

**INVESTIGATING ETHICS AND MENTAL DISORDERS
DORMY HOUSE HOTEL, 30 JUNE – 1 JULY 2004
MEETING REPORT**

1. EXECUTIVE SUMMARY

Mental disorders and their care present unusual problems within biomedical ethics. The disorders themselves, by their nature, invite an ethical critique, whilst the tendency of society and governments to treat those with such disorders in ways that discriminate against them, by comparison with those suffering physical disorders, raises profound social ethical questions. Researching the diagnosis and treatment of mental disorders also presents special ethical issues. This meeting aimed to investigate areas for current and potential research in the field, and to explore the potential uses of both theoretical and empirical research methods, and their inter-relations. Ultimately, the seminar aimed to stimulate greater 'cross fertilisation' of methods and researcher endeavours towards a stronger research record in what is an increasingly important and controversial field of biomedical ethical research.

The meeting highlighted that biomedical ethics research is not naturally limited to any one discipline and is particularly likely to benefit from an interdisciplinary approach, within an increasingly better understood relationship between theoretical and empirical methods. Useful methods for research into ethical issues can be drawn from philosophy, law and social science, amongst others.

Suggestions were made as to how the Wellcome Trust's Biomedical Ethics Programme could continue to support and encourage research in this field, perhaps by helping to establish interdisciplinary centres of excellence and by organising further meetings on this topic.

The programme of the meeting concentrated on four main areas of biomedical ethics research in mental health/neuroscience: the assessment of mental capacity; treatment and treatability; the ethics of risk assessment; and the nature of mental disorders. These choices were driven by a combination of wishing to build upon the process and results of research projects already funded by the Trust and a concern to address issues which are widely acknowledged to be of particular social and professional concern, sometimes even being highly politicised.

In addition to these main areas, other themes were identified during the meeting as particularly warranting research, including: decision-making in the assessment and care of mental disorders; analysis of public policy relating to mental disorders across a range of policy domains; approaches to definitions of mental disorders in different professional, social and political contexts; confidentiality in relation to mental disorder; mental health law and codes of practice; ethics in mental health research; criminal responsibility and mental disorders; issues of detention and justifiable discrimination; ethical implications of brain imaging and screening; behavioural genetics and mental disorders; ethical issues relating to concepts of 'enhancement', by comparison with remediation of disability; and issues relating to direct alteration, either pathological or clinician induced, of brain function.

The meeting assisted in furthering the understanding of how theoretical and empirical methods might better be inter-related across all fields of biomedical ethics research.

The meeting was attended by a wide range of people, including policy-makers, regulators, funders, social scientists, psychiatrists, psychologists, lawyers, philosophers, criminologists, and others.

2. INTRODUCTION

2.1. Purpose of the meeting

The Wellcome Trust's Biomedical Ethics Programme supports interdisciplinary research into the social, ethical, legal and public policy implications of advances in science, including neuroscience and mental health. The Programme currently funds a number of projects in this area but would like to stimulate this field of research further. In particular, the recent high profile of mental disorder ethics, determined by recent political and legal developments, and the extent of the ethical difficulties inherent within this domain, make this field of research important and topical.

This invited meeting was therefore aimed at encouraging enhanced communication within and between relevant academic, service and policy communities, so as to foster the development of high quality and policy-relevant biomedical ethics research projects in the field of neuroscience/mental health. In so doing, the organisers of the seminar hoped also to stimulate an improved understanding of the methods of empirical research that can contribute to 'empirical ethics' generally, and to establish a better defined and more fruitful relationship between empirical research and theoretical ethics, relevant to all domains of biomedical ethics. The experience of the Biomedical Ethics Panel is that a variety of methodologies, including social science methods and linguistics for example, can contribute to the field of 'empirical ethics' but that there is sometimes less than a fully developed understanding of the potential contribution of each, as well as of the relationships between different empirical methods and of their various potential contributions.

The seminar brought together practitioners, policy-makers and implementers, plus researchers from a range of relevant scholarly and empirical disciplines who have interests and expertise in fields relevant to the research domain at hand. Some of the participants already conduct, or have conducted, research in the field, sometimes funded by the Wellcome Trust. The model of bringing together experts from a variety of disciplines and backgrounds, using presentations, debate and discussions of projects already in train or completed, sought to provide a helpful springboard towards a much more developed field of biomedical ethics as applied to mental disorder and health.

2.2. Investigating ethics and mental disorders

Nigel Eastman

Professor of Law and Ethics in Psychiatry, St George's Hospital Medical School

Psychiatry¹ is ethically unusually problematic. Unlike in most other medical and health care domains, even the status of many of the 'diseases' or 'illnesses' that are treated by mental health care professionals is often the focus of ethical debate. Even the definition of what is 'treatment' is frequently, and properly, open to ethical analysis.

Yet it seems that only some psychiatry is considered obviously and unusually problematic, whilst some areas of the discipline are perceived as undifferentiated from the rest of medicine. The recent high profile political and professional debate about personality disorder and its social management has been conducted, for example, against a backcloth of profound scientific and ethical division within psychiatry itself about whether personality disorder is the proper concern of the discipline at all, given that it is a 'whole person' disorder with uncertain boundaries and uncertain treatability. But other disorders are usually perceived as straightforwardly 'medical'. Hence, dementia is a condition which, like personality disorder, presents with mental symptoms but arising out of physical deterioration

¹ In a 'politically incorrect' fashion, for brevity the term 'psychiatry' is used as a shorthand for all 'clinical mental health care disciplines'

of the brain. As a result, the usual common issue is merely whether the condition should be dealt with by neurologists or psychiatrists.

Psychiatry as a discipline therefore potentially seems squeezed between dealing with human conditions that are 'not medical enough' and others that are 'merely medical'. This emphasises the hybrid nature of psychiatry, covering as it does conditions arising from widely divergent 'causes' of mental symptoms and ranging in its nature between abutting criminology at one 'pole' and neurology at another. There is also a tendency to draw its boundaries as much in health organisational terms as according to the 'true nature' of the conditions that it treats. Hence, it is largely psychiatrists, not neurologists, who treat demented patients, based on service response being determined not by the nature of the underlying pathology of the condition but its clinical features, that is, based upon its symptoms being 'mental'. Even more broadly observed, there is also dispute about whether the personality disorder end of the spectrum of mental conditions should be dealt with not by health agencies at all but by the criminal justice system, or by other social agencies.

