NEUROETHICS

Mental disorder ethics: theory and empirical investigation

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J Med Ethics 2006;**32**:94–99. doi: 10.1136/jme.2005.013276

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Received 21 June 2005
Accepted for publication 22 June 2005

Mental disorders and their care present unusual problems within biomedical ethics. The disorders themselves invite an ethical critique, as does society's attitude to them; researching the diagnosis and treatment of mental disorders also presents special ethical issues. The current high profile of mental disorder ethics, emphasised by recent political and legal developments, makes this a field of research that is not only important but also highly topical. For these reasons, the Wellcome Trust's biomedical ethics programme convened a meeting, ''Investigating Ethics and Mental Disorders'', in order to review some current research, and to stimulate topics and methods of future research in the field. The meeting was attended by policy makers, regulators, research funders, and researchers, including social scientists, psychiatrists, psychologists, lawyers, philosophers, criminologists, and others. As well as aiming to inspire a stronger research endeavour, the meeting also sought to stimulate an improved understanding of the methods and interactions that can contribute to ''empirical ethics'' generally.

This paper reports on the meeting by describing contributions from individual speakers and discussion sections of the meeting. At the end we describe and discuss the conclusions of the meeting. As a result, the text is referenced less than would normally be expected in a review. Also, in summarising contributions from named presenters at the meeting it is possible that we have created inaccuracies; however, the definitive version of each paper, as provided directly by the presenter, is available at http://www.wellcome.ac.uk/doc.WTX025116.html.

Nigel Eastman (Professor of Law and Ethics in Psychiatry) opened the meeting by focusing on the peculiarities of mental disorder and its care. Psychiatry—meaning here all clinical mental health care disciplines—is unusually ethically problematic. Unlike in most other medical and health care domains, both the nature of the 'diseases' or 'illnesses' dealt with and the nature of their treatment are often the focus of ethical debate. Although some psychiatry is considered obviously and unusually problematic, however, other areas of the discipline are perceived as undifferentiated from the rest of medicine. For instance, while some question whether personality disorder, for example, is the proper concern of psychiatry at all, given that it is a whole person disorder with uncertain boundaries and uncertain treatability, dementia is perceived as quite straightforwardly 'medical'. This emphasises the hybrid nature of psychiatry, in that it addresses conditions arising from widely divergent 'causes' of mental symptoms and ranges in its nature between abutting sociology, or criminology, at one pole and neurology at the other.

Thomas Szasz's classic critique of psychiatry asserts that any psychiatric diagnosis that is not objectively verifiable by way of 'science' amounts to mere social labelling, not 'disease'.[1] At the same time *treatment* of *non*-'verifiable' conditions opens psychiatry up to social and political misuse, or abuse.[2] There is, however, a new framing of the debate concerning the medical validity of psychiatry. Bill Fulford (Professor of Philosophy and Mental Health, University of Warwick) argues that *all* medical diagnoses are value laden—that is, they incorporate value judgments; it is just that some psychiatric conditions are quantitatively more value laden than many other medical conditions.[3 4] That is, all medical diagnoses inherently contain a fact:value ratio and each sits somewhere along a spectrum of such ratios. Further, conditions with a high values quotient have the potential to be more easily reframed into—for example, a sociological or criminological model.

Thus, rather than requiring a definition of the boundaries of psychiatry and its social role, Fulford's model demands 'values insight' on the part of practitioners, citizens, and policy makers in relation to individual conditions. This does not imply abolition of obvious and difficult ethical and policy questions such as those originally posed by Szasz. Rather, it suggests a reframing of how such questions might be approached.

