Correspondence

In vitro fertilisation and moral equivalence

SIR
May I correct a small mistake in your otherwise excellent editorial on in vitro fertilisation in the December issue?

In the context of a discussion as to what ‘establishes moral equivalence’ you attribute to me the position that moral equivalence is established by the development of sentience, or the ability to experience pain or suffering. You then go on to contrast this with Tooley’s position that it is self-awareness which is necessary.

The problem is that to talk of ‘moral equivalence’ is not especially meaningful unless we ask ‘moral equivalence for what purpose?’ I certainly hold that if it is the infliction of suffering, or the provision of pleasure, that we are talking about, the capacity for suffering or for pleasure is the criterion which establishes moral equivalence. That is why I emphasised this criterion in my book Animal Liberation. In that work, as I stated in the first chapter, I was concerned with the infliction of pain and suffering on animals. I did not discuss the wrongness of killing, where that is distinct from the infliction of pain and suffering.

If we are talking, however, of taking life, then I do not hold that the capacity for pleasure or pain establishes moral equivalence. I turned to this issue in my later book, Practical Ethics, and there I ended up supporting a position very like Tooley’s. It is, other things being equal, a much more serious matter to take the life of a self-conscious being than to take the life of a being without any self-awareness. This is because self-conscious beings have desires for the future which are cut off when they are killed. Beings which are sentient without being self-conscious cannot have a sense of their own future in the same way and so to kill them is not to end their hopes for the future.

In the context of embryos and fetuses, the upshot of all this is that if we are considering research on an embryo or fetus, and the research might be painful (if the embryo or fetus can feel pain) then sentience is sufficient. If the fetus might be sentient, we should treat it as if its pain mattered just as much – or was morally equivalent to – the pain of any other human. If, on the other hand, it is a matter of the painless termination of the life of the fetus, the fact that the fetus is sentient is not enough to make it morally equivalent to a normal human being.

It is true that this position conflicts with widely held views (widely held in the West, anyway) about the moral status of infants. I do not regard this as a knockdown objection, but I must leave the discussion of this point for another occasion.

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Brain death

SIR
In his review of Medicine and Moral Philosophy, David Lamb objected to its essays on brain death, including one by Dr Michael Green and myself. The issues are still important and his remarks deserve a reply.

We argued for a negative thesis, i.e. that the whole-brain conception of death is terminally confused, and for a positive thesis concerning a conception of death involving cognitive function.

As Lamb correctly notes, a key point in the negative argument is that the brain stem ought to be regarded as just one more replaceable body part. No ‘artificial brain stem’ is now available as such, but, we argued, the combined efforts of the resources and personnel in the intensive care unit constitute the equivalent. We now have, in effect, a substitute for the brain stem, though we know from the rapid deterioration of brain-stem-dead patients that the substitute is imperfect.

Lamb, citing the recent report of the President’s Commission for the Study of Ethical Problems in Medicine, insists that most of the brain stem’s functions are not replaced. But the functions mentioned by the Commission are not important. Temperature regulation, blood pressure, respiration, digestion, even embryological development continue in the brain-stem-dead body if suitably maintained. The few reflexes and spontaneous movements which cannot occur are not the stuff whose absence marks the absence of life. The significance of brain stem death is its dashing all hope of any real recovery rather than in any radical deterioration in the well-maintained occupant of an intensive care unit.

Lamb’s objection to our positive thesis is not entirely clear. He raises the important question of what it is that dies when the plug is pulled on an already-

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dead, brain-dead patient, but then answers it himself correctly (ie, the patient's body). His objection is to our mention of the possibility of extending, perhaps indefinitely, the period during which the brain-dead patient might be maintained, which Lamb condemns as 'This confusion between medical facts and science fiction'.

In reply it will suffice to quote the lines which followed this mention in our paper, which incidentally were addressed to an argument of Lamb's:

'It is difficult to see why the brevity of the interval [between brain death and functional disintegration] should have any bearing on the definition of death. There are a host of medical conditions which, given the current power of medicine, also inevitably lead to the death of the system as a whole, just as renal failure did only a few years ago. There was and is no temptation to regard the onset of these conditions as the occasion of death, and, failing further argument, this judgment extends naturally to the brain.'