The 'classic critique' of psychiatry is that of Thomas Szasz. This asserts, essentially, that any psychiatric diagnosis that is not objectively verifiable by way of 'science', amounts to mere social labelling, not 'disease' (of course, the alternative notion of 'illness' does potentially incorporate psychological or social aspects). Hence, non-objectively 'verifiable' conditions, if accepted erroneously as diseases, or at least illnesses, open psychiatry up to social and political misuse, or abuse. The latter critique is particularly relevant to the current high profile dispute about the proper role of psychiatry in protecting the public from the behaviour of personality disordered individuals whose 'disorder' can be characterised either medically or socially/criminologically.

But there is a new framing of the anti-psychiatry debate. Bill Fulford argues that all medical diagnoses are 'value-laden' and that the only thing that is special about psychiatric conditions is that some of those conditions are quantitatively more value-laden than many other non-psychiatric medical conditions; they are not qualitatively different from non-psychiatric medical conditions. That is, all diagnoses inherently contain a fact:value ratio and each sits on a 'spectrum' of such ratios. Hence, personality disorder has a low fact:value ratio, whilst dementia has a high ratio. And there is commonly an association between there being a high values quotient contained within a particular condition and the potential for re-framing that condition from medicine into a different model, commonly a social model.

By implication, therefore, there is no need to attempt to define the boundaries of psychiatry strictly, nor to conduct the debate about the proper boundaries of psychiatry in terms of defining psychiatry. Rather, all that is necessary is 'values insight' on the part of practitioners, citizens and policy-makers. The lower the factual content, and the higher the values content, of a particular condition, the more open is it to social or state use, and potentially abuse. And, unsurprisingly related to this, the less fact there is in a diagnosis the more amenable is it to reconstruction into another paradigm. The core issue is not whether (parts of) psychiatry are properly part of medicine but the extent to which some conditions which psychiatrists sometimes treat can be re-framed into a different model, and the extent therefore to which there is a danger of psychiatry being used for social purposes going beyond those purposes which psychiatrists, as a body, would see as proper, given their social definition and regulation as 'doctors'.

The foregoing does not infer abolition of quite obvious, difficult and key ethical and policy questions such as: Are mental disorders 'proper medical conditions' rather than extremes or elaborations of psychological normality? Or are they merely 'social labels' used to effect social control, legal excuse or civil incapacity, sometimes resulting in misuse of psychiatry? Rather, it suggests some refinement of how such questions might be approached.

Given the special nature of psychiatry in some of its domains, it is unsurprising that it abuts not just with the rest of medicine but also with social and legal constructs. Hence, adjudicating civil capacity and criminal responsibility utilises psychiatry in ways that go beyond the use by society of medical specialties with more fact and less value within them. And the State both reinforces and modulates such roles of psychiatry. Hence, as described by Chris Heginbotham, in England and Wales, the Mental Health Act 1983 and the Draft Mental Health Bill both discriminate in their scope and rules concerning compulsory treatment against those suffering from mental disorder. Yet the very definition of mental disorder is profoundly problematic. As Eric Matthews argues, making the distinction is impossible in any robust way, and this conclusion clearly bears some relation to re-framing of the 'anti-psychiatry' debate in the way that Fulford does. So it appears there is a 'double whammy' for the mentally disordered: a law which discriminates against them by allowing overriding of their capacitous refusal of treatment for their disorder; and uncertainty as to the scope of that discrimination, because achieving a definition of mental disorder, and treatment for mental disorder, is so problematic (albeit the Courts have decided upon broad definitions of mental disorder and its treatment). A natural question which arises, therefore, is 'does law enable or constrain ethical mental health care?'

Lurking behind all of this is quite obviously politics. Government proposals for a new Mental Health Act include compulsory treatment of those with medically conceived untreatable personality disorder.² This confronts psychiatry starkly with the question of what should be the boundaries of its social role, simultaneously emphasising its own identity crisis within medicine.

Biomedical ethics research as applied to mental disorders and their treatment therefore includes, but goes far beyond, consideration of the proper uses and allocation of therapeutic interventions established as effective treatments for well defined (high fact:value ratio) medical conditions. So, if we are to incorporate a new ethics of mental health, rooted in the juxtaposition of values and facts, are there ways of creating an ethically informed and 'values aware' decision-making framework within mental health care and law?

In addressing such research questions as those just described, the Biomedical Ethics Programme aims to promote interdisciplinary empirical research. But empiricism in the field of ethics can operate in different modes. There can be research concerning solely how 'actors' operate, often clinically, within particular professional and social domains and activities, where such operation has obvious and important ethical implications. For example, much research funded by the Trust has focused on how genetics clinics function in what are inevitably ethically sensitive areas. However, it is open to debate whether, on its own, this amounts to 'empirical ethics'. Another approach would require that, for a piece of research to come within 'empirical ethics', it should address empirical questions directly in relation to a theoretical ethical framework, or at least in relation to specified ethical questions (what, in one of the discussions within the meeting, was later referred to as 'addressing an itch'), and do so in an interactive way. Hence there should be evidence of completing a circle between ethical theory and empiricism (as Tony Hope puts it), such that each reflects and then informs the other, in a continuous process of enquiry. Alternatively, is it sensible, almost administratively in terms of which funding bodies should fund which types of research, to define empirical ethics so as to include empirical investigation, often based on social science methodologies, where that empiricism is conducted in domains that are clearly ethically problematic but without requiring explicit linkage with ethical theory?

² Much of the conflict between the government and virtually all of the bodies concerned with mental disorder and its care, certainly the conflict with the Royal College of Psychiatrists, relates to the proposed abandonment of a 'treatability' test within a new Mental Health Act, and to government resistance even to a broader 'therapeutic benefit' test.

But is establishing an accepted definition of empirical ethics necessary? Perhaps ultimately not, particularly since different definitions can be constructed towards different purposes (for example, simply in order to determine which bodies will elect to fund which types of research). But definitions do clarify what is the type of endeavour envisaged and also serve as shorthand in ways that can be helpful. The importance of explicitness and clarity is emphasised by the fact that it is indeed not uncommon to label research as coming within 'empirical ethics' when, in fact, it includes little or no reference to theoretical ethics. Yet ethics is, perhaps 'ethicists' and philosophers might particularly argue, ultimately a normative and not an empirical discipline. Clearly a variety of empirical sciences, very often social sciences, can very helpfully contribute to research in ethical domains. But, without an accepted discourse about the types, and often different types, of contribution that can be made by various empirical sciences within ethical domains, there are often practical problems of assessing grant applications, often giving rise to the rhetorical question from a Panel member "But where is the ethics in it"? Even if all of this amounts to no more than an organisational problem, if the administration of research funding is properly to serve the research agenda in biomedical ethics in a coherent way such issues need to be addressed. More importantly, at least debating the boundaries must offer a better understanding of the different 'types' of empirical ethical studies.

