



ARTICLE

An introduction to clinical ethics in psychiatry*

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SUMMARY

The Royal College of Psychiatrists' continuing professional development (CPD) module on clinical ethics in psychiatry by Pearce & Tan describes some common ethical dilemmas in psychiatric practice and the work of clinical ethics committees in analysing these dilemmas. In this article we build upon their work and offer additional exploration of the nature of ethical dilemmas in psychiatry. We also build upon the models of reasoning that are described in the module and suggest ways for psychiatrists to think about ethical dilemmas when a clinical ethics committee is not available.

LEARNING OBJECTIVES

After reading this article, you will be able to:

- demonstrate refined ways of thinking about ethical dilemmas when a clinical ethics committee is not available
- show a deeper understanding of the challenges and limitations to ethical models and their application
- demonstrate awareness of the important legal cases that guide ethical medical practice.

KEYWORDS

Psychiatry and law; ethics; philosophy; consent and capacity; education and training.

We are grateful to *BJPsych Advances* for the opportunity to comment on the useful continuing professional development (CPD) module by Pearce & Tan, which describes the work of clinical ethics committees (CECs) and how they address ethical dilemmas in psychiatry (Pearce 2019). Those authors note that only 3 National Health Service (NHS) Mental Health Trusts in the UK have clinical ethics committees and suggest that psychiatrists might usefully start their own. In this article we explore why there might be so few in mental health by linking this question to the philosophical complexity of the dilemmas that arise in mental health work. We discuss how clinicians might approach ethical dilemmas when no CEC is available and some important caveats.

Four principles in mental health practice: what might they miss?

The CPD module describes the well-known 'four principles approach' to ethical reasoning in

medical ethics (Beauchamp 1979), which suggests that, when faced with an ethical dilemma, a doctor should consider a course of action that tries to respect the patient's autonomy, maximise welfare (beneficence), minimise harm (non-maleficence) and respect justice principles, including both attention to resource allocation and justice as fairness. There are other models of ethical reasoning that are used in psychiatry, such as attention to being a 'good' psychiatrist (Radden 2010) or attention to the values that are at play in any ethical dilemma in mental health (Woodbridge 2003; Fulford 2011). However, the four principles approach has been helpful in thinking about ethical dilemmas in medicine because it embraces both good outcomes and good intentions.

In this section we will highlight the challenges intrinsic to understanding the four principles model – interpreting what the principles themselves mean and resolving conflicts between them. We will also explore the challenges to applying the model to ethical dilemmas – including interpreting the facts of a case and the role the concept of identity plays in complicating psychiatric dilemmas. We will look at the legal case *Re C* (vignette 1) to illustrate these issues but we will find that they recur in the other cases discussed in this article (*RM v St Andrew's Healthcare* and *Montgomery v Lanarkshire Health Board*).

Vignette 1 – Capacity

Re C (Adult Refusal of Treatment) [1994]

Mr C had suffered from paranoid schizophrenia for many years and was detained under section 3 of the Mental Health Act 1983. While still an in-patient he developed gangrene in his foot and his surgeon advised him that the foot should be amputated to avoid a significant risk of death. Mr C refused the amputation, explaining that he is a famous surgeon who has never lost a patient and that with God's aid he would be fine. His psychiatrist disagreed with him, taking the view that Mr C did not have capacity to refuse because he was delusional. Mr C sought an injunction that would prevent an amputation occurring without his written consent.

Justice Thorpe, hearing the case from Mr C's bedside, granted the injunction, stating that 'although his general capacity is impaired by schizophrenia [...] I am satisfied that he has understood and retained the relevant treatment information, that in his own way he believes it, and that in the same fashion he has arrived at a clear choice'.

Interpreting principles

The apparent simplicity of the four principles model hides a significant but everyday philosophical problem: namely that, although we can all agree on the importance of respecting autonomy, pursuing justice and achieving good outcomes, we often disagree about what these concepts mean. Different participants in the decision-making process will often interpret them in different ways. These differences of interpretation may arise from important human group influences such as culture, class and gender; they may be influenced by the power differentials between the patient (whose capacity may be compromised by mental illness) and the psychiatrist (who has legal powers to detain and treat involuntarily). They may also reflect the fact that reasonable people will disagree with one another.

