

Book reviews

The Least Worst Death

Margaret Pabst Battin, New York and Oxford, Oxford University Press, 1994, 305 pages, £30 hb, £14.95 sb.

English speakers have only one word for self-killing: suicide. Germans have four: the traditional terms Selbstmord (self-murder), Selbsttötung (self-killing), the scientific term Suizid and the literary Freitod (free or voluntary death). The first two have negative connotations, the third connotations of mental illness. The last, Freitod, has positive connotations, being admirable and even heroic (page 264). As Battin puts it, "[i]t is associated with voluntary individual choice and the expression of basic, strongly held personal values or ideals, especially those running counter to conventional societal norms, and suggests the triumph of personal integrity in the face of threat or shame" (page 261). The term itself dates from Nietzsche, but the idea goes back to the Storm and Stress movement in German literature, in particular Goethe's *The Sorrows of Young Werther* (page 262). "Freitod itself is conceived of as an individual, intensely personal, and thus characteristically solitary act Nor does the German term suggest that one would be guided in one's decision by professionals or family members. It is an act in which one insists on choosing a different, individual course contrary to ordinary expectations; it is in this sense that it is a 'free' death. This has its advantages: almost by definition, Freitod cannot be socially 'expected', required by policy, advised by counsellors, or in any other way the norm, and hence it may be more resistant to abuse" (page 265). *The Least Worst Death* is about Freitod.

Understanding euthanasia begins with understanding suicide. If that is so, Margaret Pabst Battin is singularly

placed to write on euthanasia. Her book, *Ethical Issues in Suicide*, published in 1982, is a classic. Two chapters from it are included in this collection of 14 essays written between 1977 and 1992. *The Least Worst Death* comprehensively covers this important philosopher's views on suicide and euthanasia. For anyone with an interest in ethical issues at the end of life, this volume is essential reading.

The essays cover a variety of issues surrounding the end of life but several themes weave through the book. First and foremost is the view that a desire to die can be rational. Rational desires are "autonomous, informed, stable, considerate, uncoerced and in accord with [a person's] basic values ...". Irrational desires are "ill-considered, incoherent, unstable, misinformed, rooted in depression, unrealistic" (page 275). In "Assisting in suicide: seventeen questions physicians and mental-health professionals should ask", Battin provides a practical list of questions aimed at examining the rationality of a person's desire to die.

Battin argues that we have a basic, fundamental right to kill ourselves akin to the right to life, liberty, freedom of speech and worship, education, political representation and pursuit of happiness (page 279). These other rights are rights "to do certain things just because doing those things tends to be constitutive of human dignity" (page 280). Sometimes, Battin argues, dignity requires that a person end his life ("Suicide: a Fundamental human right?").

Battin shows more reserved support for active voluntary euthanasia. This support derives from three related considerations ("Euthanasia: the fundamental issues"). Firstly, mercy sometimes requires euthanasia. Some lives, she claims, are racked by unrelievable pain. While such people could be sedated to the point of unconsciousness, this, she argues, is tantamount to causing death.

Secondly, if we are to respect people's autonomy this will sometimes require the practice of euthanasia or assisted suicide. Battin points to the well established right of patients to refuse life-saving treatment, that is, passive voluntary euthanasia. This right is grounded in respect for autonomy. But "full autonomy is not achieved until one can both choose and act upon one's choices" (page 112). In some cases, patients may choose to die by active means but not have the knowledge or access to methods to effect this choice. Respect for autonomy then requires physicians to help patients achieve easy, painless death.

The third argument for a policy of permitting euthanasia is that such euthanasia can promote distributive justice. There is a separate chapter devoted to this theme: "Is there a duty to die? Age rationing and the just distribution of health care". Battin argues for "voluntary but socially encouraged killing or self-killing of the elderly as their infirmities overcome them" (page 76). Some of Battin's predictions appear grim. She sees many services to the infirm elderly being restricted: "CAT scans or MRIs, renal dialysis, organ transplants, hip replacements, hydrotherapy, respiratory support, total parenteral nutrition, individualised physical therapy, vascular grafting, major surgery" (page 64). Even hospitalisation and hospice care might go.

The important premise in Battin's argument is that spending money on the elderly is inefficient. The young benefit more. If patients were allowed to cut short their lives when death became foreseeable due to illness, this would free up considerable resources for more effective deployment at earlier stages of life. This would maximise each person's chance of reaching a ripe old age.