We therefore hope that the results of this seminar will have relevance not only to ethics research in relation to mental health, but also to biomedical ethics research as a whole. We hope also that it will inform an ongoing debate concerning the contributions of varying theoretical and empirical methods within such research.

3. SUMMARY OF PRESENTATIONS (DAY 1)

3.1. Ethical issues in mental health policy, practice and research

Chris Heginbotham

Chief Executive, Mental Health Act Commission

Mental health care has been undergoing a transformation as new treatments become available, new service models are developed and new policy frameworks are written. The National Service Framework heralded a new era for mental health services but many of its promises have still to be delivered. To the patient or service user the changes seem barely visible: services remain patchy, fragmented and uncoordinated; many service users and staff question the commitment of government and health agencies to fulfil the latent promise of higher quality care; and resources never seem to be sufficient to achieve the aspirations of policy.

Much of the significant research, service and policy programme currently in hand has an explicit ethical dimension, with evident ethical and values-based tensions. For example, two parliamentary Bills are in preparation that affect mental health directly - the Mental Capacity Bill and the Mental Health Bill - but they have very different basic rationales and philosophical underpinnings. Whilst new, sometimes untried, models of care are introduced without the necessary testing that would normally accompany the implementation of new methods of assessment or treatment in other medical domains.

The treatment of patients with mental disorders has traditionally suffered from a paternalistic social and political attitude, with little respect for autonomy – and this persists today in many areas. Whilst the need for good mental health service provision has never been greater: approximately 46,000 detentions are effected every year under the Mental Health Act; and increasingly Section 3 (detention up to 6 months) is being used over Section 2 (detention up to 28 days).

Two recently proposed pieces of legislation relating directly to mental disorder are, in comparing one with the other, confusing, and likely also to cause client and professional confusion in their operation. Regarding the Mental Health Bill, major concerns remain among service users and patients, providers, clinicians and advocacy agencies about the definition of mental disorder adopted, which is extremely wide, the conditions for compulsion, misuse towards preventive detention directed towards public welfare, and the availability of appropriate treatment, among others. The proposed Bill might raise the threshold for compulsion for those with clearly defined of mental disorder, but lower the threshold for those with less defined mental disorders – how can this be ethically justified?

By contrast, the Mental Capacity Bill favours a ‘capacity’ and ‘best interest’ test, rather than a dangerousness test, so as to achieve a non-discriminatory approach, that is, between physical and mental ill health. However, concerns remain regarding the civil rights protection of patients under the proposed Mental Capacity Bill. Mental capacity is undoubtedly an area for continuing research.

Other current important problems in mental health services and care provision include: the increasing number of deaths of detained patients in hospital; stigma; institutional isolation and inappropriate placements of those with mental disorders in high secure hospitals; *de facto* compulsion; questions concerning the appropriateness of current treatment of prisoners with mental disorders; plus inequalities and institutional discrimination within mental health services generally.

3.2. Recent advances in severe mental illness: causes and treatments

Shôn Lewis

Professor of Adult Psychiatry, University of Manchester

Four vulnerability genes for schizophrenia, each conferring an individually small effect, have now been confirmed. The role of environmental factors has become increasingly clear in the aetiology of schizophrenia, with the role of psychosocial environmental factors becoming more important. Early neurological risk factors such as obstetric complications confer approximately 5-fold increased relative risk of schizophrenia. Later psychosocial risk factors include urban upbringing, which increases the risk of eventual schizophrenia by about 7% for each year spent in a city during childhood. The role of cannabis use has been highlighted, whereas previously it was thought to be a triggering factor, it is now likely that cannabis is a true etiological factor, increasing the risk of schizophrenia about 5-fold, with use in early teens increasing the risk most. It is likely that such environmental factors operate on a pre-existing genotype.

The phenotype of psychosis continues to be redefined. The prevalence of isolated psychotic symptoms in the general population appears to be considerably higher than previously thought, perhaps up to 15% of the population, although usually these symptoms are not accompanied either by distress or help-seeking behaviour. The implications this has for the nosology of schizophrenia and psychosis has yet to be resolved. The phenotype also extends backwards, such that so-called prodromal symptoms, for example hallucination-like phenomena, cognitive disorganisation, have been reliably identified. When accompanied by help-seeking behaviour, these increase the risk of schizophrenia markedly such that 20-40% of such individuals will develop an axis 1 psychosis within one year.

The first early intervention trials for prodromal states, purporting to be primary prevention and involving drug or non-drug treatments are now reporting. However, is it ethical to give treatment to those who may not need it? Conversely, is it ethical to withhold treatment from those who may need it? More widely, early intervention in psychosis is now an international priority, where individuals with psychosis are detected early and treated early in order to

theoretically enhance longer term outcomes. The Mental Health Research Network is part of this international effort.

3.3. Ethics and the distinction between mental and physical disorder

Eric Matthews

Emeritus Professor and Honorary Research Professor in Medical Ethics and Philosophy of Psychiatry, University of Aberdeen

There are contradictory attitudes to mental disorder in modern culture, and the uncertainty this contradiction creates bears on the ethics of psychiatric treatment. One of the principal roots of the problem lies in philosophical confusion about the concept of the mental; addressing this confusion can therefore go a considerable way towards clarifying the ethical issues in mental health research. It is hard to draw a sharp distinction between physical and mental disorder, instead there is a continuous spectrum of states that raise various ethical difficulties.

In the biomedical model of disease, illness arises from an externally caused biological malfunction, which impedes normal activity and ultimately survival. However, the biomedical model does not apply very well to mental disorder. Such disorders are departures from human norms rather than normal biological function. For example, hearing voices is only a sign of mental illness when it can't be accommodated within cultural norms (either your own or your neighbours'). The same pathology is likely to underlie instances of hearing God's voice commanding the murder of prostitutes, and God's voice commanding the evangelisation of prostitutes. But the notion of mental disorder will apply differently in the two cases. Accepting the biomedical model for mental disorders means attempting to locate and eliminate an underlying pathology, even if the individual does not self-identify as ill. This then commits to wholesale medical paternalism, which offends against individual autonomy: interventions for mental disorders are designed to prevent harm to others, not for the person's own good (cf. JS Mill). How then can we develop an ethics of treatment regarding mental disorders?

The philosophical basis of the biomedical model is Cartesian, and herein lies the root of the problem: Cartesian dualism leads to the idea of the mind as a substance separate from the body. The mind is not a machine, as the body is; it operates in terms of reasons, so it can't be diseased in the way that the body can. Mental illness is therefore self-contradictory. Anti-dualists argue that the mind is purely physical ("the mind is the brain"). Both parties make the fundamental mistake of treating the mind as a thing.

