liberties are being infringed, both by their being placed on a register and by their being subjected to the close surveillance that this entails. Costs judicial review will follow, the beneficial outcome of which may be that a legal framework for supervision is derived ultimately from case law. In the meantime, others who seek the aid of mental health services may find themselves disadvantaged by the shift of resources necessary to service the registers.

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1 Harrison G, Bartter P. Supervision registers for mentally ill people. BMJ 1994;309:552-3. (9 September.)

Most patients in Bow and Poplar would be on the register

EDITOR,—Robert Pugh and colleagues report a census of psychiatric inpatients to calculate the possible number of supervision registers on psychiatric services.1 Using operational criteria, they found that a high number (179 of 234 inpatients) fulfilled the Department of Health's criteria for inclusion on the register, and they conclude that the register would have considerable resource implications for community teams. The register is "intended first and foremost for patients being cared for outside hospital." Pugh et al.2 report that the Bow and Poplar local mental health team provides a multidisciplinary service to an inner city population of 60,000 in a socially deprived area of London. On 23 June we had a caseload of 229 patients. Keyworkers were asked to answer a questionnaire regarding their patient, covering six criteria for inclusion on the supervision register as specified by the Department of Health (table). The questionnaire was completed for 209 (91.3%) patients.

<table>
<thead>
<tr>
<th>Number of patients fulfilling each criterion for inclusion on supervision register (n=229) *</th>
</tr>
</thead>
<tbody>
<tr>
<td>Criterion</td>
</tr>
<tr>
<td>Current risk of suicide or serious self harm</td>
</tr>
<tr>
<td>Current risk of serious self harm</td>
</tr>
<tr>
<td>Current risk of serious harm to others</td>
</tr>
<tr>
<td>Informed consent for treatment</td>
</tr>
<tr>
<td>If untreated, risk of serious self harm</td>
</tr>
<tr>
<td>If untreated, risk of serious harm to others</td>
</tr>
</tbody>
</table>

*Data available for only 209 patients.

Thus, therapies that represent the principles of autonomy, beneficence, non-maleficence, and justice can and should be usefully discussed together as guides in medical practice, I believe firmly that justice is a concept of an entirely different order and should be treated separately. Perhaps what is really needed is a deeper understanding of each of these important concepts, when ethical questions are exercising the minds of us all.

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The four principles may clash

EDITOR,—Raanan Gillon describes the four principles of medical ethics and gives a commentary on their use for his team of health care workers.1 In several places he hints at the likelihood of a clash in the application of these principles, and it might have been helpful if he had worked through an example. For instance, I agree that to practise beneficence and non-maleficence we need empirical information about the probabilities of the various harms and benefits that may result from proposed health care interventions. The gold standard for accurately estimating the cost versus benefits of any new intervention in a properly controlled clinical trial, yet patients participating in randomised controlled trials are to some extent objects rather than subjects and therefore, according to Kant's definition, have lost their right to self determination. Here we observe a classic clash of categorical imperatives.

The conventional argument in dealing with this paradox is that patients can retain their autonomy by volunteering for these trials and giving full informed consent. Yet how often is this consent fully informed, and what about the danger, when consent is being sought, of alarming patients by giving them unsolicited and frightening information, which in turn is a breach of the moral principles of beneficence and non-maleficence?2

Another problem arises when increasing numbers of patients exercise their right to self determination by refusing to participate in the randomised controlled trial while at the same time demanding the best treatments based on the outcomes in volunteers in previous generations of trials. Do such patients have the right to autonomy while denying their responsibility to the very society that presumably confers these rights?3

For too long people such as myself at the cutting edge of research on cancer have been subjected to the ill informed attacks of self appointed ethicists and "consumers' advocates." Gillon puts it eloquently when he states, "such disagreement about the value of randomized trials is not just one more example of all that I disagree with us bad of fault or incompatible moral standards. In principle it is open to resolution within our shared moral commitment." Please help me to resolve this ethical dilemma.

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Author's reply

EDITOR,—Does Paul J Heath's moral stance really allow him to believe that doctors do not need to consider themselves within or fair in their medical practice? If not, as I assume, then he agrees that justice is a relevant part of medical ethics. Of course justice is a complex and vigorously debated moral issue, as I tried to indicate—but then it is not being argued away by the need for it. As for Aristotle, I think that I gave a reasonable and fairly standard interpretation, but exegesis too is inherently contestable.

In response to M Baum, I do not have a general answer to how to resolve conflicts between the principles, though I believe that as a profession we should do so collectively and within the norms of our society provided that it too is committed to them. Fundamental moral principles. With regard to clinical research and research ethics, however, no such conflict need arise. It is morally acceptable to treat people as means to an end provided that they understand and agree—that is, provided that they are also respected as ends in themselves. Such respect does not require full information in relation to consent, which is just as well since full information is unattainable. What is required is adequate information, and adequacy varies with people's circumstances.

Yes, it is undoubtedly true that sometimes people, having been given adequate information, do refuse to participate in clinical trials even though they themselves may have benefited from clinical trials on previous patients. Nonetheless, for my own part I would reject any attempt to coerce them into such participation. The participation of patients in clinical trials is admirable but...