Much psychiatry abuts not just medical and social models but also legal models. Hence, notions of civil capacity or criminal responsibility use psychiatry in ways that go beyond the use by society of medical specialties with more fact and less value within them. The state then uses psychiatry within an approach that may discriminate legally against those with mental disorder, as described by Chris Heginbotham and Genevra Richardson in their contributions (see below). Yet the very definition of *mental* disorder is opaque. As Eric Matthews argues (again, see below), making the distinction between physical and mental disorder is at least problematic. So it appears there is a ''double whammy'' for the mentally disordered: law which discriminates against them and uncertainty as to the scope of that discrimination. A natural question which arises, therefore, is ''does law enable or constrain ethical mental health care?''[5]

EMPIRICAL ETHICS

The Wellcome Trust's biomedical ethics programme aims to promote interdisciplinary research, but empiricism in the field of ethics can operate in different modes. It can—for example, address how *actors* operate within ethically sensitive clinical areas. Or it can address empirical questions directly in relation to a theoretical ethical framework. Tony Hope, in his contribution, suggests that ''empirical ethics'' should comprise empiricism *and* ethical theory, with each reflecting and then informing the other, in a continuous process of inquiry. More important than *defining* empirical ethics, however, is clarity of description of what methods, theoretical and/or empirical, and their intended interrelations (if any), are used within any particular biomedical ethics research project.

MENTAL DISORDER ETHICS

Policy background: some sources of ethical concern

Much ethical concern relating to mental disorder arises from, and is reflected in, public policy. Chris Heginbotham (Chief Executive, Mental Health Act Commission) argued that mental health policy and care has been undergoing a transformation as new treatments become available, new service models are developed, and new policy frameworks are written. He summarised that the National Service Framework[6] heralded a new era for mental health services but that many of its promises have still to be delivered. He added that policy approach as to patients with mental disorders had persistently suffered from a paternalistic attitude, with little respect for 'autonomy'.

Two recently enacted or proposed pieces of legislation relating directly to mental disorder are founded on mutually contradictory philosophical bases, and are confusing both in themselves and in their operation. Hence, the Mental Capacity Act 2005 adopts an 'autonomy' approach to the treatment of physical conditions; while the Draft Mental Health Bill adopts a predominantly paternalistic and 'public protection' approach. Major concerns remain among service users, providers, clinicians, and advocacy agencies about the extremely wide definition of mental disorder adopted within this bill, the conditions for compulsion, misuse of such legislation for preventive detention, and the (non-)availability of appropriate treatment.[7] Overall, the proposed bill is likely to lower the threshold for compulsion of those with less clearly 'medically valid' disorders.[8 9] How can this be ethically justified? Even within the Mental Capacity Act there are concerns regarding the civil rights protection of patients under the act.

Ethics and the distinction between mental and physical disorder

Observation of the disparity between legal provisions relating to treatment for physical and mental conditions led naturally to a presentation by a philosopher here, Eric Matthews (Honorary Research Professor in Medical Ethics and Philosophy of Psychiatry, University of Aberdeen). This sits alongside the writings of Fulford concerning values based diagnosis in both mental and physical health domains, and later alongside Fraser's suggestion to the meeting of ''convolving'' facts and values (see below).

Matthews argued that much policy and law relating to mental disorder is not only discriminatory but also assumes that the distinction between mental and physical disorders, and between treatments of those disorders, is robust. Is this a reasonable working assumption?

There are contradictory attitudes to mental disorder in modern culture, creating uncertainty, which then bears on the ethics of psychiatric treatment. Also, philosophical confusion about the concept of the mental is a primary source of uncertainty; so that addressing this confusion philosophically can assist in clarifying ethical issues in mental health research.

In summary, it is hard to draw a sharp distinction between physical and mental disorder, instead what exists is a continuous spectrum of states.

In the biomedical model of disease, illness arises from an externally caused biological malfunction; this model, however, does not apply very well to mental disorder. Many such disorders are departures from human norms rather than from normal biological function. Accepting the biomedical model generally for mental disorders means attempting to locate and eliminate an underlying biopathology, even if the individual does not self identify as ill. This then commits the practitioner to wholesale medical paternalism, which offends against individual autonomy.

