoretically aggressive, fully resting on empirical research—sociological work on bioethics has truly come of age.

References

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