

century), in the Mass, and in the corpus of literature produced by the Latin church fathers, which was even larger than that of their Greek counterparts. The Renaissance humanists looked for inspiration to these “sacred” texts, as well as the ancient non-Christian ones, giving them “the same editorial care and typographical embellishment,” Pelikan writes. Nineteen editions of Augustine’s *City of God*, for instance, were made before 1500.

The “crowning achievements of sacred philology” during the Renaissance were the many Bibles produced, Pelikan writes. There had been numerous efforts during the

Middle Ages to rid the Latin Vulgate translation of corruptions. But the proliferation of printed Bibles in the late 15th and early 16th centuries gave “the Renaissance enterprise of textual criticism . . . a new impetus.” Robert Estienne’s superb edition of the Vulgate, the *Biblia* in two parts, first appeared at Paris during 1527–28. Estienne’s Greek Bible, *Novum Testamentum Graece*, of 1550, “formed the basis of the Greek *textus receptus* for, among other translations, the Authorized (‘King James’) Version of the English Bible,” Pelikan says. The Renaissance and the Reformation, it seems, had much more in common than many have supposed.

## SCIENCE, TECHNOLOGY & ENVIRONMENT

### *Dr. Death is a Quack*

“The Kevorkian Epidemic” by Paul R. McHugh, in *The American Scholar* (Winter 1997), 1811 Q St. N.W., Washington, D.C. 20009.

By helping more than 40 depressed sick people to kill themselves, Dr. Jack Kevorkian has helped give life to the controversy over assisted suicide—and won scattered acclaim as a humanitarian crusader. McHugh, director of the Department of Psychiatry and Behavioral Sciences at the Johns Hopkins School of Medicine, says Michigan’s “Dr. Death” is outrageously, even insanely, mistreating those who put themselves in his care.

“Most suicidally depressed patients are not rational individuals who have weighed the balance sheet of their lives and discovered more red than black ink,” McHugh writes. “They are victims of altered attitudes about themselves and their situation, which cause powerful feelings of hopelessness to abound.” Their depression is treatable—and it should be treated. Modern medicine no longer regards even terminal illnesses as “signposts to the grave,” he notes, but views diseases rather as “processes in life for which the body has ways of compensating and resisting, even if only temporarily.”

Depression among the seriously ill comes in two forms, McHugh says. Patients with certain illnesses—including Parkinson’s disease, multiple sclerosis, Alzheimer’s disease, AIDS dementia, and Huntington’s disease—are often afflicted by depression as a *symptom* of their ailments. “They are overcome with a sense of hopelessness and despair, often with the delusional belief that they are in some

way useless, burdensome, or even corrupt perpetrators of evil . . .,” he writes. “These patients lose their capacity to concentrate and reason, they have a pervasive and unremitting feeling of gloom, and a constant, even eager willingness to accept death.”

Though that may seem a reasonable assessment of the patients’ situation to family members and physicians, it is actually part of the illness, as much a symptom of it as fevers, pain, or loss of energy. Modern antidepressant drugs, McHugh says, are “usually effective at . . . restoring the patient’s emotional equilibrium.”

Of course, some seriously ill patients are suicidally depressed for other, “perfectly understandable reasons, given the grueling circumstances of their progressive and intractable disease.” But their demoralization—unlike symptomatic depression—tends to wax and wane, to come in waves, and to be worse at certain times, such as during the night. “All patients afflicted with disease—curable or incurable—are susceptible to bleak assumptions about their future and their value,” he says. “These susceptibilities can be magnified or diminished by the behavior of their physicians.” In short, demoralization, too, is treatable.

Most pain-ridden patients suffering from terminal or progressive diseases do not in fact go in search of death, McHugh points out.

Those who do are not the norm; they are people who need the help and protection of their physicians. The death-dealing Dr. Kevorkian instead “trades upon the vulnera-

bilities and mental disorders of these patients and in so doing makes a mockery of medicine as a discipline of informed concern for patients.”

## *Chilling Out Los Angeles*

“Painting the Town White—and Green” by Arthur H. Rosenfeld, Joseph J. Romm, Hashem Akbari, and Alan C. Lloyd, in *Technology Review* (Feb.–Mar. 1997), Bldg. W59, MIT, Cambridge, Mass. 02139.

Los Angeles could be a cool place. But right now, it isn't. On a typical summer day, the temperature in central L.A. is a full five degrees F. higher than in the surrounding suburbs and rural areas. Many other big cities are also overheated. Is this, as many assume, due mainly to heat generated by cars, office buildings, and factories in the city? Guess again, say Rosenfeld, Romm, and Akbari, who are with the U.S. Department of Energy, and Lloyd, who works at the Desert Research Institute in Reno, Nevada. That heat accounts for only one percent of the temperature difference. The chief culprit, they say, is dark surfaces, such as roofs and asphalt pavements, which absorb heat that lighter surfaces would reflect away.

“With white roofs, concrete-colored pave-

ments, and about 10 million new shade trees,” the authors point out, “Los Angeles could be cooler than the semidesert that surrounds it, instead of hotter.” Besides providing cooling shade, the trees would soak up groundwater, which then would “evapotranspire” from the leaves, indirectly cooling the surrounding air.

Reducing the average summer afternoon temperature in Los Angeles by five degrees, the authors calculate, would cut the need for air conditioning by 18 percent and lower the smog level. The energy savings, not to mention the reduction in medical costs, would be substantial. But it would take about 15 years to achieve this effect. “Los Angeles, or any other large city,” the authors note, “cannot be cooled in a day.”

## *Stop Talking Race*

“Bred in the Bone?” by Alan H. Goodman, in *The Sciences* (Mar.–Apr. 1997), New York Academy of Sciences, 2 E. 63rd St., New York, N.Y. 10021.

Most anthropologists agree that race is an unscientific concept, that distinct biological races simply do not exist. Yet even scientists themselves fall into the race trap, observes Goodman, an anthropologist at Hampshire College, in Amherst, Massachusetts.

Anthropologists and medical and health professionals use race “as a shorthand to describe human biological variations,” he says, even though those variations “blur from one race into the next, and are greater *within* so-called races rather than among them.” Whether racial shorthand is employed in police work, medical studies, or public health situations, Goodman argues, the fact remains that “race science is bad science” and can be misleading, even dangerous.

Take forensic anthropologists, for example. They maintain that while race may be “socially constructed,” the people in one racial category still tend to look enough alike to make “race” useful in police forensics. To

back this up, Goodman says, the anthropologists often cite a study done in the early 1960s suggesting that it is possible to correctly identify the “race” of a skull between 85 and 90 percent of the time. But, he writes, in three of four efforts to replicate the study, “the formula proved less accurate than a random assignment of races to skulls—not even good enough for government work.”

Race thinking, Goodman contends, sometimes leads criminal investigators needlessly astray. That happened in the aftermath of the 1995 bombing of the Alfred P. Murrah Federal Building in Oklahoma City. A forensic anthropologist concluded that a leg found in the rubble that did not match any of the recovered bodies probably came from a “darkly complected Caucasoid” male. But the leg eventually turned out to belong to a woman who was, according to one forensics expert, “obviously black.”

The use of race as shorthand in medical