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: but the mind is not a machine, as the body is. It operates in terms of reasons, so it cannot 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, however, 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. In theorising about it, however, 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. Hence, we reveal our minds to each other in many ways (voices, facial expressions etc), which then lead to meaningful interactions. To talk about minds therefore is to talk about people by focusing on their meaningful interactions. 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 of a person's whole relation to the world and to others. And treatment of mental disorder should aim to restore the full range of meaningful interaction to the individual. That is, autonomy. Because, however, autonomy is perceived to have been *lost* in mental disorder, its restoration via psychiatric treatment does not simply mean following the patient's currently expressed wishes. So we can act to restore autonomy even if we override patient refusal of our doing so.

Ethics, research, and the legal framework

Bringing legal disparities and theoretical ethics concerning the physical and mental together, Genevra Richardson (Professor of Public Law, University of London) examined the relationship between ethics, mental health, and the law. She posed three questions. First, is the *legal framework* governing mental health care ethical? Second, is the *practice* of this branch of medicine ethical? Third, is the conduct of *research* relating to this branch of medicine ethical?

In addressing the first and second questions, attention must focus (again) on the Draft Mental Health Bill and the Mental Capacity Act, which differ in several respects. 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 Act must be applied; if the treatment is for mental disorder, and there is capacity and refusal, then the Mental Health Act/Bill can apply. What happens, however, concerning treatment for mental disorder in the absence of capacity both where the individual is compliant and where s/he resists? If, in such situations, the Mental Health Act is used, it arguably provides better safeguards; however, it can increase stigmatisation of the patient, and does not explicitly make provision for a patient's 'best interests' and 'advance decisions'. Moreover, the Mental Health Act does not elaborate any underlying principles governing its application, with respect to the distinction between mental and physical disorders or the proper conditions for non-consensual treatment. So perhaps the only way to avoid discrimination in mental health care is not to treat mental disorders as legally, and clinicolegally-special. In addressing the third question, one can ask whether research directed toward mental disorders is *ever* ethical. Is it ethical to conduct research within a branch of medicine itself governed by an unethical framework? Also, does such research comply with usual ethical requirements; or is regulation in research ethics strangling relevant research in this field? Notwithstanding these concerns there are roles for philosophers, lawyers, and social scientists in investigating what an ethical legal framework for mental health care might look like, especially with respect to issues of autonomy and capacity. Addressing such issues might ultimately lead to a more considered legislative framework for mental health care.

RESEARCHING MENTAL HEALTH AND ETHICS: CURRENT WORK

The meeting contained presentations of empirical projects from within four fields of research endeavour.

Mental disorders: medical conditions or social labels?

Introduced by Gwen Adshead (Consultant Forensic Psychotherapist, Broadmoor Hospital), this session began by considering the question addressed by Matthews—namely, can we validly distinguish between physical and mental conditions?

The group highlighted most physical conditions as being at the high fact end of the fact:value spectrum but emphasised that even 'fact' can have its own evaluative basis. And hybrid conditions, including but not limited to mental disorders, are more open to interpretation as disorders, since they evidently incorporate value judgments.

Values were seen as forming part of the 'sense of self'. In some mental disorders this can be negatively affected, but the reverse can also be the case—for example, people with personality disorder often do not sense that they have a disorder, and/or they do not always sense that their condition is a bad thing. Alternatively, acceptance of a person's values, and sense of self, can abolish any diagnosis of disorder, as suggested in a different group by Tan (see below).

Some participants suggested that there is inherently a moral hierarchy of mental disorders; consequently, mental disorders have their *own* social labels. Personality disorder—for example, is so stigmatising a label that patients can ask to be reclassified as 'schizophrenic', both because schizophrenia is illness *and* because it is a condition often seen as clearly medically treatable (by comparison with personality disorder).