For example, the principle of non-maleficence states that doctors should act in ways that do no harm and the principle of beneficence states that they should act in ways that maximise the patient's welfare. In ordinary medical practice this largely involves weighing up the costs and benefits to the patient of one course of action rather than another. In mental health services though, most psychiatrists will be required to think about the risk of harm in a broader sense. They are often expected to act in ways that prevent their patients doing harm to others, even if that means overriding the wishes of their patient. Psychiatrists can find themselves prioritising the welfare of people other than their patients on the basis that prevention of harm to others is beneficent, which of course it is. However, as in *Re C*, from the patient's point of view there may be nothing beneficent in having their liberty removed, their autonomy overridden and their values dismissed as less important than risk reduction. This problem has probably become more acute since the introduction of healthcare delivery in the form of businesses that fear reputational risk and legal action.

Conflicting principles

Even where there is agreement on what the principles themselves mean, there is still the problem of what to do when the principles conflict or how and when to prioritise one principle over another. Psychiatric practice is remarkable for operating within a legal framework that directly empowers doctors to make significant compromises between these principles. It allows them, for example, to trump a patient's autonomy in the pursuit of good consequences – as happens whenever a person is detained involuntarily for treatment. Of course, the fact that detention is legally sanctioned does not mean that the ethical dilemma is resolved, only

that there has been some kind of social consensus that overriding autonomy may be justified.

Mr C's case raises questions about the interaction between the principle of autonomy and the principle of beneficence: where there is disagreement about what is a good outcome, who gets to decide? Most would agree that if someone lacks capacity to take care of themselves it is morally justifiable to try to do what is best for them, even if they are not able to exercise choice and agree formally to this. But in many cases in psychiatry, it is not always clear that people lack capacity; in fact, they may seem to be making decisions that are very harmful to themselves and yet their decision-making capacity is not obviously compromised. Conversely, it is all too common that professionals do not explore a patient's capacity to make choices because the patient's decisions align with the professionals' views. This dilemma over capacity was at the heart of the 2007 amendments to the Mental Health Act 1983; there were powerful arguments put that no one who has capacity should be treated involuntarily, but this argument failed and it is still legally possible to give involuntary treatment for a mental disorder to a person who has full capacity.

Interpreting facts

In *Re C*, the court decided that Mr C had the capacity to take a decision that was risky, albeit 'in his own way', and that decision had to be respected. It is relevant that the clinical assessment of the 'facts' turned out to be incorrect: the anticipated harmful outcomes did not occur.

In the CPD module by Pearce & Tan (2019), models of ethical reasoning as used by CECs are set out and they usually ask that we begin with an analysis of the facts. However, just as professionals may interpret ethical principles differently from patients, so they may also see the facts in different ways, especially in terms of the possible consequences of any course of action and their likelihood. In *Re C*, the clinicians had one view of the facts of what might happen without surgery and the patient had a different view of those facts and perhaps a different emotional response too.

When mental health professionals disagree with patients about the facts of the case, these disagreements are very likely to be based on their experience, which is, of course, often different from those of the patient. They do not come to these dilemmas in an ethically 'neutral' state of mind; their accounts and interpretation of the facts may be biased by many factors, including their emotional response to the situation, their professional concerns about the response of the institution in which they work and their past experiences as professionals or patients.

We should note too that many of the ‘facts’ of a case are not descriptions of things as they are now, but are instead forecasts about what things could be like in the future. As when thinking about principles, reasonable people can differ in their predictions of the future. It would be a mistake to assume that these forecasts can be treated as incontestable. Like principles, they permit better or worse interpretations.

In any ethical dilemma there are an almost unlimited number of facts to draw on and many more contestable predictions – it is an ethical choice in itself as to which are given more or less attention and emphasis.

Identity

We suggest that there is a final complex concept to address here, which is the concept of personal identity (Glover 2003), an issue not directly addressed by the principle of autonomy but often implicit in any discussion about a psychiatric patient’s care. The issue of identity and how this relates to choice is often the first question that strikes psychiatric trainees as they begin their training. They may not be sure what to make of a family’s talk of their relative not being ‘their usual self’ or, conversely, their reassurances that the more unusual behaviour is in fact ‘just them’. Age and social context are relevant here: consider a young man who suffers a sudden onset of a first episode of psychosis during which he becomes paranoid and refuses treatment. Such a person often has family and friends who can provide a background history of who this person is, their interests, values, hopes and aspirations, helping doctors to look beyond the patient in front of them and make decisions on behalf of their ‘usual’ rather than their ‘pathological’ self. Such a case looks relatively straightforward in terms of trying to be respectful of the personal values that constitute that person’s identity.