Gilbert Ryle argued that the dualism debate turned on a 'category mistake'. We know how to use the word 'mind' in ordinary language, but in theorising about it we have been misled by the fact that the word 'mind' is a noun, into assuming that it must name a thing, a substance.

One possible way of overcoming this problem is to go back to the ordinary meaning and use of terms – we reveal our minds to each other in voices, movements, facial expressions etc., leading to meaningful interactions. To talk about minds is to talk about people in a particular way (ie. one that focuses on their meaningful interactions). This does not presuppose a 'non-material self', nor does it identify thoughts with brain processes. We can thus avoid having to choose either pole of the dualism debate.

This transforms the terms in which we should view mental disorder. If mind is shorthand for the full range of meaningful interactions with other people, then mental disorder must be viewed as a deficiency in those interactions. Mental disorder is therefore a disorder in a person's whole relation to the world and to others. Treatment of mental disorder should aim to restore the full range of meaningful interaction to the individual (ie. it should aim to restore

lost autonomy). However, because autonomy has been lost in mental disorder, it is not the case that restoration of autonomy via psychiatric treatment simply means following the patient's currently expressed wishes. We can be acting to restore autonomy even if we override patient refusal or do not observe patient confidentiality.

3.4. Discussion of presentations

Despite their apparent differences, the presentations identified a common theme: consideration of mental health policy is crucial to ethics research in mental health. The importance of this is exemplified by the dichotomy between intervention and judgment, and the tension between autonomy and paternalism in policy-making. So what are the areas or questions that we might profitably address in this field? The following strands emerged from discussion:

- One approach could be to examine issues relating to the clash of values in mental health policy –including consideration of when, should, or how does one set of values 'trump' another? And how might one develop methodologies to see how these clashes are resolved, or not?
- Conceptual work should be tied in with practical work in research: engaging with a problem sometimes reveals that the problem is often about meaning. Investigation of communication, language is central to this field of research.
- It would be of interest to examine the impact of legislation on people affected by mental disorders, and to set the results in a theoretical ethical context or critique.
- Should research in this field address hypothesis-driven questions, or be driven by issues that come arise from in medical research or practical policies or law making?
- Ethics research that is policy-led moves away from the conceptual and should be flexible in its methods. A research portfolio in this area could include projects with immediate policy relevance, and projects examining underlying key issues, with more sustained investigation pursued over time and in different and developing policy contexts.
- More methodological pluralism is needed in this field.
- It would be of interest to undertake international comparative research, with particular comparison of England and Wales with Scotland, given that the two jurisdictions have pursued very different policy approaches, based on very different underlying ethical principles.

4. DISCUSSION GROUPS

4.1. Is mental incapacity researchable and, if so, how?

Chair: John McMillan, University of Cambridge

General hospital and old age psychiatrists are frequently asked to assess whether patients with physical illness have mental capacity to make decisions regarding medical treatment. Dr Matthew Hotopf introduced research using the MacArthur Competence Assessment Tool-Treatment (MacCAT-T), assessing the capacity of patients admitted acutely in a general hospital setting and of those admitted to three psychiatric wards. The research assessed the inter-rater reliability of the MacCAT-T when two psychiatrists interviewed patients separately. In summary, Dr Hotopf's data suggest that capacity can be reliably measured in this way and that the MacCAT-T is a valid measure of capacity. Significant levels of cognitive impairment exist in general hospitals; the research supports conclusions that patients who are quite physically ill often lack capacity, and that incapacity often occurs in general medical contexts and unrelated to functional mental illness. A degree of agreement between clinical teams and relatives exists, although the study demonstrated that clinicians do miss many cases of incapacity. A useful next step would be to look at where the threshold for capacity should be

set, since the MacCAT-T does not offer a cut off for the binary decision concerning loss of capacity.

In a second presentation, Dr Jacinta Tan presented findings from a pilot study that explored the beliefs, values and attitudes to treatment (including compulsory treatment) of adolescent female patients with anorexia nervosa and their parents, as well as with consultant psychiatrists having a range of types and levels of experience in treating eating disorders. Patients with different onset and duration data for their anorexia nervosa, different experiences of treatment, plus eight sets of parents, were interviewed. Their competence was also assessed using the MacCAT-T, and despite it being onerous to administer, patients did well on measures of capacity. However, they all spoke of difficulties in decision-making. This reflected the distinction between 'cognitive' and 'evaluative' disabilities contributing to incapacity to consent to medical, including psychiatric, treatment. Whilst Dr Tan's study and that of Dr Hotopf offered a similar comparison, since the majority of patients in his general hospital sample who lacked capacity did so as a result of cognitive deficits, arising in turn from physical, rather than functional mental, ill health.

This body of research aims to clarify the concept of incompetent refusal of treatment, to help resolution of clinical ethical dilemmas involving patients who frequently resist or refuse treatment, and to provide policy solutions for managing treatment refusal, given the current wide range of professionals' responses to such patients.

Dr Tan explained the dilemma often faced in cases of anorexia nervosa: if a patient is competent to refuse treatment then that refusal should be respected; however, if their competence is absent then health professionals must act swiftly to protect the patient from their effects of their own decisions. She further highlighted that decisions concerning consent are often systemic in their determination, with two particular typologies: a patient makes decisions within their family and with professional support, or, a patient makes decisions himself or herself. Restricting choices left available to the person can have the effect of shoring up the 'real self' against the 'anorexia nervosa self', such that the battle in treatment/recovery is directed towards reclaiming the real self.

In summary, Jacinta Tan hopes that this type of research will help to improve the understanding of how anorexia nervosa patients make treatment decisions and that this, in turn, will contribute to a better understanding of competence. It is hoped that, thereby, tools and policies can be developed to help clinicians to strike an 'appropriate' balance between protection of the patient from harm and protection of the freedom of the patient.

The group discussion raised several points. Some wanted to emphasise use of the element of 'appreciation' (of situation) which is included in the MacCAT-T, in order to address the evaluative disability in patients represented by mismatch between externally observed 'fact' and 'self-view', as evidenced by Dr Tan's findings. Others emphasised the importance of disorders of volition in some groups of individuals coming into contact with mental health services (for example, those exhibiting anorexia nervosa, substance abuse, addiction to substances or otherwise, deliberate self-harm), such that it might also be fruitful to measure 'volitional impairment'.

Questions arose regarding research processes: the semi-structured interview technique allowed Jacinta Tan to pursue unexpected issues, facilitating patients in identifying issues of relevance to them, rather than imposing the researcher's method or view of framing problems. Moreover, capacity may be most difficult to assess reliably where no definite cognitive impairments exist. Thus the duration of a disorder or event may necessarily affect research design. From a purely clinical point of view, many of the patients interviewed Jacinta Tan felt had some capacity but would not be measured competent on the MacCAT-T for example. By contrast, some patients had the ability to reflect on thought processes but

those processes themselves seemed to evidence incapacity. This poses an interesting tension for the researcher, perhaps arising from the inappropriateness of thinking of appreciation as a cognitive issue.