If this is the justification, the practice is not age-rationing at all. It is rationing according to cost-effectiveness. Indeed, Battin rejects a fixed age

limit. Rather, she advocates that resources be restricted as one approaches death. "It is not old age itself which is medically expensive; it is the last month, six months, or year or two of life. Variation in costs and efficacy of treatment are not so much a function of time since birth as time to death" (page 75). This argument requires that care to the young be restricted when that care has little chance of success. Battin, invoking a "veil of ignorance", argues that we would not spend money on severely defective neonates or catastrophically damaged accident victims (page 62). This, however, is a consequentialist argument about maximising benefits, together with the premise that the elderly near death often do not derive much benefit from more medical care. On reflection, it is not so frightening. It is an application of currently employed health economic principles.

A problem-oriented approach

This collection is particularly timely. Battin writes, "[M]any observers are predicting that euthanasia will become the social issue of the next decade" (page 163). While this claim is a little hyperbolic, our practices are changing. In November 1994, citizens in Oregon approved The Oregon Death with Dignity Act which permitted physician-assisted suicide (PAS). This has been subject to a legal challenge. The Northern Territory in Australia has just passed the first legislation in the world legalising active voluntary euthanasia (AVE).

But Battin's work is timely in another way. Battin is not only a good philosopher, she is a practical philosopher. She adopts a problem-oriented approach to bioethics, selecting a specific issue and always attempting to provide circumspect and reasoned solutions. For example, in "Fiction as forecast: euthanasia in Alzheimer's disease:", Battin finds that traditional philosophical approaches (from the perspectives of mercy, autonomy and justice) fail to provide a definitive answer as to whether we should prolong the lives of patients with Alzheimer's. Battin claims that when the stakes are high, sometimes social policy cannot "wait for philosophers to sift through these questions" (page 152). She turns to novel thought experiments to help people to decide now for themselves whether they would want to be treated in such a state. In "The least worst death", the first essay, Battin shows how uninformed refusal of medical treatment

can lead to a painful or undesirable death. She then explores the ways physicians can help patients to choose the best available death by exercising their right to refuse life-sustaining treatments within current law.

Students and many philosophers can learn from Battin's practice of considering the strongest version of her opponent's objections. Foremost in her mind are the slippery slope arguments that permitting euthanasia will lead to abuse. Indeed, in "Voluntary euthanasia and the risks of abuse", she claims that "it is morally responsible to advocate the legalisation of euthanasia and assisted suicide only if one can conscientiously argue either that abuse would not occur or that it could be prevented" (page 165). She offers a range of thoughtful suggestions to prevent interpersonal, professional and institutional abuse.

An interesting and effective strategy employed by Battin to examine how assistance in dying works in practice is cross-cultural comparison with countries with more liberal aid-in-dying laws. In "A dozen caveats concerning the discussion of euthanasia in the Netherlands", Battin examines the Dutch practice of tolerating AVE. She is critically sympathetic to the Dutch system, but illustrates the significant problems of instituting a similar system in the US because of different relationships with primary care, different levels of universal health insurance and social equality, and different legal systems.

In "Assisted suicide: can we learn from Germany", Battin offers a fascinating historico-linguistic analysis of suicide in Germany. Germans have a different attitude to suicide than English-speakers, reflected in the concept of Freitod. Germany permits assisted suicide but not AVE. Although assisting suicide is not illegal, physicians in Germany are rarely involved because they have a conflicting legal duty to rescue their patient. "Fear of euthanasia and suspicion of authoritarian physicians" result in most suicide occurring in private. Suicide was assisted by the German Society for Humane Dying, DGHS, until a recent scandal involving cyanide-profiteering by the founder. The challenge presented by the German system is: what should be the role of the physician in assisted suicide?

The very notion of "rational suicide", Battin argues in "Manipulated suicide", invites abuse. Unremitting pain in the face of terminal illness is a reasonable ground for suicide. But

"[o]ld age, insanity, poverty, and criminality have also sometimes been regarded as grounds for rational suicide in the past; given a society afraid of demands from increasingly large geriatric, ghetto, and institutional populations, one can see how interest in producing circumstantial and ideological changes, in order to encourage such people to choose the 'reasonable' way out, might be very strong" (page 200). We are caught on the horns of a dilemma. If we admit the concept into ordinary use, we will admit the possibility of manipulation. If we don't admit the concept, we will be linguistically ill-equipped to allow individuals in intolerable circumstances to die. The second is worse than the first, Battin claims, so we should admit the concept.