The boundary between a medical diagnosis and a social label was thought capable of being productively investigated by researchers. However, the dichotomy has most significance and real meaning for service users who live within and across the boundary. Hence the group agreed that future research should include direct involvement of the views of service users, particularly, with regard to related risk assessment and stigma (see also below).

Treatment and treatability of mental disorders: ethics and objectivity

Mariam Fraser (Senior Lecturer in Sociology, Goldsmith's College) introduced this discussion by describing her research examining the first legal case to come before the US courts concerning the safety of Prozac. The case concerned one Joseph Wesbecker who had been prescribed the antidepressant drug in 1989 shortly before he shot 20 of his colleagues and then committed suicide. The legal case included argument over whether the manufacturers of Prozac had behaved ethically and legally in the manner in which they had established the safety and efficacy of the drug.

Fraser argued for a view of science and medicine that embraced complexity and contingency, rather than treating them as 'noise' to be minimised via 'objective' methods. Treatment was a complex 'occasion' that could not be disaggregated into separate and autonomous parts. Complex medical conditions, such as Wesbecker's, had to be approached on their own terms. Although suggesting that clinical trials should be abandoned in favour of non-trialed therapies, Fraser argued that the scientific numerical data generated by clinical trials should be recognised in its specificity—that is, that clinical trials provide *statistical* information as to the efficacy and safety of a drug—and that its relevance beyond the specialised domain of the clinical trial be held open. In other words she argued that the relations between biochemistry and mental health and illness should be understood to be a question rather than *the* question. Fraser drew on the work of Isabelle Stengers, and in particular on the concept of 'relevance', in order to explore the enfolding of facts and values in contrast to scientific, and sometimes ethical, approaches that seek to distinguish them.

Fraser's work draws on Isabelle Stenger's concept of ''relevance''. This perspective stresses that facts and values are convolved, in contrast to ethical (and scientific) approaches that seek to distinguish them.

The group recognised that interdisciplinary approaches might not be appropriate for the full range of research questions in ethics and mental health and that, in *some* areas, there would be advantage in examining issues via a range of separate empirical approaches and theoretical perspectives. Such issues might include treatability *per se*; plus determining different purposes of treatment, including effecting physiological change, attitude adjustment, and even the induction of 'repentance' in offenders. These studies might *then* form the basis for subsequent interdisciplinary collaborations.

Risk assessment and management of mental disorders: techniques and ethics

George Szmukler (Dean, Institute of Psychiatry) gave a presentation on the application of risk assessment techniques to mental health care, highlighting the tension between individual and public rights by reference to the mathematics of prediction.

He argued that predicting rare events, including serious acts of violence by the mentally disordered, is difficult, whereas the research tools for predicting such acts are extremely inaccurate and infer an enormous number of 'false positives' for violence. Concerning values, key questions include what level of false positives in risk assessment is acceptable and who should make that decision? Ultimately, a cost/benefit trade off is being enacted: the benefit being that society is supposedly protected, whereas the cost is that patients with mental disorders, already a socially excluded group, are further discriminated against.

Hence, Szmukler argued, the policy that mental health practitioners should subject *all* patients to risk assessment is both flawed and profoundly illiberal, because it accepts that many will have to be detained in order to prevent one seriously violent act.

The question then arises: why are *these* 'dangerous people' risk assessed, given that, within a Venn diagram of total social violence, those with mental disorder represent an extremely small proportion of the total, so that such discrimination is not only mathematically unjustified but inefficient as a means of limiting risk to the public.

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 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*, the search is constantly for 'perfect decision making', while the advantages of risk management systems that accept, and plan for, human error are ignored.[10] The model is therefore both potentially unethical and practically inefficient.

The group decided that the overriding principle at stake in this debate was justice; and, while there *might* be justification for discrimination against the mentally disordered, such discrimination needed *to be justified*.

Is mental incapacity researchable and, if so, how?

