Rehabilitation

Two major factors determine the outcome of most hand surgery: firstly, the character of the patient, his willingness and enthusiasm to cooperate, withstand local pain and discomfort, and work diligently at rehabilitation; and, secondly, the provision of a properly manned occupational therapy and rehabilitation service. An occupational therapy unit must include a person who can attend the hand clinic regularly to provide assessment of hand function both before and after operation. This evaluation includes work and domestic environments and also assesses the range of movements in individual joints and the strength of various grips, etc. The facilities offered by the unit should include wax baths, an ice machine, ultrasound, and the ability to make customised splints. Once the initial surgery has been undertaken and the wounds have healed the patient should then progress to a home orientated unit; and there should be a workshop with the ability to adapt implements to preserve a patient's independence both at work and at home. After nerve repairs sensory retraining is important. This includes the recognising of shapes and textures of various fabrics and materials.

Mr D M Davies, FRCS, is consultant plastic surgeon, West London Plastic Surgery Centre, West Middlesex University Hospital, Isleworth, and consultant plastic surgeon and honorary senior lecturer, Royal Postgraduate Medical School, Hammersmith Hospital, London W12 0HS, and Mr R W Smith, FRCS, is research registrar in plastic and reconstructive surgery, Royal Postgraduate Medical School.

Philosophical Medical Ethics

To what do we have moral obligations and why? II

RAANAN GILLON

In my last article I looked at claims that all living human beings have special moral importance including a "right to life" just because they are living human beings. I contrasted these claims with the Benthamite claim that all creatures that can experience suffering and pleasure are morally equal and that all moral issues including that of the right to life depend entirely on calculations of overall pleasure and pain, irrespective of difference in species. I shall now consider arguments about the moral importance of: being human; "viability"; and being a "person."

"Speciesism"

Professor Peter Singer, a contemporary utilitarian, argues against both the simple Benthamite moral equating of humans and other sentient animals and what he dubs the prejudice of "speciesism" (a neologism attributed to Richard Ryder and intended to be a pejorative term analogous to racism and sexism—"specism" would have been better). Thus, so far as pain and suffering go, Singer argues that "pains of the same intensity and duration are equally bad

whether felt by humans or animals."¹ To be prepared to inflict such pain on animals but not on humans, other circumstances being the same, is irredeemably speciesist. On the other hand, argues Singer, human beings tend to have many interests that most other sorts of animals do not and cannot have. It is possession of such differing interests that can ground different moral rights and moral evaluation of human beings who possess these interests. Thus human lives that have a capacity for self awareness, ability to plan for the future, ability to have relationships with others and close family and personal ties, importance to other affected human beings, and other attributes such as the capacity for abstract thought and complex communication may, claims Singer, be legitimately valued more than lives that do not have these qualities.

This, he argues (somewhat contentiously), in no way undermines the principle that in making any moral decision the interests of all sentient beings affected by that decision must be taken equally into account; it is just that those interests are often vastly different. Such differences, however, are not determined simply by membership of a species. For instance, so far as a right to life is concerned "mere membership of our own biological species cannot be a morally relevant criterion. . . . A chimpanzee, dog, or pig, for instance, will have a higher degree of self awareness and a greater capacity for meaningful relations with others than a severely retarded infant or someone in a state of advanced senility. So if we base the right to life on these characteristics we must grant these animals a right to life as good as, or better than, such retarded or senile humans."²

Imperial College of Science and Technology, London SW7 1NA

RAANAN GILLON, MB, MRCP, director, Imperial College Health Service, editor, *Journal of Medical Ethics*, and associate director, Institute of Medical Ethics

Dame Mary Warnock doubtless speaks for many when she summarily rejects arguments against speciesism as "absurd." Such speciesism, she claims, far from being arbitrary prejudice "is a supremely important moral principle. . . . To live in a universe in which we were genuinely species-indifferent would be impossible, or if not impossible, then in the highest degree undesirable."³ She does not, however, give much argument for her position and, like many doctors, she none the less wishes to differentiate morally between those very young human beings whom, or which, doctors are prepared to kill or let die in various circumstances and those to whom they wish to attribute a right to life that would prevent them doing so. Her answer is not quite clear but seems to require distinctions based on whether the embryo or fetus is (1) "plainly human" (in this context she offers as two exemplifying criteria the ability "to experience pain [and] to perceive their environment"); and (2) "a full human being" (alas, she does not say what she means by this). Over and above distinctions based on the nature of the developing human embryo or fetus she also puts great emphasis on respecting other people's moral outrage at any proposed action.

The trouble with all this is that in so far as it is clear it does not hold together. As Dame Mary writes, "human is a biological term"; but as such it cannot (in the absence of some additional moral criterion) give us a basis for the "supremely important" moral principle she desires. In any case, if her pro-human principle is to be understood biologically it will claim that all human beings are of equal moral importance, and this she clearly rejects. Furthermore, her criteria of experiencing pain and perceiving the environment cannot in themselves make the embryo or fetus "plainly human," either biologically construed (for many non-human biological species have these attributes) or morally construed, for there is nothing morally speaking specifically human about feeling pain and perceiving the environment. She may even be implicitly accepting such criticisms when she adds that it should be "absolutely prohibited" to anaesthetise the sentient human embryo for the purpose of experimenting on it. If, however, capacity for sentience and perception are to be her moral cut off points in the developing human embryo (1) she is no longer relying on specifically human attributes as she claims and (2) she offers no moral justification for rejection of the same moral cut off points in relation to other animal species.