PAS v euthanasia

I began reading this book firmly believing that euthanasia should be legalised. I finished less sure. This is a result of the even-handedness of Battin's approach. Throughout *The Least Worst Death* (chapters 5, 6, 12), Battin provides arguments for the preferability of physician assisted suicide (PAS) over active voluntary euthanasia (AVE). Battin would reserve non-voluntary euthanasia only for those cases in which a patient is "permanently comatose or otherwise irretrievably inaccessible" (page 123).

The argument is based on the privileged position of the patient to know that her suffering is worse than death. A physician may misinterpret what her patient is saying. This, together with the risk of manipulation and coercion, suggests that patients should initiate the choice to die (page 123). The physician should check for evidence of mental and emotional disturbance, and whether pain and approaching death are present (pages 123-4). Physician assisted suicide has other advantages. It requires less institutional change and lessens the possibility of development of standardised routines. It would slow the slide down the slope of involuntary "thrift-euthanasia".

This is one of Battin's most important conclusions. Although sympathetic to the reasons for AVE, I have wondered why we need such practice when patients can kill themselves. One objection not considered in detail by Battin is that some people are so debilitated that they cannot kill themselves. However, virtually any competent person can swallow a cyanide pill. If death is unpleasant by this means,

once the pill has been swallowed, the patient could be assisted with sedation or anaesthesia. Perhaps some patients cannot swallow. We could limit AVE to these patients. But in the context of competent patients communicating a desire to die (the battleground of AVE), such patients could communicate a desire to refuse food and water. Once they had clearly decided to do this, there is much that medicine can do to support them during the dying process. But it is central to PAS, as Battin stresses, that *the patient initiates* the train of events that lead to death.

Battin's argument is empirical, based primarily on worries about abuse. There are other conceptual reasons for preferring PAS to AVE. The matter of whether one lives or dies should be settled by oneself. If one chooses to be killed, it is oneself who should do the killing, or at least start it. There are various ways of supporting these claims. One route is to claim that getting another to kill oneself is not self-rule, but rule by another. Active voluntary euthanasia frustrates autonomy; PAS promotes autonomy. To be sure killing oneself is difficult. But in other difficult decisions in life, autonomy requires doing the difficult things oneself. A patient who handballs responsibility for his death to his physician shirks a duty to himself.

Consider a parallel between patient-physician and physician-nurse relationships. It might be argued that a physician who delegates to a nurse the administration of a lethal dose of morphine to a terminally ill patient avoids responsibility. He should give the lethal injection himself, as doctors in the Netherlands do. This view is contentious. In a health care team, in which each member knows the patient and the decision is a shared one, it may be appropriate for a nurse to give the injection, if she is willing. But a doctor would be avoiding responsibility if he made the decision to end the patient's life and asked a nurse to perform such a procedure without a written order. He must act so as to set the ball rolling. In the patient-physician relationship, it is the patient who must perform this initial act. We need a reliable signal of resolve. That signal is action. As a reliable barometer of resolve, actions speak louder than words.

Making choices

Another major theme that percolates through several essays is that patients should make choices when they are

competent about when and how they want to die. Battin objects to our passive acquiescence, accepting the "favourably regarded" progression to death: aggressive initial treatment, followed by palliative care, withdrawal and withholding of care and finally do not resuscitate orders. "Dying in 559 beds: efficiency, 'best buys', and the ethics of standardisation in national health care" argues that both national health services and free market systems preclude a person "having a death of one's own". It is only when a person makes active choices about death that death can be good for the person whose death it is ("Euthanasia: the fundamental issues").

Active choice has other advantages. We have already seen how making choices to limit treatment would save scarce resources. It would also facilitate altruism. As patients become incompetent, they are treated according to what is in their best interests. Yet if they were competent, they might make altruistic choices. They might choose to die earlier for the sake of their family or others. Such an altruistic choice cannot be made by surrogates. Hence, not making one's own choices during times of competence precludes altruism ("The eclipse of altruism: the moral costs of deciding for others").