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. Matthew Hotopf (Professor of General Hospital Psychiatry, Institute of Psychiatry) introduced research using the MacArthur Competence Assessment Tool-Treatment (MacCAT-T),[11] showing it to be a valid measure of capacity in the UK. The research also found that incapacity occurs *often* in general medical contexts and originates in physical rather than functional mental illness, and that clinicians miss many cases of incapacity.[12]

In a second presentation, Jacinta Tan (Honorary Consultant in Child and Adolescent Psychiatry, University of Oxford) described findings from a study that explored the beliefs, values, and attitudes to treatment of adolescent female patients with anorexia nervosa, their parents, and consultant psychiatrists.[13] Again using the MacCAT-T, patients did well on measures of capacity. Most still spoke, however, of *difficulties* in decision making. This disparity reflected the distinction between cognitive and evaluative disabilities contributing to incapacity. Tan identified some patients as having the ability to reflect on thought processes, but that those processes themselves seemed to be evidence of incapacity. This picture contrasted with the general hospital study by Hotopf, in which if patients lacked capacity they usually did so as a result of cognitive deficits, arising in turn from physical rather than functional mental ill health. Tan hopes her research will contribute to a more subtle and interactive understanding of capacity.

In discussion, some wanted to emphasise use of the element of 'appreciation' (of the person's 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*. Others emphasised the importance of assessing volitional impairment of patients exhibiting—for example, anorexia nervosa, substance abuse, addiction to substances, and deliberate self harm.

Potentially, both presenters' research implies that the clarity required by law in terms of capacity is not yet available clinico-ethically. Tools such as the MacCAT-T can help to enhance the justifiability of decisions but these tools are limited in relation to evaluative incapacity—that is, incapacity that occurs as a result of disordered evaluation of the self or others, as opposed to cognitive incapacity; other, more values based, schedules are required.

Overall, 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.

How can empirical research reflect and inform theoretical ethics?

A second main aim of the meeting was to focus on methodological issues as such, and in particular on the interrelations of empiricism and theory. Tony Hope (Professor of Medical Ethics, University of Oxford) suggested a way to look at the relationship between theoretical and empirical ethical work, within a notion of ''empirical ethics''. He highlighted the uncertainty and confusion within 'biomedical ethics' concerning the relative contributions of each. Hence, some theoreticians may argue that ethics is really philosophy, and that knowledge from the real world has nothing to offer to normative analysis; whereas some empiricists operate in a fashion that is divorced from ethical theory, albeit they may be researching in domains that are profoundly ''ethical'' in nature or in their implications.

The classical model of biomedical ethics has relied upon a linear relationship between theory and data, within which a clinical dilemma gives rise to a real issue of concern for medical ethics, which then results in an application. Hope argued, however, that 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. It must include systematic collection of empirical data, and the ethical analysis must affect the empirical design, and vice versa.

In an accompanying presentation, Alastair Campbell (Professor of Ethics in Medicine, University of Bristol) refuted the notion that philosophy is irrelevant to mental health policy and practice. Rather, it's application of rigorous moral reasoning, going beyond simply stated principles, and it's wealth of theory about morality can both enrich and add critical value to the domain.[14]

TOPICS AND METHODS IN FUTURE RESEARCH

''Big or small questions''?

Some members of the meeting expressed the view that many of the issues being discussed reflected familiar dilemmas, that is, 'the big questions', and that these remain insoluble. It was suggested that smaller and developing frontier areas should be focused upon, such as confidentiality, screening, behavioural genetics, enhancement, and direct alteration of brain function. However, others expressed concern that the familiar problems should not, or even could not, be neglected, since they *are* enduring precisely *because* they are inevitable, and are often *reflected* in smaller and more specifically defined questions. 'Big questions' are also likely to be those of most pressing concern to patients and research subjects, and new methodologies should be applied to familiar problems.

Policy related research

The meeting highlighted that mental health policy is a rich source for ethics research, exemplified by the frequent tension within policy between pursuit of paternalism and autonomy.