Technical differentia

Dame Mary's dividing lines (if such they be) are among an enormous variety of such lines that have been proposed to distinguish morally between embryos and fetuses at different stages of development,⁴ including the simple and widely accepted distinction between being unborn and born. Few, however, who think critically about the problem can justify this simple distinction (essentially based on the position of the infant relative to the mother's vulva) as being of moral importance.

A common medical fallback position is to claim that it is viability of the fetus that makes the moral difference. Before a fetus is viable it is seen as a morally acceptable candidate for abortion; after viability abortion becomes morally indefensible. (A less extreme version of this position has found its way into American law⁵ via the Supreme Court's ruling in *Roe v Wade*.)

There are numerous problems with this position, among them the ambiguity, perhaps even incoherence, of the concept of viability. If, however, viability is taken to denote the stage of fetal development at which it becomes possible to maintain the fetus alive after it has left the uterus the alleged moral criterion turns out to be a (merely) technological criterion and a constantly changing one as medical technology makes it ever more possible to preserve the lives of premature infants. In theory any human embryo at any stage is viable with appropriate technology. Given the evidence of man's existing technological wizardry there seems to be no reason why Aldous Huxley's prediction of such complete mechanical incubation of human embryos should not become possible in reality, in which case the criterion of viability would collapse into the orthodox Roman Catholic criterion of fertilisation.

Viability, like so many other technical differentia, offers no (direct) moral rationale to justify treating previable human fetuses differently from viable fetuses. In any case, even without technology, are not most fetuses viable in the ordinary sense provided they are left alone to develop in the uterus?⁶

Personhood

So far I have suggested that a simple reliance on sentience, or on membership of the human species, or on technical differentia such as viability are highly implausible candidates on which to ground the scope of our moral obligations, including our recognition of a right to life.

In an earlier article about deontological theories of ethics I wrote about the radically different theoretical approach to problems about the scope of morality offered by Kant, for whom it was rational willing agency that afforded the moral criterion for distinguishing entities that had and were owed moral obligations from entities that were not. Such rational willing agents he called persons. John Locke, that most illustrious physician philosopher, also differentiated the "forensic" category of persons, to which praise and blame and other forensic attitudes were appropriate from other entities. Like Kant, and unlike many contemporary philosophers, Locke distinguished between the moral or forensic strand in the concept of a person and what might be called the ontological strand (ontology being the study of what is or what exists). While Kant saw rational willing agency as the essential characteristic of persons, Locke saw the ability to think combined with self awareness over time as the essence of personhood. Thus for Locke a person was "a thinking intelligent being that has reason and reflection and can consider itself as itself, the same thinking being in different times and place; which it does only by that consciousness which is inseparable from thinking and as it seems to me essential to it."⁷

One of the consequences of adopting either the Lockean or the Kantian criteria for personhood is that not all living human beings are persons. Embryos, fetuses, very young infants, and humans with severely damaged or severely defective brains may be able neither to think nor to be self aware, and if the Kantian requirement of rational agency is to be met many older children and some adults will fail to fall into the net of personhood. Yet the idea that a single living human being starts its existence not being a person, develops into a person, and then at some stage may stop being a person while remaining a living human being seems to be intuitively plausible both as an account of what happens and also as a basis for at least some sorts of important moral distinction. Indeed, it may be some such assumptions that prompted the World Medical Association in its Declaration of Sydney (about death) to assert, "clinical interest lies not in the state of preservation of isolated cells but in the fate of a person."⁸

Quite apart, however, from producing conflicting moral intuitions of this sort, the idea that living human beings can be persons at some stages of their lives and not at others produces many other sorts of philosophical difficulty, especially problems clustering around the concept of identity. Attempts to overcome such difficulties are legion in philosophical works and include three broad categories.

The first resorts to dualism, whereby physical bodies are understood to be composed of substances ontologically distinct from spiritual substances, minds or souls, with personhood being understood necessarily to require some non-material substance. (Descartes offers the classic dualist position in his sixth meditation, and Popper and Eccles argue for dualism,⁹ though it is generally speaking out of philosophical favour.)

The second uses some variant of the identity theory whereby persons are identified with their bodies or some part or parts of their bodies, notably their brains.¹⁰

The third approach is to deny that personhood is an intrinsic property of any human being and instead to postulate it as a "social construct"—that is, an attribute socially conferred on some but not all human beings by other human beings.¹¹

Problems with all these approaches are shown in the vast amount

of philosophical writing discussing personal identity,¹² often by means of imaginary problem cases. These range from Locke's own example of the prince and the cobbler who swap souls and Shoemaker's modern analogue in which Brown's brain is successfully transplanted into Robinson's head (who is the result?) to real cases of the so called "multipersonality syndrome" and brain bisection at the corpus callosum with one half of the brain implicitly answering the same question differently from the other half.

