

construction of physical bodies. The text includes a well-versed discussion of the gendered lens often applied to aging. For example, although women have traditionally put more “back-stage” effort into appearance management than men, the authors contend that the balance is shifting as men increasingly pay attention to their bodies.

Body work materially shapes the corporeal body. Exercise routines sculpt the contours of the surface of the body while also affecting its capacity to function and perform. Cultural diet and eating practices also impact the body’s function and appearance, as does “rejuvenation medicine” (p. 145), including hormone replacement therapy and surgeries such as facelifts and hip replacements. The increasing use of wrinkle creams, balding remedies, and engaging in jogging and yoga – all are aspects of personal wellness management and self-governance. Gilleard and Higgs deftly illustrate that these and many other self-care practices are deeply ingrained among contemporary aging baby boomers, evidenced by common social mantras such as “you are only as old as you feel” or “60 is the new 40”. Clearly, contemporary cultural performances of age significantly impact the biology of aging.

The chapter focusing on sex as it relates to age is particularly compelling. Asserting that the notion of “health” is a public virtue, the authors conclude that sex is no longer a private practice, but has become a public concern as an expression of living a healthy lifestyle. The authors identify social conceptions of a healthy sex life as a site of potential oppression, particularly for men. People lacking a vigorous libido may find themselves diagnosed as dysfunctional and presented with psychological, pharmaceutical, and prosthetic interventions and therapies. The authors suggest that academics would do well to examine the sexual practices of older people, in particular among queer communities where sexual practice is deeply imbricated with identity construction and maintenance.

One area of the book that sits uncomfortably is its treatment of race in chapter four. This chapter superficially assesses only a black-white binary of skin colour; racialized identities other than African-American are not mentioned. The authors present race not as a project of colonization, but as a project of biology. This is surprising, since they approach age, gender, sex, and sexuality as embodied identity practices that have significant impacts on corporeal experience. Clearly, the authors could engage more fully with race and ethnicity in relation to their ideas about the “new aging”.

Graduate students, professionals, and academics in the field of aging would be well-served by this book. Though avoiding an overtly convoluted and knotty writing style, this is a dense text drawing from post-structuralist, post-modernist, and phenomenological theoretical traditions, and is thus unsuitable for undergraduate students or non-academics. Lastly, the book cover is rather farcical, depicting a sunglasses-wearing, tanned and fit white male (albeit apparently prematurely grey), sitting on a sun-drenched beach in a well-accounted power chair. Changing lifestyles of disability with a contemporary treatment of youthful aging aside, the image appears contrived.

Despite the identified limitation of their approach to age as it intersects with race, Gilleard and Higgs skillfully explore contemporary issues surrounding the embodied practice of aging and its impacts on cultural constructions and on corporeal bodies. As nations increasingly contend with aging populations, shared conceptions of age are a compelling topic that deserves exploration. The new aging of Gilleard and Higgs is a sociology of aging that positions the body as both a possibility and constraint, the site for practices of freedom as well as the site of vulnerabilities.

Reference

Gimlin, D. (2007). What is “body work”? A review of the literature. *Sociology Compass*, 1(1), 353–370.

Megan-Jane Johnstone. *Alzheimer’s Disease, Media Representations and the Politics of Euthanasia: Constructing Risk and Selling Death in an Ageing Society*. Surrey, United Kingdom: Ashgate, 2013

Reviewed by Michael Gordon, MD, MSc, FRCPC, Baycrest Geriatric Health Centre and the University of Toronto

doi:10.1017/S0714980815000112

This well-researched and well-written book could not have come at a more opportune time for Canadian readers. It is relevant to scholars in the fields of aging,

palliative care, dementia, ethics, and law as well as members of the general public who are facing the difficult decisions which are the topic of this book.

Not a week – sometimes not even a day – goes by without an article or survey released in the popular media, or in health care professional circles, about the two main topics which intersect so dramatically and are the reason this book is so timely. First, the rapidly aging population is well-known to almost anyone who has any interest in current societal trends. Media sources and pundits in the fields of economics, sociology, and clinical health care focus heavily on the often-deemed dire results of this unfortunately named “silver tsunami”. That such a negative descriptor is often used to describe the aging population (which one could otherwise construe as one of the great miracles of modern medicine) has moulded the conversation about aging’s potentially dire economic and social impacts on contemporary or near-future society.