A policy issue as such, does not necessarily infer an ethics research question, however; and ethics research that is policy led may move away from the conceptual. Hence, research into policy should be focused on 'an ethical dilemma'—for example, an ethical issue not yet addressed by legislation, or the approach adopted by a piece of legislation *toward* an ethical issue. Also, ideally, a research portfolio in this area would contain projects with immediate policy relevance *and* projects examining underlying key issues, including investigation pursued over time and in different policy contexts. Finally, conceptual work should be linked to empirical research, if only because engaging with a problem can reveal that 'the problem' is often about meaning. Investigation of communication and language is therefore central to this field of research.

Much policy is played out in law, and several ethicolegal topics for future research emerged:

- investigation of the interplay between the law and different legislative and ethical codes
- how, ethically, the Mental Health Act is implemented by practitioners[15]
- the implications of abandoning separate mental health legislation and relying on a single 'Incapacity Act'[16]
- how one set of values can 'trump' another
- the impact of legislation on people affected by mental disorders
- the use of public and user opinions about compulsion toward achieving relevant mental health law reform
- the expression of values in defining mental disorder in various ways through the legal system.

Defining mental disorders

Potential future areas and questions for exploration in this area were identified:

- public, professional, and patient constructions of mental disorders;
- patient experiences of diagnostic and social labels;
- whether new drugs frame new diseases;
- how diagnoses change, including for social and service reasons;
- approaches to defining mental disorders in different professional, social, and political contexts;
- the role of personal identity in defining and diagnosing mental disorders;
- ethical issues of diagnosis and personhood raised by new technologies—for example, through various forms of brain imaging;
- ways of conceptualising mental disabilities and their impact on patients and the practice of psychiatry, and
- the politics of resource allocation in mental health services in relation to diagnosis.

Treatment of mental disorders

Research proposals here included:

- investigation of what concepts of treatment and care are used in different contexts by different professionals;
- determining different purposes or definitions of treatment, including effecting physiological change, attitude adjustment, and reduced risk;
- how measurement of 'normal' brain function, and *change* of function, impacts on notions of 'self' and 'enhancement', by comparison with remediation of disability, and
- reversal of the medical paradigm.

Risk assessment

Proposed research topics here included:

- the impact of risk assessment on patients;
- the costs of risk assessment to those other than the patient;
- the impact of a risk assessment culture on patient consent to treatment, or research;
- the impact of a 'high risk' assessment on a patient;
- how risk is enshrined in policy and practice;
- possible ethical justifications for discriminatory policy and practice that benefit society at a cost to a small number of the mentally disordered;
- alternative ways of balancing protecting society against individual rights;
- whether policies in different policy domains reveal differences in underlying values;
- description of the language of risk and the social basis of risk aversion;
- whether assertive community treatment is ethical, and
- the role and methods of experts in risk assessment directed toward criminal and mental health tribunal legal decision making.

Capacity

Much research into mental disorder ethics currently focuses on the definition and operation of capacity. Yet the results of this research seem to be poorly translated into policy and practice, and many clinicians are still unsure how to use the concept in various circumstances. Even in the USA, where mental health statutes are often *based* on capacity assessment, such statutes arguably have had little impact, since patients with mental disorders still experience greater violation of their human rights than patients with physical disorders. Valuable research might therefore focus on how often, and by what means, people with mental disorders are compelled into treatment compared with those with physical disorders. There is also a developing research field concerned with 'coercion' in mental health care.[17–19]

Other potential themes for investigation included:

- autonomy and concepts of the self;
- assessment of volitional impairment as complementary to the MacCAT-T;
- the concept and understanding of 'appreciation' within the MacCAT-T;
- enhancement of capacity;
- longitudinal studies examining capacity and best interest over time, and
- studies of fluctuating capacity.