Lamb's remarks notwithstanding, the case for whole-brain death has not been successfully made. The tolerance of logical disorder by the medical community in this matter is quite remarkable.

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Reply to Professor Wikler

SIR

Professor Wikler's reply to my review of his paper in Medicine and Moral Philosophy deserves careful attention. Not only does it call into question the concept of 'whole-brain death' advocated in the Report of the President's Commission for the Study of Ethical Problems in Medicine, there is also implicit dissatisfaction with the 'brain stem' concept of death which was advocated by the Royal Colleges of Medicine and their faculties in 1979 and more recently articulated in Dr C Pallis's The ABC of Brain Stem Death in 1983 (1). In this reply I can do little more than indicate the substantive differences between Professor Wikler's position and my own, and invite further discussion on this extremely important issue.

Confusion in the brain death debate is often generated out of a failure to articulate the concept of death in question. The concept of death underlying my criticism of the original paper by Professor Wikler was 'the irrecoverable loss of integrated functioning of the organism as a whole'. This includes the irreversable loss of the capacity for consciousness and respiration. The point in the process of dying when criteria for this concept are met, is the moment when tests clearly indicate the death of the brain stem. The assumption underpinning this concept is that the brain stem is uniquely essential and, by the standards of present medical knowledge, irreplaceable.

In contrast, Professor Wikler advocates a 'conception of death involving cognitive function'. If I understand this correctly he is saying that death, according to his conception, could be pronounced before tests had indicated an irreversible cessation of brain stem function. Yet part of his case for demonstrating the extent to which 'the whole brain concept is terminologically? confused' rests on an appeal to methods of artificially maintaining certain integrative functions after brain stem death. But even according to a concept of death equated with loss of 'cognitive function' a patient without a functioning brain stem would be dead, since a functioning brain stem is essential to the capacity for consciousness and cognition. It is interesting that many philosophers seem unaware of the relation of the brain stem (and in particular of its reticular formation) to the capacity for consciousness.

Another part of Wikler's case against 'whole-brain' death consists of stressing the persistence of certain functions after brain stem death. Quite clearly this is a long way from his earlier emphasis on the 'loss of cognitive function'.

This argument seems to rest on a concept of 'bodily death', according to which as long as some organs continue to function after brain stem death the patient is deemed to be alive. From the standpoint of 'brain stem death' this concept is unacceptable. Brain stem death must be seen as the equivalent of decapitation (2). In such a state any residual functions, such as the temporary persistence of cardiac contractions, should not be regarded as life indicators. But on Wikler's terms if, following decapitation, exsanguination was prevented and ventilation and blood temperature were somehow maintained, the 'victim' could be said to be alive. It is doubtful whether any medical or legal community would endorse such a concept of death and it would be interesting to see if philosophical arguments could be produced to establish that a headless corpse was alive.

In cases involving the completion of embryological development after maternal brain stem death, which are hinted at by Wikler, I would suggest that there is no more evidence of maternal 'life' in the uterus of the ex-patient than in an incubator, or other artifact employed for fetal survival.

The substantive difference between us is that whereas Wikler sees brain stem death as a state of no greater significance than other medical conditions which lead to the death of the system as a whole, the brain stem conception of death, which I endorse, appeals to the fundamental uniqueness of the brain stem. Thus the difference I see between a patient ventilated after brain stem death and any other 'well-maintained occupant of an ICU' is not merely that the former will not recover, but that what is being ventilated is no longer an integrated organism surviving with the aid of mechanical support, but a combination of artificial procedures prolonging cellular life in certain cell aggregates. This is not to deny that an artifact, under other circumstances, can help to restore the organism to a state where it can function as an integrated whole. Kidney dialysis, mechanical pacemakers, and so on, can help restore the integration of the whole just as they can replace the loss of a part. But they do so primarily because they help to restore and/or maintain brain stem function. For this reason Wikler's derogation of the role of the brain stem to that of the kidney is unwarranted. Loss of renal function was lethal because it set off a chain of events which culminated in brain stem death. Machines can now prevent loss of brain stem function in these conditions and insofar as the kidney is replaceable the machine has eliminated a particular cause of brain stem death. But the brain stem itself remains irrereplaceable. Science fiction begins when the critical role of the reticular formation is challenged.

References