The second topic that intersects with aging is the other very vividly described challenge to current societal actions and norms: the acknowledged increase in prevalence and incidence of dementia. In many ways, this is the natural accompaniment of increased longevity, given a strong association between aging and dementia prevalence, in all Western societies for which such data are available. Increased societal vulnerability to dementia should be considered in the context of an emphasis on an autonomy paradigm as an ethical framework for health care decision-making. This paradigm (principlism) emerged in the 1970s with the publication of the first edition of *Principles of Bioethics* by Beauchamp and Childress (1979) from Georgetown University. Prior to this, the primary foci of ethical decision-making was based on a combination of beneficence and non-maleficence; from this point, the principle of autonomy very rapidly became the overriding ethical principle especially in North America, probably for cultural, historical, and some might say anthropological reasons: in America, especially, the locus of decision-making more broadly has always been centred on the individual rather than the collective (i.e., society).

Herein lies the premise of the book – the coming together of what is often deemed to be the “worst of all illnesses” and a loss of autonomy. Dementia is often characterized in the most negative manner – often worse than what previously had been thought of as the “worst” disease states such as cancer. Furthermore, it is increasingly characterized as worse than even what otherwise was thought to be the ultimate in “bad” (i.e., malignant disease). One often hears of it characterized as “dying while alive”, “a slow death”, or a “the loss of self”; for those who cling to and treasure their cognitive being as key to their identity, this can be deemed “a fate as bad as or worse than death” (Ofri, 2014). If indeed that has become or will become the model that dementia is seen to represent,

and for which there is no immediate “cure” on the horizon, it is not surprising that many people view dementia with a sense of impending doom – and their loss of cognitive self and subsequent loss of autonomy as a dismal fate.

The author eloquently develops her thesis that the apparent ultimate act of “freedom” (the decision to die at a time of one’s choice, either alone or with help) is clearly attractive to those who believe that being in control of the time and nature of their death is their ultimate act of autonomy and selfhood, aspects which are threatened by the necessity of living with dementia and facing gradually cognitive and often behavioural decline.

Johnstone describes and dissects the genesis of these very popular belief systems and attempts to identify the common fallacies in beliefs behind the desire to “take control” or at least “hand control” to someone else who will do their bidding of assisting in the time and means of death. Even the use of language has been carefully massaged, and includes very poignant and attractive words such as “dignity”, “preserving of self-hood”, and prevention of “suffering”. Further, the concept of “peace of mind” coupled with one’s last “act of self-hood” and autonomy are very hard to argue against – thus the compelling movement to seek aid in dying, whether through assisted suicide, euthanasia, or some variation thereof, is likely going to continue unabated. Just as so many other social norms have so drastically and quickly evolved over the past few decades, it is more than likely that some sort of aid in dying will become generally socially (and legally) acceptable, despite pockets of opposition – including from those whose focus is on enhancing participation in life at any possible level during whatever period of life still remains, or from religions for which the concept of sanctity of life retains priority over “quality of life” and “autonomy”.

What trajectory the autonomy movement will take when it comes to assistance in dying for those with dementia remains to be seen. Quebec’s Bill 52 was the first proverbial “nail in the coffin” of the existing prohibition of assisted death in Canada. The recent Supreme Court ruling (February 6, 2015) will change the nature of the debate in Canada. However, the ruling has to be translated into law by Parliament, but there is ample experience from jurisdictions in Europe and the United States where various iterations of aid in dying (beyond the usual principles of palliative care) are already established (Cheadle, 2015). Those experiments are still somewhat new in terms of human history and practice, so it remains to be seen whether the ending of life becomes more cavalier and whether our patience in dealing with dying individuals wears thin.

How dementia factors into the autonomy-focused assisted death movement is a major challenge because for now most jurisdictions require cognitive engagement to make such decisions; however, that too can change over time.

Whatever one's opinions are on the subject, this book lays out the issues, conflicts, and common suppositions that fuel the arguments in a cogent and readable fashion. I would recommend it to all health care practitioners who deal with any combination of the following: (a) clinical care, (b) policy formulation, (c) ethics, (d) law and the interface between dementia, (e) end-of-life care, and (f) options for professionally assisted death. It will further be of interest to anyone interested in pondering the broader implications in terms of the basic respect and compassion for those living with dementia, and how and whether human

meaning can be continued and enhanced despite the ravages of illnesses related to dementia.

References

- Beauchamp, T. L., & Childress, J. F. (1979). *Principles of biomedical ethics* (1st Ed.). New York, NY: Oxford University Press.
- Ofri, D. (2014). The silence of doctors around Alzheimer's. *New York Times*, May 8, 2014. Retrieved 6 February 6, 2015 from http://well.blogs.nytimes.com/2014/05/08/the-silence-of-doctors-around-alzheimers/?_php=true&_type=blogs&_php=true&_type=blogs&_r=2.
- Cheadle, B. (2015). Supreme Court reverses course on doctor-assisted death; ban unconstitutional. *CBC News*. Retrieved 6 February 2015 from <https://ca.news.yahoo.com/death-docket-supreme-court-rules-today-doctor-assisted-093009610.html>.