Methods

The meeting emphasised that biomedical ethics research is not naturally limited to any one discipline and is likely to benefit from an *inter*disciplinary approach within an increasingly better understood relationship between theoretical and empirical methods.

The group explored how different disciplines understood 'ethics' as a subject of inquiry. It became clear that mutual incomprehensions were common between disciplines and that for interdisciplinarity truly to work, an understanding of each discipline by the other must precede collaborative working—that is, interdisciplinarity is not additive but interactive.

Much discussion surrounded ethical analysis, its boundaries, and its relationship with empirical inquiry. Some argued that theoretical analysis is diverse, and that empirical studies can sometimes be incongruent with a given ethical analysis, throwing up yet further questions for empirical study and/or theoretical analysis. Rather than being seen as at odds with Hope's model, however, such diversity can be incorporated into the cycle of empirical ethics research, and if empirical data are inconsistent with ethical analysis this can, in turn, stimulate further productive research.

The comparison emerged between 'bottom up' and 'top down' approaches to empirical ethics. This reflected a natural tendency toward conflict between theoreticians and empiricists. Thus, philosophers tended to be researchers of ethical theory in search of an example; while empirical scientists tended to take examples of ‘empirical domains’ and to conduct research based on that particular methodology’s own conception of ethics. The beginnings of a resolution of this conflict emerged, however, in that participants agreed that, whatever research method was adopted, be it theoretical or empirical, ethics research should focus on ‘an itch’ (that is, there must be some normative question which ‘bothers’ the researcher); and that ‘scratching the itch’ can operate within different methodological frameworks. The *absence* of an ‘itch’ from a given research project, however, implied that it amounted to descriptive research, although it could be *relevant* to ethical consideration of a particular ‘itch’.

CONCLUSION

What can be learned from this meeting and where might, or should, it take us?

As well as focusing on ethical aspects of mental health policy and law, the meeting emphasised the need to address fundamental questions concerning the definition of mental disorder and treatment, as well as the assessment of incapacity and risk *arising from* mental disorder. The role of *values* was seen as central not only to balancing the rights of the individual against those of society but also to defining disorders and treatment as such. Here Fulford’s construction provides a helpful model for addressing professional roles in relation to conditions that can be constructed either medically or sociocriminologically. Fraser’s inclusive notion of treatment clearly justifies therapeutic eclecticism—that is, drawing on the total range of treatments available. And Matthews’s definition of mental disorder, seen as failure of function of the whole person, might be used similarly to support relatively unrestricted use of mental health care, and legislation directed toward patient and public welfare. These latter approaches counter the Szaszian restrictive definitional approach, which is designed heavily to *limit* the social role of mental health care.

Differentiated legal treatment of physical and mental disorders also became a particular focus of the meeting: incapacity, specifically, can be seen as at the core of debate both about legal discrimination and about the role of mental health legislation in pursuing public safety. Its importance extends, therefore, beyond its role alongside ‘best interests’, in relation to non-consensual treatment of physical disorders.[20]

Perhaps the most significant outcome of the meeting, however, related not to topics but to methods. Out of what threatened to be a divisive interdisciplinary war over the ‘territory’ of biomedical ethics arose consensus. Although different disciplines, both theoretical and empirical, may variously conceptualise and operationalise ‘ethics’, the subject is not defined by any one method. There is likely to be much advantage in methodological pluralism and in pursuing a ‘circle of inquiry’ between theory and empiricism, both within any single project and across projects. Finally, based on the deliberations of this meeting, biomedical ethics is clearly not a discipline but a field of inquiry.

ACKNOWLEDGEMENTS

The meeting referred to in this paper was sponsored by the Wellcome Trust. The authors would like to thank all the participants at the meeting, in particular the speakers for their contributions and agreeing to make their presentations available for this report.

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Competing interests: NE is Chair of the Wellcome Trust’s Biomedical Ethics Funding Committee. BS is an employee of the Wellcome Trust.

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