An important instrument of active choice is the advance directive. Battin expresses reservations about these (pages 161–2). However, she argues that completing an advance directive is the most realistic way of limiting treatment to patients with Alzheimer's disease.

Valuing the lives of competent patients

If we are to permit assisted suicide or AVE, we need a clear procedure for valuing the lives of competent patients. We need a clear sense of who has a good reason to die and who does not. What makes continued life good for a person? Is the value of life subjective, relative to that person's own evaluation of its worth? Or is it objective, independent of that person's own evaluation of its worth? On one simple version of a subjective conception of value, continued life is good if the person whose life it is believes that it is worth living. Continued life is of value on an objective conception if it has some objective quality, such as the capacity to experience meaningful human relationships. My own opinion is that such evaluations must take the objective perspective. My one major

disappointment with *The Least Worst Death* is that Battin is unclear about how we should value the lives of competent patients. Indeed, at times she offers apparently conflicting views.

At some points, Battin appears sympathetic to subjective evaluation. Thus she writes that whether continued life is a benefit or a burden "is a function of subjective preference and choice" (page 106). Battin claims that "when a suffering person is conscious enough to have an experience at all, whether that experience counts as a benefit overriding the suffering or not is relative to that person and can be decided ultimately only by him or her" (page 106). "We cannot objectively determine whether life is a benefit to a person" (page 107).

Subjective evaluation results in the collapse of a principle of mercy (beneficence) into respect for autonomy. If I desire to die, then on a subjective conception of the value of life, my life is not worth living. Battin claims that "... the principle of mercy is conceptually tied to that of autonomy ..." (page 107). But they are different concepts. A person may autonomously desire some end that is not good for him. Subjectivists rule out paternalism by definition: if I prefer death to suffering, then death is better than suffering.

The glitter of subjective evaluation often arises from a conflation of two different questions: (1) what should we do to this person? and (2) what would it be best for this person to do? If a person autonomously desires to die, we might not compel her to stay alive. But we can still claim that it would be better for her to live. What a person ought to be compelled to do is different from what a person ought to do.

Elsewhere Battin more openly embraces objective evaluation. Her most detailed philosophical examination of evaluating a person's desire to die comes in "Suicide: a fundamental human right?". She begins with a contrast between two suicides. One is an 80-year-old woman in a nursing home who was blind, had metastatic bowel cancer and chronic pain. The other is a 15-year-old boy who jumped off a bridge because his favourite TV programme, *Battlestar Galactica*, was axed.

Objectivists have no trouble locating a problem with such *Battlestar Galactica* suicides. The problem is that the desire is not worth satisfying. Dying because *Battlestar Galactica* was axed is not a good reason to die. Such

a response is not open to subjectivists. If there is a problem with such a desire to die, the problem has to do with the way the desire is formed.

Battin's analysis of these two suicides appeals to evaluation of the object of the suicide. She differentiates between two kinds of suicide. "[V]iolent' suicides [are] desperate, aggressive acts, that display both contempt and hatred for oneself and for others as well". The other kind is "nonviolent" suicide. These often involve "cessation" rather than "obliteration and annihilation", are often anticipated and planned in a purposeful way, are sometimes sacrificial to another person or cause, do not seek to punish or retaliate against oneself or others, and are often out of self-respect (page 284).

Battin's appeal to an objective conception of value is in places more explicit. The youth's suicide "precludes indefinitely continuing life" while the elderly woman's suicide precludes "inevitable death by another more painful or degrading means" (page 284). The notion of dignity itself is an objective conception: "... it ... is a notion rooted in an ideal conception of human life, human community, and human excellence ..." (page 280). The youth gave up "love, purposeful occupation, social contribution, and the attainment of ideals" (page 281). The elderly woman faced only "human degradation" (page 282) or loss of dignity: "increasing debility, dependence, financial limitation, loss of communication and affection; increasingly poor self-image; increasing depression, isolation ... blindness and pain" (page 281).

Battin thus appears sympathetic to the objectivist conception of value of life. Indeed, it is hard to see how we could criticise the youth's desire to die on a subjective conception. The desire could be rational, in that it could be "autonomous, informed, stable, considerate, uncoerced and in accord with his or her basic values ...". In the same way as some people believe that freedom is worth dying for, this individual could, in his own solitary way, believe that the continuation of *Battlestar Galactica* is something worth dying for. Of course it is not, and that shows the limitations of the subjectivist account of value.