A number of concerns with determining 'best interest' were identified. How should proxy decision-making work in practice, for example, and whose view of a patient's best interest should hold sway? Should this always be the person making the decision? In practice, will it always be that person? There is evidence to suggest that the correlation is very poor between the wishes of those who are competent and the surrogates they would wish appointed in advance of becoming incapacitated. And, when considering a patient's ascertainable wishes, currently as well as previously, how much weight should be given to the former? Three legal approaches were identified, the merits of which might be explored:

- In Scotland, a guardian makes decisions for the benefit of the person, with greatest involvement achievable for the individual and according to certain principles.
- In England and Wales, the person who needs the decision to be made is responsible for judging both capacity and best interests, in consultation with others.
- The USA prefers a substituted judgement approach, based on written or other evidence of the person's wishes where possible, or on knowledge of the individual from which a decision-maker can make a judgement. The best interest model is least favoured.

Potentially, both presenters' research implies that the clarity required by law in terms of capacity is not yet available. Tools such as the MacCAT-T do offer ways to make assessments more inter-rater and inter-case reliable and also help people be explicit about both their values and the process for decision-making; it can therefore help to enhance the justifiability of decisions. But can the law provide a framework for judging decisions, eg. by setting out the principle that functional ability should be considered over and above disease status?

Fluctuating capacity could be an opportunity to study both decisions made by the proxy decision maker and then by the re-capacitated person, and to explore the person's view of their own decision making over time. It was emphasised that both concepts and instruments need to deal with 'the person located in the world'.

Some in the group felt it important not to focus solely on measuring and understanding existing capacity, but to explore ways to facilitate improvement. Research in the US looking at learning disabilities has shown that those with low scores on the MacCAT-T can improve their scores through repetition of information and the use of different and interactive media as means of communication. This suggests a two stage approach, which may take account of the tension experienced in Jacinta Tan's work: to facilitate first, and then compensate for those who need greater protection.

It is also important to distinguish between decisions regarding capacity and those regarding best interest, as the latter can be unexpected. For example, some anorexia nervosa patients have or need a cyclical therapeutic experience, others a one-off intervention.

Finally, discussions focused on the possibilities of collaboration and pooling of resources, methods, and areas of interest. And the question was posed, for example, of whether the Wellcome Trust might emulate the MacArthur research networks by bringing together and funding groups to design programmes of research. This would allow legal and policy analysis to combine with theoretical conceptual work and with empirical work involving a wide range of groups (eg. such as those conducting work which falls within the scope of the Mental Capacity Bill).

Potential themes for future investigation included:

- Autonomy as a systemic issue, placing it within an understanding of its relationship with the environment.
- Autonomy and concepts of the 'self'.
- Assessment of volitional impairment as complementary to the MacCAT-T.
- The concept and understanding of 'appreciation' in capacity, as already included in the MacCAT-T.
- Capacity as a framework for creating a therapeutic alliance, including by recognising the interplay of professional and familial relationships.
- Capacity as part of a legal framework – where is greater clarity regarding capacity needed to form the basis of law? What should be the threshold for capacity? What are the elements needed for judging individual competence?
- Moving beyond the assessment of capacity to the identification of ways to enhance and retain capacity.
- Longitudinal studies examining capacity and best interest over time.
- How to shift attitudes towards an enabling approach for capacity?

4.2. Treatability in mental disorders: ethics and objectivity

Chair: Adrian Grounds, Institute of Criminology, University of Cambridge

Dr Mariam Fraser led the discussion with a paper on her Trust-funded research project, which had examined the first case to come before the US courts concerning the safety of Prozac. This had been prescribed in 1989 to one Joseph Wesbecker shortly before he shot 20 of his colleagues (eight of whom died), and then committed suicide. The court case involved arguments over whether Eli Lilly (the manufacturers of Prozac) had behaved ethically in the manner in which they established the safety and efficacy of the drug. This was closely connected to the question of whether Eli Lilly's clinical trial methodology was objective, or whether (for example) it had been unduly influenced by commercial imperatives.

Rather than adjudicating between the opposing parties' claims to objectivity in the Wesbecker case, Dr Fraser sought to establish an alternative perspective. She argued for a view of science and medicine that embraced complexity and contingency, instead of treating them as noise to be minimised via 'objective' methods. Treatment was a complex 'occasion' that could not be decomposed into other factors. Complex medical conditions such as Wesbecker's had to be approached on their own terms, and the results from clinical trials could only be of limited use. This perspective sought to avoid reductionism, whether social or biological.

Dr Fraser's work drew on Isabelle Stengers' concept of 'relevance'. This perspective stresses that facts and values are convolved, in contrast to ethical (and scientific) approaches that seek to keep them apart.

One context of application for this idea would be the placebo effect (which is very important in psychiatry). What would medicine and medical research look like if the placebo effect were approached positively and constructively, rather than merely as a confounding factor?

Regarding the case study itself, some members of the group felt it did not provide a sufficient basis for the claims being made concerning ethics and objectivity. Interpretation of the court's proceedings should focus instead on the 'language games' played by US lawyers rather than contested notions of ethics. Other members of the group preferred to see this particular context as a potential strength of such research; the legal framing of the issues

should be 'foregrounded', and could be used to examine the ways in which legal discourse employs ethical terminology.

The group went on to explore wider questions of how different disciplines understood 'ethics' as a subject of enquiry. There were important methodological differences; for example, a philosopher would seek to evaluate the arguments being deployed in a particular situation in order to determine which should or should not be accepted, whilst an anthropological approach might focus on the patterns of deployment of ethical argument by various actors, and their underlying purposes. More fundamental difficulties could also arise when the core assumptions or methods of one discipline were taken by another discipline as legitimate subjects in themselves for enquiry and critique.

The group felt that some issues in ethics and mental health would benefit considerably from an interdisciplinary approach – one in which, ideally, all researchers should engage so that genuinely novel methodologies and findings could emerge. Possible issues included:

- The notion of the real child (which is released by Ritalin) held by some parents of children with ADHD
- The relationship between the development of new pharmaceuticals and the evolution of psychiatric diagnostic categories.

The group recognised that interdisciplinary approaches might not be appropriate for the full range of research questions in ethics and mental health. In some areas it would be a positive advantage to examine issues via a range of separate approaches and theoretical perspectives:

- The notion of treatability
- What are the different purposes of treatment? To effect physiological change, attitude adjustment, induction of repentance in offenders, etc.?