Some philosophers have argued that the moral and philosophical problems of personhood are resolvable on the basis of the Lockean intuition that persons are essentially self conscious. Professor Michael Tooley, for example, has argued that self awareness is at least a necessary feature for being a person in the morally important sense of having a right to life.¹³ As fetuses are not self aware they do not have a right to life. He confronts the obvious intuitive objection to this stance head on: newborn infants are not self aware either and therefore they too by parity of reasoning do not have a right to life and thus infanticide may be morally permissible. Tooley argues that, far from being a disadvantage of his position, this is a positive advantage in that it corresponds to a further widespread moral intuition; "most people would prefer to raise children who do not suffer from gross deformities or from severe physical emotional or intellectual handicaps. If it could be shown that there is no moral objection to infanticide the happiness of society could be significantly and justifiably increased."¹⁴ He has recently changed his mind,¹⁵ but the change is based on philosophically rather technical distinctions, and even under his new formulation persons necessarily possess, either now or in the past, a sense of time, a concept of a continuing subject of mental states, and a capacity for episodes of thought.¹⁶

Professor Tristram Engelhardt, an American physician philosopher, also argues that self consciousness is a necessary (though not sufficient) condition of being a person,¹⁷ as does Professor David Wiggins (but in a very different way and for very different reasons).¹⁸

Among the many problems faced by this sort of position are the widespread and deeply felt intuitions (a) that newborn infants are of the same moral importance as the rest of us and have the same right to life; and (b) the slippery slope intuition that once

handicapped infants are deprived of a right to life other infants and other handicapped people are at risk, as, ultimately are all human beings. Indeed, there are undoubtedly grave problems associated with any of these theories about what properties ground a right to life, and the problems are manifested particularly clearly in consideration of the moral standing of very young human beings, of live but brain dead and live but permanently unconscious human beings, and of animals of varying attributes. Although such issues have received considerable philosophical attention fairly recently, the subject still represents a lacuna in ethics as a whole and medical ethics in particular.

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WORDS PLASTER OF PARIS. As distinct from naturally occurring gypsum (Gk γύψος) (CaSO₄.2H₂O), gypsum plaster (plaster of Paris) is principally the hemihydrate (CaSO₄.½H₂O), a product obtained by heating gypsum to drive off water of crystallisation. When water is mixed with plaster of Paris it forms a solid mass of interlocking crystals and is reconstituted as the fully hydrated form with which every doctor is familiar. This phenomenon was known in antiquity to the Egyptians and Greeks, who used it for building and for lining walls. Splinting of limb fractures by means of plaster of Paris was practised by Arabs as early as the tenth century, but was not effectively used in Europe for this purpose until the plaster impregnated bandage was introduced in Holland by Anthonius Mathijssen in the 1850s. There was some initial resistance to its adoption in England and France, where slow setting egg white and starch on linen strips were preferred.

In English the word "gypsum" is used solely for the native mineral; likewise "le gypse" in French. By contrast, in most other European languages there is no terminological distinction between the mineral, the calcined hemihydrate, and the final product as applied to architectural, artistic, or surgical use, where the term used is a derivative of the Latin "gypsum." Thus it is "gips" (with a hard g) in Dutch, German, the Scandinavian languages, and Russian; "gipsz" in Hungarian, "kips" in Finnish, "gypos" in modern and ancient Greek, "gesso" in Italian and Portuguese, and "yeso" in Spanish. The French call the secondary products "plâtre de moulage" (plaster for moulds), but in surgical practice usually just "le plâtre."

Only in English are the hemihydrate and final product called plaster of Paris. This stems from the large deposits of gypsum in and around Paris and at Montmartre in particular, where it has been mined since the twelfth century. France is still the largest producer of gypsum in Europe. The

Parisian epithet was probably introduced into English by Henry III, who is said to have imported plaster for decorative purposes in 1254 after a visit to Paris. The *Oxford English Dictionary* quotes: "(1387) Bysides Parys is greet plente of a manere stoon þar hatte gypsus and is i-cleped white plaistre. (1462) The chambyr he lett make fast Wyth plaster of parys þat will last." And even though we now get it from Nottinghamshire, plaster of Paris it still is.—B J FREEDMAN.

A woman with episodic depression has much improved since she has taken clomipramine. Recently, however, she has had angina on exertion. If this is a side effect of clomipramine would mianserin be a possible alternative, and if so at what dosage?

Clomipramine like other tricyclic antidepressants may be associated with a degree of cardiotoxicity even in therapeutic doses. Possibly, therefore, the angina that this patient has developed may be precipitated by the clomipramine, which is known to increase the heart rate. While a causal relation cannot be easily shown it is advisable to switch to one of the safer antidepressants thought to be less cardiotoxic. Mianserin has less cardiotoxic effect than the tricyclic antidepressants.¹ It may be used in standard dosage of 60-90 mg daily, which is tolerated best as a single dose of 60-90 mg at night. In the elderly, because of their slower drug clearance, it is appropriate to use the lower dose.—S A MONTGOMERY, reader in psychiatry, London.

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