But consider by contrast a 60-year-old man who has lived with chronic schizophrenia for 40 years with few social or family contacts and a long history of ill health. It is less straightforward to see how the psychiatrist is going to be able to connect with this man’s premorbid personality. After so many years that person may in a sense be lost and the patient’s illness may have come to define much about him. In such instances, do psychiatrists address the patient directly according to the values they express now (although they may be symptoms of their disease) or do they search for deeply hidden or maybe even never-developed interests? Perhaps they act on an account of what a reasonable person would want in such circumstances.

These challenges raise another important question: what is the aim of treatment of mental illness? As Michael Slade explains, conceptual clarity is

required when talking of ‘recovery’ in psychiatry. A medical model may emphasise only a remission in symptoms and a return to ‘normal levels of functioning’, what Slade describes as clinical recovery. Important too though is personal recovery – enabling and supporting a patient to develop individual ambitions, satisfactions and meaning to their life, whether unwell or not (Slade 2008).

Undoubtedly, these are some of the questions that will have troubled Mr C’s treating team. His case also reminds us that many patients with chronic mental illnesses rely on others to help them make their choices and their autonomy is best understood as a ‘relational’ autonomy, which is based on the relationships with those who care for them (Agich 1993).

Common ethical dilemmas: consent and covert medication

In this section, we explore consent to psychiatric treatment in more depth, as this is a major area of ethical tension in psychiatry. The CPD module provides an example of an ethical dilemma involving consent, namely covert medication. These kinds of case arise quite regularly in mental health services, perhaps most commonly in older persons’ mental health and also in secure care, which is where the case in our second vignette took place.

Vignette 2 – Consent

RM v St Andrew’s Healthcare [2010]

Mr M suffered from organic delusional disorder and epilepsy and was detained under section 3 of the Mental Health Act 1983. Hostile and violent to staff, and denying he had a mental illness, he was covertly medicated. When the hospital referred his case to the First-tier Tribunal it was disclosed to Mr M during proceedings that he was being treated covertly. He was very upset, refused to take any medication and became suspicious of food and drink. His mental state deteriorated, he suffered more frequent seizures and he became violent to others, requiring physical restraint and periods of seclusion. Covert medication was resumed and he improved. Mr M was aware that he had improved so applied for discharge from hospital on the grounds that he did not have a mental illness that needed treatment, as it was clear that he was well without it.

In preparation for a second tribunal regarding the discharge the hospital this time requested that the reports documenting covert treatment were kept from Mr M. Mr M’s lawyers took the case to court, which found that Mr M was entitled to challenge his detention effectively and that he could not do this if he did not know he was being treated covertly.

The court in this case acknowledged that there was evidence that Mr M was angry and unhappy about being twice deceived and that disclosure would cause short-term harm to the therapeutic alliance. However, this short-term harm could not

justify preventing his access to justice. The court's decision echoed a previous House of Lord's decision about consent to treatment, which stated that doctors were not allowed to lie to patients (*Sidaway v Board of Governors of the Bethlem Royal Hospital* [1985]). Generally speaking, deception of any patient by a doctor would usually be seen as demeaning and unjust, and a possible basis for unfitness to practise on probity grounds. It is a high-risk strategy even with good intentions and even when there are good outcomes. In Mr M's case, it may reflect how much anxiety his clinical team were feeling about managing him.

A more recent case, *Montgomery v Lanarkshire Health Board* [2015], also looked at consent and what consent discussions should involve.

Vignette 3 – Informed consent

Montgomery v Lanarkshire Health Board [2015]

Ms Montgomery was a pregnant woman with diabetes seeking advice about potential delivery complications. Her obstetrician advised vaginal delivery and deliberately did not discuss some rare risks to vaginal delivery because, in her experience, doing so encouraged mothers to opt for Caesarean section, something she felt was more risky. Sadly, Ms Montgomery experienced a rare obstetric complication and her baby suffered hypoxia and subsequently developed cerebral palsy.

Ms Montgomery argued that it was negligent of her obstetrician not to discuss the rare obstetric complication she experienced, and the Supreme Court found the obstetrician negligent for failing to discuss the risks and options.

In *Montgomery*, the doctor was prioritising the value of women not having a Caesarean section if it was not needed and Mrs Montgomery was prioritising having the kind of delivery that would be safest for her baby. As in *RM v St Andrew's Healthcare* the Court found that the patient had been deprived of information that would have been important for her to have known and would have added significant value to her decision. In this respect, the Court reaffirmed that appropriate discussions about consent require a certain standard of risk disclosure to be met. However, the Court stressed that informed consent must also entail a human dialogue (Hughes 2018). This requires determining what matters to the patient and exploring the different value perspectives of all those involved. The obstetrician's sincerely held belief that their treatment plan was best is only one factor in the consent process.