These studies might then form the basis for subsequent interdisciplinary collaborations.

4.3. Mental disorders: medical conditions or social labels?

Chair: Michael Parker, The ETHOX Centre, University of Oxford

Dr Gwen Adshead introduced the session by asking: Can we validly distinguish between physical and mental conditions?

The group defined a physical condition as something that could be seen, referring to the structure of the body, manifest through pain and pathology, sometimes caused by an external agent, independent of mental state, hence highlighting the presence of most physical conditions at the fact end of the fact:value spectrum. Fact has its own evaluative basis. Hybrid conditions, including but not limited to mental disorders, are more open to interpretation, as they incorporate more value judgments.

Values were seen as forming part of the 'sense of self' and therefore as challenging notions of personhood. In some mental disorders, the sense of self can be negatively affected, but it can also be positively affected. For example, people with personality disorder often do not feel that they have a disorder, and/or they do not always feel that their condition is a 'bad thing'.

Some suggested that a moral hierarchy of mental disorders already exists; consequently, mental disorders have their own social labels. For example, because personality disorder is so stigmatised, patients are asking to be 'reclassified' as schizophrenic, since this is a condition seen as medically treatable. However, the hierarchy is not straightforward.

This led to a discussion of how psychiatry 'fits into' the taxonomy of medicine, and the impact of this on end-users. Members of the group felt that mental health conditions presented greater complexities in terms of values than other medical disciplines (although it was noted that some areas of medicine were becoming more value-laden), due to the inherently diverse nature of human values. Added to this, it was felt that scientific/biological explanation in psychiatry has less authority than in other medical disciplines.

The boundaries between a medical diagnosis and social label can be productively investigated by academics; however, this dichotomy has most significance and real meaning for service users, as they live within these boundaries. The group agreed that more future research should include the views of service users, for example with regard to risk assessment, stigma, etc. Although some such research has been carried out, much of it has not been translated into policy. And this begged the wider question of how mental health policy is driven? Some doubted that research had much impact.

Finally, the group agreed that values play a key role in any research undertaken in mental disorder and ethics, and that any such research would benefit from interdisciplinarity and a relatively broad agenda, including issues of social exclusion and stigma. Potential future areas and questions for exploration were identified:

- Public constructions of mental disorders
- Patient experiences of social labels
- The politics of resource allocation in mental health services
- Do new drugs frame new diseases?
- How do diagnoses change? How can a diagnosis of personality disorder change to one of schizophrenia, for example?
- Personal identity in mental disorders
- Is it through the legal system that values relating to mental disorders are expressed?
- How do past attitudes influence future diagnoses?
- Ethical ethnography
- Ethical issues raised by new technologies, for example, brain imaging
- How is disability conceptualised? How does this impact on psychiatry and on patients?

4.4. Risk assessment and management of mental disorders: techniques & ethics

Chair: John Crichton, Royal Edinburgh Hospital

The Chair opened the session by introducing the topic of risk assessment and highlighting that the Government's ideal of being able to predict violence and therefore prevent it before it happens was the stuff of science fiction.

Dr George Szumukler gave a short presentation on the way in which risk assessment is used in mental health settings, highlighting the tension between individual rights and public rights by reference to 'the mathematics of prediction':

- Numbers – predicting rare events is difficult, and predicting serious acts of violence in mental health is no exception. The research tools for predicting serious acts of violence are extremely inaccurate (eg. Buchanan and Lees model, based upon – analysis of multiple outcome studies is correct only 2 times in 100, based upon a presumed 1% base rate of violence; the McArthur foundation model is correct 3 times in 100). Either model therefore infers an enormous number of false positives for violence. Hence, the policy that mental health practitioners should subject all patients to an assessment is flawed and profoundly illiberal. This is because it assumes that many will have to be detained in order to prevent one seriously violent act.
- Values – What level of false positives in risk assessment is acceptable? Who makes that decision? Ultimately, a cost/benefit trade-off is being enacted: the benefit being

that society is supposedly protected; the cost is that patients with mental disorders, already a socially excluded group, are further discriminated against and stigmatized.

- The question also arises: why are not all 'dangerous people' risk assessed (not just those with mental disorders)? Risk assessment in mental health policy is discriminatory against mentally disordered people, or patients, so that it is unethical to support risk assessment in the manner that it has been introduced in this country. Within a Venn diagram of 'total social violence', those with mental disorder represent an extremely small proportion of the total, such that discrimination in favour of risk assessment of the mentally disordered is mathematically unjustified and socially inefficient as a means of limiting risk to the public.

The Chair then asked the question, given the above analysis of risk assessment, what research questions need to be explored?

Research questions suggested were:

- What is the impact of risk assessment on the patient?
- What are the other costs of risk assessment?
- Are patients more likely to consent to treatment, or research, after risk assessment?
- Are there benefits to those people who have undergone risk assessment and are perceived to be at high risk (eg. better treatment)?
- Is it justifiable to operate within a system in which society benefits at the cost of a small number of people?
- To what extent is this a unique problem? Does it belong to a class of problems?
- Within ethical policy analysis – how is risk enshrined in policy? Do comparisons of policies in different policy domains reveal difference in underlying values? Might such analysis influence government?
- Are there circumstances in which current policy could be considered ethical? For example, are there circumstances in which discrimination against the mentally disordered could be ethical? That is, given that discrimination is not, of itself, what matters is the 'justification' offered for any discrimination adopted.
- What is the language of risk? What are meant by the terms used in the risk discourse, and how are they used?
- How do you balance protecting society versus individual rights? What does comparison of different attitudes (eg. surveys of publics, end-users, philosophers) reveal?
- Is there a social basis for risk aversion?
- What should we do about the dangerous, when and how?
- Within assertive community treatment (going to see patients who do not want to be seen, when is such 'intrusion' or 'coercion' justifiable; thus when do you visit a patient who does not want to be seen?
- When and how is new law being made? Where the Law Commission is asked to review areas of law related to the mentally disordered, to what extent does it consider ethical issues, either explicitly or implicitly?
- What are judges' perceptions of what experts can offer within legal decision making concerning the mentally disordered?

It was decided that the overriding principle at stake in this debate was 'justice', but that it was likely that society is content, even keen to accept the high number of false positives, with unjustified deprivation of liberty, in order to save one life.

Within the group, there was general agreement that the current practice of asking first whether a person has a mental disorder, and second, whether they are a risk to others, is to address matters 'the wrong way round'. Rather, the primary question is: Is this person

dangerous? Thereafter, consideration of whether to intervene, and in what way, might properly depend upon their mental health status.