A subjective conception of value severely constrains the role of discussion and advice at the end of life. On the subjective conception, discussion of end-of-life issues is limited to discussion of how a judgment arose, what information was available, how

the person thought about the issues, and so on. It precludes discussion of the person's reason itself – for example, that the axing of *Battlestar Galactica* is a very bad thing.

It also fails to take account of the fact that people can be mistaken about the value of their life. We have no hesitation in saying that some lives of incompetent people are worth living. For example, John has mild retardation but lives a happy and productive life, has many friends, and so on. Imagine some new treatment improves his cognitive abilities. He becomes competent. But he now also more clearly sees the negative aspects of his life. He comes to judge it not worth living. The life itself – the experiences, the relations, and so on – have not changed. Why change our evaluation of the life? It is more plausible to say that John is mistaken in his evaluation.

Battin suggests that a person is the best judge of the value of his life (page 107). That may be true. But it does not imply that he is an incorrigible judge. Nor does it mean that the value of his life is relative to his own judgment.

In places, Battin seems sympathetic to this objectivist view. Thus she writes, "... [T]he principle of autonomy is dependent on the principle of mercy in certain sorts of case" (page 111). "When there is no evidence of suffering or pain, mental or physical, and no other evidence of factors like depression, psychoactive drugs, or affect-altering disease that might impair cognitive functioning, an external observer can accurately determine whether life is a benefit: unless the person has an overriding commitment to a principle or a cause that requires sacrifice of that life, life is a benefit to him or her" (page 111).

However, Battin has reservations about full commitment to objective evaluation. If a person chooses death rather than pain, Battin claims that we cannot demand "independent, objective evidence" that death is better than pain. The incessantly pain-racked person is better placed than anyone else to make such an evaluation, given her intimate acquaintance with the pain and her own beliefs and fears about death (page 111).

Indeed, Battin appears hostile to the offering of advice about the value of life. She has admiration for Freitod, which she describes as "a solitary, profoundly individual choice" (page 265). Battin objects to those with terminal disease, severe disability or

old age being directly counselled not to suicide or be killed (pages 174–5, 271–2). She believes counselling should be non-directive, exploring a person's desire to die.

Battin could be interpreted as claiming that an individual is often best placed to make judgments of the value of his own life. He should be assisted to make the best judgment possible. Advisors should be aware of their own limitations in determining the relevant features of a person's particular situation. However, if this is her argument, it is not an argument against directive counselling per se, but against ill-founded or overambitious directive counselling.

Although decisions at the end of life are deeply difficult, we do believe that there is a place for directive advice about whether to live or not. A rebel captured by a vicious, suppressive regime might be given a cyanide pill by a sympathetic guard. "Tomorrow, you will experience unspeakable tortures," the guard explains. "You should take this pill now. You will be better off dead." Such advice is not out of place and may be right. Sometimes, others do know what is best.

Free choice need not be solitary. One's death is not unfree if one receives considered counsel, advice or argument about what is best. Indeed, to make a fully rational choice or a choice which is positively free, one needs to evaluate not only information, but the arguments of others as to which is the best course. Perhaps rationality does not require that a person agree with others, but it does require that he at least consider the plausible arguments of others.

Battin is concerned that people will be manipulated into killing themselves by others promoting objective ideals of the worth of life, or "ideological manipulation". This concern should not be so great as to push us to subjectivism. The promotion of an ideal does not necessarily constitute manipulation. It can constitute good advice. Many people now have an ideal of physical fitness, but that does not mean that they have been manipulated into valuing physical fitness.

Moreover, on some conceptions of value, people may become convinced that they were mistaken in wanting to die and that their lives are really worth living. (The sanctity of life doctrine, although I do not support it, is an objective conception of value.) Battin's concern about such abuse seems more justified on some conceptions of objective value rather than others.

Such ideological manipulation is most likely when objective evaluation is incomplete. Manipulation is sometimes based on the invalid move from "Xness in life is a good reason to die" to "Xness in life makes life not worth living". Extreme pain is a reason to die, but it does not necessarily make life not worth living. Other features of that life may provide stronger reasons to live. Severe disability is a good reason to die; but it does not necessarily make life not worth living.

