moral imbecile, uneducable in moral matters. I remain convinced that someone who is unable to see that there is something wrong with beating a child to death or to appreciate in any way the experiences of the vulnerable, does show a serious moral defect. These observations concern much more basic intuitions than Seedhouse's allergy to the idea that children might benefit by hearing about the images human beings have used to try and understand their spirituality and therefore those intuitions and perceptions are much more plausible candidates for whatever it is that underlies our moral thought in general.

Seedhouse seems to believe that intuitions are non-negotiable, a singular experience for most involved in medical ethics, and this I think colours his reading of my paper;. For my part there is a dynamic and mutually formative relationship between certain moral intuitions or perceptions and moral reasoning. John Rawls, discussing a concept drawn from Aristotle, refers to a "reflective equilibrium" between moral principles and our shared experience. The idea of sensitivities, perceptions and intuitions which are grounded in and draw from our experiences with others is also found in the writing of Martha Nussbaum and those who are exploring the ethic of care. These writers regard the intuitive and experiential as a starting point for moral thought. I argued that the basic *moral sense* which allows the relevant perceptions, judgments, or intuitions to take shape is shown, for instance, when we recognise the evident goodness of caring for children. Intuitions thought of in this way are not rigid or imperialistic, but rather open to and shaped by relationships. And these relationships should be informed by a range of sensitivities to the way it is for other people. If this is so then our intuitions quite obviously are altered by discourse which re-formulates our ways of understanding those situations in which we and others stand. But they cannot be altered if we lack the basic capacity to appreciate what those others are feeling. I myself find all this hard to square with the idea of imperialism but perhaps there is something I am missing.

Readers' Views

The Editor July 1994

Dear Editor

I was interested to read the case commentary on Brian in the June 1994 edition of the *Otago Bioethics Report*. Brian is a man with borderline intelligence and paedophilia, who presented some psychiatric symptoms which were not clearly defined. I was sorry that there was not a commentary from a psychiatrist, particularly a forensic psychiatrist, who on a daily basis has to grapple with the ethical problems which the case brings up. Perhaps I might add a few comments of my own.

There seemed to me to be three issues of greatest relevance:

a) Brian's status in relation to the definition of mental disorder within the Mental Health Act.

b) Whether it is appropriate to invoke the Mental Health Act proceedings.

c) The relationship between psychiatry and public expectations of the control of dangerous behaviour.

There are two issues that may relate to the definition of mental disorder. The first is, has he a disorder of mood given that he at times is suicidal and self destructive? If that is associated with a pathological disturbance of his mood, he may meet the definition. Secondly is his report of abnormal auditory experiences. That would clearly be a disorder of perception if they were true hallucinations.

The relationship however between his abnormal mental state symptoms and his dangerousness to children is of major importance. Should he be able to control his behaviour towards children at all times except when his mental state is disturbed either by depression or by psychosis, one would feel more strongly motivated to treat him compulsorily than if his offending towards children occurred irrespective of his mental state. The simple concurrence of mental disturbance and paedophilia in the same person does not argue for compulsory treatment on the basis of his dangerousness to children.

That leads directly to the issue of whether or not one should invoke such an order. One is often presented clinically with situations when one feels that it is possible to mount an argument that under the loosely defined terms such as disorder of volition or disorder of cognition, an argument for placing somebody under a Compulsory Treatment Order can be made. The dilemma is whether as a psychiatrist one should mount such an argument. Whilst one can avoid the dilemma by putting the matters before a Judge, that does not, it seems to me, obviate the psychiatrist's responsibility to decide on the ethical limits of compulsory treatment.

Finally, the limits to how society wishes us to define and to detain dangerous people is also very unclear as the recently introduced Mental Health (Compulsory Assessment and Treatment) Bill 1994 indicates. There is considerable political pressure to widen the conditions of detention within mental health systems of people who present a danger to the public. Ethically, that felt very uncomfortable and I agree fully with John Dawson's comments on the appropriate legal outcomes. The difficulty of psychiatric decision making is increased by that amount of political and media pressure acting on a circumstance. Psychiatrists feel these ethical dilemmas most deeply.

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