Risk assessment is routinely used outside of mental health and general health services, for example in the airline industry. In these settings, it is assumed that mistakes will occur, and human frailty is acknowledged. Risk management systems are therefore designed to take account of the 'inevitability' of human error. In psychiatry, this is not the case, and the search is constantly pursued towards 'perfect decision making', whilst there is ignoring of the advantages of risk management systems which accept, and plan for, human error.

4.4. Summary of plenary discussion of group reports

Much of the general discussion regarding the different breakout groups focussed on models of interdisciplinary working. It was highlighted that mutual incomprehensions were common whenever different disciplines started working together. And, for interdisciplinarity truly to work in ethics research, an understanding of each discipline by the other must precede collaborative research – that is, the achievement of "true mutuality". Put alternatively, interdisciplinarity does not simply constitute an additive model of different disciplines, but an interactive one.

It was felt that the field of biomedical ethics should not be defined by any one discipline, and that it offers a fertile ground for innovative interdisciplinary research. Such research should attempt to marry theoretical and empirical work, incorporating 'value' content in an explicit research question, without neglecting essential 'blue-skies' research. The Biomedical Ethics grants programme, defined as supporting research into the ethical, legal, social and public policy aspects of biomedical science, has always embraced many disciplines (cf. its genetics funding portfolio), and continues to do so. And the programme can assist in building interdisciplinary research, by providing advice on methods and models of different disciplines working together, based upon its experience of evaluating and sometimes supporting multiple interdisciplinary research projects.

Specifically regarding ethics and mental disorders, some expressed the view that many of the issues being discussed at the meeting reflected familiar dilemmas (eg. capacity), that is 'the big questions', that remain insoluble, albeit they will continue to be debated. It was suggested that smaller and 'developing frontier' areas could be focused on: for example, screening, behavioural genetics, enhancement and direct alteration of brain function, and confidentiality. However, concerns were expressed that the familiar problems should, however, not be neglected, and that the reason they were 'enduring' was that they were 'inevitable', could not be avoided, and were often reflected in 'smaller' and more specifically defined questions. And, for example, one should consider patients' views of 'old issues', since these may, in fact, be the issues most relevant to mental health service users. Whilst, in addition to promoting research into the implications of cutting edge advances in neuroscience and mental health (be these defined by academics and/or by service users), research should also be encouraged into new methodologies as applied to familiar problems.

Regarding research into policy aspects of mental health, it was emphasised that a policy issue does not necessarily constitute an ethics research question. Research into policy in mental health needs to be focussed on an ethical dilemma, for example, an ethical issue not yet addressed by legislation, or how a piece of legislation deals with an ethical issue.

Another strand of discussion concerned the relative contributions, and inter-relations, of differing empirical and theoretical methodologies. The comparison emerged of 'bottom up' and 'top down'. Hence, philosophers tended to be researchers of ethical theory in search of an example; whilst social, and other empirical scientists, tended to take examples of

'empirical domains' and to conduct research based on that particular methodology's own conception of 'ethics'. There was a 'fundamental' debate about differing definitions of 'ethics' arising within and from different disciplines, both theoretical and empirical. This tended, initially, to pose a conflict between theoretician and empiricist, which has not uncommonly been represented within biomedical ethics research, with concern by theoreticians that empiricists ignore normative imperatives, whilst empiricists reject the notion that a philosophical 'overlay' was at all necessary, since social science methodology contained, within it, its own conceptualisation of ethical theory. There was the beginnings of a resolution of this conflict towards the end of the discussion, in that there was general agreement that, whatever research method was adopted, be it theoretical or empirical, there must be 'an itch', that is, there must be some normative question which 'bothers' the researcher and which is the focus of the research endeavour. The absence of any such 'itch' implied that any empirical research conducted was likely to be descriptive only and that, although its results might be relevant to ethical consideration of an 'itch', it must fall short of addressing any 'itch' directly. This discussion came to a much clearer resolution in day two, particularly after discussion emanating from the presentations that dealt with potential models of theory and empiricism interacting with one another and 'assisting' one another.

5. SUMMARY OF PRESENTATIONS (DAY 2)

5.1. Ethics, research and the legal framework

Genevra Richardson

Professor of Public Law, Queen Mary, University of London

In examining the relationship between ethics, mental health and the law, three main questions present themselves. First, is the legal framework governing this branch of medicine ethical? Second, is the practice of this branch of medicine ethical – in general, in a particular hospital, by a particular clinician? Third, is the conduct of research relating to this branch of medicine ethical?

In addressing the first question, attention must focus on the two legislative frameworks currently (or shortly to be) in existence. On the one hand, the Mental Health Act provides compulsory care and treatment of those with mental disorders in the interests of reducing risk; at its core lies the primacy of risk reduction, medical paternalism and little consideration for autonomy of the patient. Moreover, the Act treats mental disorders as fundamentally different from physical disorders. On the other hand, the draft Mental Capacity Bill acts to provide a substitute decision-making framework for all those who lack capacity, in which the autonomy of the patient is levelled by their best interests. Importantly, these two frameworks differ in several respects, both in definition and provision of capacity, best interests, treatment, resistance, safeguards and advance decisions; thus confusion remains as to which framework to use when.

Some certainties are apparent in the application of each framework: if treatment is required for a physical disorder and there is no capacity, the Mental Capacity Bill must be applied; if the treatment is for mental disorder, and there is capacity and refusal, then the Mental Health Act can apply. But what happens in the treatment for mental disorder in an absence of capacity, both where the individual is compliant and where the individual resists? If, in such situations, the Mental Health Act is used, it arguably provides better safeguards; however, it can increase the stigmatisation of the patient, and does not explicitly make provisions for a patient's best interests and advance decisions. Moreover, the Act does not elaborate the underlying principles governing the application of the Act, with respect to the distinction between mental and physical disorders, the proper conditions for compulsion, the priorities attached to patient autonomy and to social protection, and the diagnostics categories, which can be viewed as discriminatory. Perhaps, in dealing with the current

ethical dilemmas posed by mental health legislation, one could argue that the only way to avoid discrimination in mental health is not to treat mental disorders as 'special'.

In addressing the third question, one can ask whether research directed towards mental disorders is ever ethical? Does such research comply with ethical requirements; more specifically, is regulation in research ethics strangling relevant research in this field? Is it ethical to conduct research within a branch of medicine governed by an unethical framework? Notwithstanding these concerns, research into mental health and ethics might focus on several areas. There are roles for philosophers, lawyers and social scientists to investigate what an ethical legal framework might look like, especially with respect to issues of autonomy and capacity. Research into the mental/physical divide in medicine, and into the distinction drawn between ordered/disordered thinking would be useful. Regarding diagnosis, one might investigate how it is culturally determined, and implemented in the delivery of healthcare. How valid are definitions of capacity? What is encompassed in the definition of treatment: what a clinician actually does, or what they are seeking to achieve? Addressing such issues might ultimately lead to a more considered legislative framework for mental health.