Evaluation of the quality of life of a competent person's life is not relative to that individual's own judgments of the worth of that life. It is in this sense not subjective. It is in important ways objective. Battin displays loyalties to both camps, though her view is complex. I have not addressed Battin's approach to valuing the lives of non-competent patients ("Fiction as forecast: euthanasia in Alzheimer's disease?"). That also seems to me problematic. My hope is that Battin will clarify her approach to valuing life in the future.

Conclusion

A book that fails to stimulate discussion is unlikely to be saying anything significant. This book says much that is significant, and there is much more to praise than to criticise. It is a fine example of scholarship, a rich resource of historical and contemporary examples, and US case law. For the second time in a decade and a half, contemporary bioethics owes a debt to Margaret Pabst Battin.

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Concepts and Measurement of Quality of Life in Health Care

Edited by L Nordenfelt, Dordrecht, Kluwer Academic Publishers, 1994, 283 pages, £58.50.

In the introductory essay to this edited collection Lennart Nordenfelt suggests a number of questions, amongst which are the following: what is the purpose of measuring quality of life?; is its aim to determine the extent to which resources should be allocated, for example, to health care in general,

or to some patients rather than others?; or is it instead to be used to measure the relative success of different medical interventions?; given the relevant aim(s), which aspects of individuals' lives bear upon their quality of life?; and, finally, how should the values and tastes of individuals, as patients or voters, figure in the selection of those aspects? Such questions have considerable philosophical interest, and should be matters of urgent political concern. Each contribution to the collection contains views relevant to some or all of these questions. They are, without exception, thoughtful and serious discussions, though philosophically informed readers may find much of the territory they traverse familiar.

The volume is divided into three sections, the first of which addresses the concept of quality of life in general, and contains essays by E Ostefeld, P Cattorini and R Mordacci, P Liss, T Moum and S Naess, as well as the editor himself. The second begins with a sociological essay, by M Bury, suggesting reasons why quality of life is now so widely discussed amongst students of health. It is followed by papers from A Fagot-Largeault, P Sandoe and K Kappel, and A Musschenga. These examine specific ethical problems arising for judgments about quality of life in the context of health care, and include one particularly illuminating account of how changes in an individual's preferences might bear upon changes in her health status. The third section contains papers by R Fitzpatrick and G Albrecht, S Bjork and P Roos, A Aggermaes and M Kajandi, and focuses on problems of measurement. These are not, however, merely technical investigations, but include, amongst other things, a very helpful discussion of the moral problems involved in extending quality of life measurement to various decision-making contexts in health care.

One of the collection's prominent themes concerns the extent to which standards of interpersonal comparison should depart from the objective dimension of individuals' lives, concerning their biological functioning and basic capabilities, and encompass subjective aspects, such as the extent to which their lives are successful according to their own lights. Given the centrality of this problem, more reference to post-Rawlsian criticisms of so-called welfarist metrics, which focus on preference satisfaction, would have been welcome. For many contemporary political philosophers

argue that whilst subjective standards are appealing for liberal reasons (since they lessen the need to rely on controversial judgments about what goods individuals should care about) they may be deficient for other reasons; for example, because of the existence of malformed or expensive tastes.

The absence of reference to such discussions is indicative of a more general feature of the collection, namely the extent to which it tends to treat judgments of health-related quality of life in a normative vacuum. Although references to utilitarianism are quite widespread, it would have been desirable to explore the way in which different conceptions of quality of life might be embedded in distinct moral and political theories concerning the just distribution of health care. That omission is striking given that, as noted, Nordenfelt himself suggests that one of the reasons to measure quality of life is concerned with resource allocation. Readers interested in those issues would do better to consult the very useful collection by Nussbaum and Sen.¹

References

- 1 Nussbaum MC, Sen AK. *The quality of life*. New York: Clarendon Press, 1993.

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Primum non Nocere Today: a Symposium on Paediatric Bioethics

Edited by G Roberto Burgio and John D Lantos, Amsterdam, Elsevier Science BV, 1994, 175 pages, US\$ 142.75, 250 DFL

This book is an edited record of the International Symposium on Paediatric Bioethics held at Pavia in May 1994. Eleven (including paediatricians, an academic lawyer, an anthropologist and three bioethicists), of the main contributors were from Italy. Two contributors came from Chicago, and one each from France, Germany, the Netherlands and the United Kingdom. The proceedings make a stimulating and enjoyable if rather expensive read.