Both *Montgomery* and *RM* highlight the importance of a values-based practice (VBP) approach to medicine (Fulford 2011). Such an approach understands that the process of ethical reflection requires not just interpreting ethical principles or analysing the facts relevant to a dilemma. It also requires exploring the different value positions of those

involved. Such a process can be described as dissensual, reflecting another reality of ethical decision-making: that the values of those involved may not always be reconciled to a consensus, but should nevertheless 'remain in play', under consideration and in tension (Fulford 2012).

Making good-quality ethical decisions: points to consider

The CPD module helpfully sets out the different ways that CECs address ethical reasoning about common dilemmas in clinical care. In this final section we want to explore the human difficulties in tackling dilemmas in daily practice and provide some practical guidance.

Suboptimal outcomes and bad feelings

Important to note is that ethical dilemmas often arise in situations where there do not appear to be any good options available. Put another way, if there were an obvious good option then psychiatrists would likely pursue it. Ethical tension arises when the psychiatrist cannot see good outcomes, or fears that the outcomes have significant costs that render them less good or 'suboptimal'. This ethical reality adds an important caveat to the use of any model for ethical reasoning, which is that they do not always identify an ideal outcome. They may only offer the 'least-worst' course of action.

It should also be noted that, even when the ethical 'answer' seems justified – whether by a model of ethical reasoning or not – it can still lead to strong emotions in staff and 'bad' feelings. Silva et al (2017) describe a case where a patient was forcibly treated with clozapine via nasogastric tube. Although the patient made a full recovery and went home (after years of detention), many members of the clinical team felt very uncomfortable about the treatment, finding the patient's distress upsetting. Not all ethically justifiable decisions will come with a promise of professional peace of mind.

Interpersonal and institutional pressures

The case as described in Silva et al also highlights that, as in any team endeavour, ethical dilemmas will always contain complex interpersonal dynamics. The influence of other members of the clinical team is important and there is an expectation that the psychiatrist will be a team player, whose view is only one of many. The General Medical Council requires doctors to work in teams and yet the psychiatrist is the responsible clinician legally and ethically. If things go wrong, it is the psychiatrist who is likely to be the focus of criticism. In the Silva case, the consultant was heavily criticised for pursuing their course of treatment against the views of staff who felt upset

by the process. This criticism persisted even when the patient wrote to thank his team and the consultant for their help in his recovery.

Given this, in any ethical dilemma in mental health it is vital to consider the relational context. Some ethical ‘dilemmas’ will resolve if the relationship between relevant parties changes. For example, a psychiatrist may be reluctant to discharge a person to their home because of the family dynamics, although the patient is keen to go. If the family dynamics could change (with therapy, say) then the dilemma would disappear.

Ethical models may sometimes fail to capture the relational context to an ethical dilemma. In some institutional contexts ethical models may be forgotten altogether. Reflecting on some of the atrocities that humankind has committed over the past century, ethicist Jonathan Glover (1999) asked how good people can bring themselves to do such terrible things. One answer, among others, is the tendency for humans to act as tribes and, in doing so, create a moral distance between themselves and others. Respect for another’s human dignity can be discouraged through a culture of dehumanising behaviour and language, such as dark humour or metaphor. In institutions where this behaviour is commonplace individuals can evade responsibility or deny involvement in wrong-doing, perpetuating injustices and creating a ‘culture of denial’ (BBC News 2020). It is salutary to recall that the history of psychiatric practice is chequered with injustices and abuses. At its most essential, ethical medicine requires each clinician to have the courage to recognise when wider institutional or team behaviour encourages bad practice – and to challenge it.

When there is no clinical ethics committee

Not everyone will have access to a CEC nor be in a position to set one up, so all psychiatrists need to enhance their ethical reflective and communication skills to help bring about the most morally respectable decisions. Robust ethical decision-making involves recognising and trying to avoid the personal, interpersonal and institutional biases that can distort moral reasoning. It includes considering the values of all those involved in the decision-making process. Perhaps the really difficult aspect of ethical dilemmas in mental health is not that the moral principles falter, but that professionals do not always take enough time to reflect on them. It is important to remain calm and not let other people’s anxiety create an urgency that is actually illusional. Taking time to do the process of ethical reflection properly may be the most ethically respectful and defensible thing to do.