Discussion

The question was posed: What would happen if there was no separate Mental Health Act, or the current proposed new Bill was dropped? Currently, psychiatrists use the Mental Health Act according to their own ethics and exercise a degree of conscientious objection with regard to the Act. The new draft Bill allows less room for conscientious objection, thus likely to incur more defensive practice on behalf of psychiatrists. Dropping it altogether would cause more dependence on the criminal justice system, argued by some as entirely appropriate.

Much research currently focuses on the definition of capacity, yet this research seems to be poorly translated into policy and clinicians are still unsure as to the use of the concept in various circumstances. The comparison was drawn with the situation in the US, where mental health statutes are based on capacity assessments but which, arguably have had no impact, since patients with mental disorders still experience greater violation of their human rights than patients with physical disorders. This, in turn drew the comment that valuable research might focus on how often people with mental disorders are compelled into treatment compared to those with physical disorders. Moreover, research could investigate the social context of decisions regarding compulsion.

A shift towards more attention being paid to research on users' views, public opinion (in a similar way to the recent consultation on sex selection), and various understandings of mental disorders towards establishing mental health legislation was encouraged.

5.2. How can empirical research reflect and inform medical ethics?

Tony Hope

Professor of Medical Ethics, The ETHOX Centre, University of Oxford

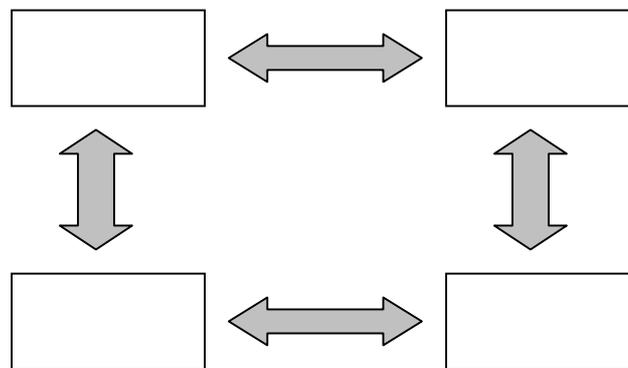
The "is-ought" distinction, originally drawn by David Hume, has led to the traditional belief that philosophy is about values, science is about fact and the two can never be reconciled, due to their fundamentally different natures. Extending this to the consideration of ethics, two arguments have been levelled against the notion of 'empirical ethics'. The first is that ethics must be concerned with the "ought", in other words, the normative. No amount of empirical information (which is concerned with the "is") will add up to an "ought". Thus, empirical work will not be ethics and so empirical medical ethics is a contradiction in terms. The second is that, although, in deciding what we ought to do, we often combine facts and values, the

empirical facts can be separated from the values. Science and ethics are both relevant to making decisions, but there is no reason to conceive of a discipline of empirical medical ethics. The classical model of medical ethics has relied on a linear relationship in which a clinical dilemma gives rise to a 'real' issue of concern for medical ethics, which then results in an application.

However, there are ways in which normative theory and empirical studies can interact:

- Empirical facts can form a key part of an ethical argument.
- Empirical studies can give rise to and identify ethical issues
- 'Ethical' interventions can be assessed through empirical work
- Surveys of views about an ethical issue (descriptive ethics) can inform ethical analysis
- Some ethical theories lead directly to empirical work
- Testing the validity of the empirical 'slippery slope'

Rather than being constrained in a linear model, a more useful representation of empirical ethics would rely on a cyclical model, in which ethical analysis, empirical issues, new data and empirical studies inform each other in a continuum.



Empirical ethics must therefore be normative in some way (ie. it must involve some ethical analysis that addresses the issue of what is morally right or wrong), it must include the systematic collection of empirical data, and the ethical analysis must affect the empirical design, and vice versa.

In this way, empirical ethics, or "critical bioethics", is a recognisable interdisciplinary field. It involves a cycle, at the macro or micro level, in which ethical analysis leads to empirical work that demands more ethical and conceptual analysis.

5.4. Debate

Much discussion surrounded the definition of ethical analysis and its boundaries. The point was made that ethical analysis is diverse, that empirical studies can sometimes be incongruent with ethical analysis and can throw up fresh questions for further empirical studies and/or ethical analysis. The counterpoint was made that, rather than being seen as being at odds with the model proposed, these comments could in fact be incorporated into the cycle of empirical ethics research: the model is not rigid in defining from where new avenues for ethics research can come – traditional philosophical questions and/or new concepts thrown up by empirical studies. If empirical data are inconsistent with ethical analysis then this can, in turn, stimulate further research. Importantly, the point was made that biomedical ethics research cannot be collapsed into a single discipline, be that philosophy, or social science, for example. Rather, it should be seen as a research field properly incorporating many different disciplines working together, drawing on and informing each other. It was suggested that, if biomedical ethics research did not relate in some way to

philosophy or ethical analysis, then it did not constitute ethics research, but some other type of research.

Overall, it was felt that researchers from different disciplines working together, or at least interacting with each other, would enable a better understanding of a particular research arena, enrichment of research carried out and a clearer understanding of the likely impact of research. Delegates felt that the Biomedical Ethics Programme could provide a valuable service in this area, both by making grants available for small meetings between researchers, including from different disciplines (which it already does), and by offering advice, through contact with the office. The officers of the Trust expanded on plans afoot to make these schemes more visible. Emphasis was also placed on the importance of funded activities, perhaps through the creation of 'virtual centres', directed towards increasing networking, information sharing and research possibilities.

Research projects that might benefit from an interdisciplinary approach were identified as including:

- What is the interplay between the law and different ethical codes, and how can an understanding of the relationship be translated into Codes of Practice?
- How is the Mental Health Act implemented?
- How is 'dangerousness' determined by mental health practitioners, and also courts?
- How are ethics used in decision-making?
- What is the definition of a disorder?
- Are the main ethical issues in mental health care the same for professionals, carers, families; if not, how do they differ, and why, in ethical terms?
- What concepts of treatment and care are used in different contexts?
- What are the ethics of early intervention studies?
- How do issues of measurement and the development of instrumentation specifically to define 'normal' brain function impact on notions of ourselves?

5.5 Concluding remarks

Officers of the Trust welcomed the process and conclusions of the seminar and indicated their intention to put the detail of discussions conducted over the two days, expressed in the form of a Report, to others within the Trust.