pseudocyesis and is the first case to demonstrate an interval of normality between resolution of pseudocyesis and onset of psychotic symptoms. This case highlights the necessity for adequate follow-up of patients with pseudocyesis: severe psychiatric illness may supervene even after a period of normality.

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Ethics of 'brain transplants'

Sir: O'Shea (*Journal*, August 1990, **157**, 302) raises the issue of brain transplants and their relation to the ancient debate concerning mind and body. A number of points seem worth making.

The hypothetical operation of transplanting A's brain into B's body (and *vice versa*) was discussed by Shoemaker (1963) and further elaborated by Williams (1970) in connection with the problem of personal identity. The issue initially appears to be whether one believes that the self (however constituted) will similarly be transferred with the brain or will remain with the body. Williams shows that both views can be cogently argued for, and discusses the links between the issue of personal identity and that of the relation of mind and brain.

It might be thought that such speculation was best left to the realms of science fiction, but there are two reasons for regarding discussion of such hypothetical cases as important. Firstly, as O'Shea implies, less dramatic forms of brain surgery already occur. One example is that of commissurotomy for intractable epilepsy. The philosophical difficulties raised by this operation are addressed by Nagel (1976). He discusses how many minds these patients can be said to have and shows that the results of the operation tend to break down our natural assumption that we (the unoperated) have one mind.

A second reason for considering these operations lies in the special way that they point up the links between issues in the philosophy of mind and ethical difficulties that are of particular relevance to psychiatry. Consider the question: How much change does someone have to undergo before thay do not exist any more (for example, removal of the brain and replacement by another)? This now looks very like the question that we ask and answer in cases of brain death. From this point it is a small step to considering cases of direct relevance to psychiatry such as the dementing relative ("she's not herself any more") or the psychotic patient during a florid episode ("he's changed beyond all recognition").

O'Shea's informal poll of a number of psychiatrists produces much the same result as my own. Most psychiatrists appear to hold either to a form of materialistic behaviourism or to some kind of dualistic position, and few are aware that the debate has moved on considerably. Neither position is philosophically coherent (good critiques of both can be found in Smith & Jones (1986)). Importantly, it cannot be a matter of indifference that we hold incoherent positions, since they do have practical consequences and lead to incoherent actions. An example worth considering in this respect would be the rationale of offering a combination of psychotherapy and medication for depressive illness. Whenever this question is discussed it is clear that (often unexamined) assumptions about the philosophy of mind are in operation.

We have begun to recognise that these issues are important. A philosophy group has now been formed within the College, and at my own hospital we now hold regular philosophy meetings.

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CORRIGENDUM

Journal, August 1990, **157**, 316. The author of *Not Always on the Level* is E. J. Moran Campbell.

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