Ethical reasoning is also a self-reflective process that should ask questions such as ‘What am I

worried about most?’ and ‘What makes me most uncomfortable about other people’s views on this dilemma?’. This is a practice that goes back to the probing questions of Socrates to the people of Athens. Socratic questioning remains a challenge because it aims to reveal muddled thinking where there was certainty and uncover issues that had not been previously thought of, making things more complex than they first seemed. Many can find this a difficult and unwelcome experience. However, psychiatrists are well placed to engage in these discussions because they involve some of the same skills that they need for their clinical work: listening before speaking, not jumping to conclusions, resisting black and white thinking and practising the kind of imagination that sees what a situation might look like from another person’s perspective, even if they think that perspective is invalid or irrational.

Finally, when the going gets tough, the tough get help and advice. If faced with an ethical dilemma, the virtuous psychiatrist consults with senior colleagues and those who have experience in these matters, which may include the chaplaincy, local moral philosophy departments and legal experts.

Conclusions

Terms such as harm, autonomy, justice and fairness are value-laden – professionals draw on them to justify their actions as right and proper – but what they mean is open to differing and competing interpretations. Ethical principles are also tricky because, even when we share an interpretation of the moral concepts they express, they can directly clash. This is the reality of value pluralism in a civilised society (Berlin 2002) and of debates among reasonable people. In day-to-day practice the important thing is not so much coming to an objective or consensus view of what these values and principles mean but knowing that, when we draw on them to justify our moral actions, we should be clear about the way in which we are defining them.

Values give moral character to decisions and to decision makers. As psychiatrists, we want to stand up for a virtuous mental health service even if what this looks like is something we cannot always agree on. Ethical decision-making, particularly in the context of psychiatric dilemmas, is a human endeavour and is therefore not easily tied to algorithms. Where human values and emotions are involved there will also be human irrationalities, interpersonal and institutional traps, disagreements of fact, and power imbalances. All we can hope to do is try to minimise the irrationality as far as possible. To this end it is always worth asking oneself ‘What am I not thinking about?’.

Clinical ethics committees provide a forum where decision-making can be supported but, whether there is a CEC available or not, it is down to each psychiatrist to enhance their moral reasoning: we can all improve. There are many formal ways to do this – courses in ethics and law, grand rounds and clinical case reviews, supervisions and formalised reflections – but like all of medicine the art of the profession takes practice, repetition and confronting those clinical cases that make us feel uncomfortable. There are, of course, experts on hand to guide us but it is worth noting that the Latin for expert, *expertus*, means simply to have tried. On that basis we can all try to be experts in the ethics of mental health.

Author contributions

Both authors have made substantial contributions to the design of the work. Both have drafted and critically revised it and approved this version for publication. Both authors agree to be accountable for all aspects of the work.

Declaration of interest

None.

ICMJE forms are in the supplementary material, available online at <https://doi.org/10.1192/bja.2020.46>.

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MCQ answers

1 c 2 c 3 d 4 b 5 d

MCQs

Select the single best option for each question stem

1 Which UK Supreme Court case was significant for its redefinition of the standards of informed consent for medical treatment?

- a *Sidaway v Board of Governors of the Bethlem Royal Hospital* [1985]
- b *RM v St Andrew's Healthcare* [2010]
- c *Montgomery v Lanarkshire Health Board* [2015]
- d *Re C: (Adult: Refusal of Treatment)* [1994]
- e *Aintree University Hospitals NHS Foundation Trust v James* [2013].

2 Which philosopher is known for a style of question and answer dialogue that aims to clarify meaning, uncover assumptions and eliminate contradictions?

- a Jeremy Bentham
- b Isaiah Berlin
- c Socrates
- d Jonathan Glover
- e Mary Midgley.

3 Which UK High Court of Justice case held that a mentally unwell patient with capacity has the right to refuse to medical treatment, even if this puts their life at risk?

- a *Sidaway v Board of Governors of the Bethlem Royal Hospital* [1985]
- b *RM v St Andrew's Healthcare* [2010]
- c *Montgomery v Lanarkshire Health Board* [2015]
- d *Re C: (Adult: Refusal of Treatment)* [1994]
- e *Aintree University Hospitals NHS Foundation Trust v James* [2013].

4 The term expert is derived from the Latin *expertus*, which means:

- a love of wisdom
- b to have tried
- c to have declared publicly
- d the science of morals
- e to have picked out.

5 Personal recovery from mental illness is, according to Slade, best understood as:

- a a reduction in one's symptoms
- b a return to normal levels of functioning
- c a sustained remission in symptoms, accompanied by independent living
- d developing new meaning and purpose to one's life beyond the course of an illness
- e returning to a mental state 'baseline' after an acute relapse.