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Help and Coercion from a Care Ethics Perspective

Guy A.M. Widdershoven¹ and Tineke A. Abma²

¹*VU Medical Center EMGO+ institute/Department of Medical Humanities,*

²*VU Medical Center EMGO+ institute/Department of Medical Humanities,*

Amsterdam,

The Netherlands

1. Introduction

At present, there appears to be a tendency to attribute (shared) responsibility to (healthcare) professionals, such as medical doctors, parole officers, mental health care workers and child services employees, in questions of safety. At times they may be asked to alert the police or other authorities in order to protect the safety of their patient/client or his environment. This raises the question of what you would do, as a professional, when you suspect your client becomes involved in criminal activities or neglects or abuses his housemates.

In such cases, professionals are often hesitant to inform the authorities. They feel they ought to respect the autonomy of their client and should not invade his privacy. This reflects our common belief that help and coercion are contradictory and conflicting values. Autonomy is one of the core values in our Western culture and equated with independence and freedom of choice (Widdershoven, 2000; Verkerk, 2001). Within the context of health care self-determination is also considered an uncontested right. The idea of the self as free and independent mirrors itself in the shift from the patient as a passive recipient of care to the patient as a 'consumer' or 'critical customer' (Emanuel & Emanuel, 1992; Thorne & Paterson, 1998; Guadagnoli & Ward, 1998).

Yet, the question remains whether not interfering or not steering the client is in fact the optimum way to respect the client's autonomy. To what extent can one speak of autonomy when we close our eyes and allow someone to get involved into criminal behavior? From the viewpoint of the professional should one not attempt to change the client's mind, stimulating him to engage in different activities, deliberately preventing him from such behavior? Indeed, should one perhaps even consider employing persuasive or coercive tactics, even if this includes restrictions in the freedom of the client?

In this article, we propose and recommend a view of autonomy based on the ethics of care (Tronto, 1993; McKenzie & Stoljar, 2000; Verkerk, 2001a). Herein autonomy does not equal self-determination and self-ownership without the interference of others, but is defined as the ability to direct and shape one's own life based on and in relationships with others. From such a perspective, actions of third parties may actually be necessary to enhance autonomy. Autonomy is thus not understood in opposition to relations of dependence and

connection. A relational conceptualization of autonomy in which vulnerability and dependency on others are considered to be part of life and constitutive of autonomy helps to find legitimate ways to intervene in the lives of clients.

This does not mean, however, that every manner of intervention is justified. The issue is not whether or not an intervention is indicated (legal perspective), but how this intervention can be shaped so that the people concerned feel empowered and supported by it (ethical perspective). We illustrate this relational view of autonomy based on the ethics of care with a case description from a primary care organization for people with a physical or intellectual disability in the Netherlands.

2. Case MEE

MEE is a Dutch primary care organization for people with a physical or intellectual disability. Part of their client population consists of young adults (under 30 years) with mild intellectual disabilities who live independently and who sometimes have so-called 'double' difficulties as they also suffer from behavioral problems or personality disorders. This group can be highly impressionable and is often found to be involved in a variety of criminal behaviors, such as growing hemp plants, illegally claiming cars and dealing drugs. Especially those with double difficulties frequently end up in the justice system. This may entail involvement in a wide range of sometimes serious or violent criminal activities. Part of this population has been the topic of case discussions in local safety houses where representatives of municipal, judiciary, care, and welfare organizations have gathered to devise strategies on how to deal with these adolescents and young adults. To facilitate discussion, the participating organizations are expected to share all relevant information about this group of youngsters including to the department of justice, when illegal acts are involved.

Counselors at MEE are habitually confronted with facts that point to the (suspected) involvement of their clients in criminal activities. They may see a weapon in their rooms, smell marijuana plants in the attic, find stolen goods, etc. At times clients may even talk to their counselors about their illegal behavior or there could be other clues that something is going on, for instance when there suddenly is a lot of money or expensive equipment in the house, while the client does not have any financial resources.

The police expect MEE counselors to report these situations or file a case when appropriate. However, the counselors hardly ever do this. This can be explained by a number of factors. For example, they may feel it is not be the job of the professional to report someone. After all one is there to provide care not to act as a policeman. The protocol for social workers also states that such action is not indicated. In this protocol, the importance of the client and particularly the respect for his privacy is emphasized rather than the importance of society or general interest that is served by reporting the crime. The counselors also have their own opinions on the behavior of their clients: they may not always feel it is that bad. This differs amongst counselors (i.e. where one feels more strongly about the presence of marijuana plants than another). In addition, some counselors may feel it is not (always) their business. They consider the presence of, for example, stolen goods in the clients' house not to be part of the professional contact/interaction they have with the client. They are, in their opinion, no detectives and feel it is not their job to find out if something is wrong or acting illegal. In other words, only when the client himself reports involvement in illegal activities is there a

possible role for the counselor. However, even in that case, most counselors do not feel they need to report it to the justice system. On occasion they may confront the client themselves, at other times they confer with colleagues or they take no action at all as they feel they do not have to or cannot do anything. Sometimes counselors may also be afraid to speak up about what they see. As a result, oftentimes counselors do not do much about the signs and suspicions that their clients are involved in criminal behavior.

3. Two approaches to autonomy

In ethics, autonomy is often identified with self-ownership and self-determination. Somebody is autonomous when he or she can decide for himself what happens. Following John Stuart Mill (1859), autonomy as self-ownership describes the freedom of the individual to shape his own life unhindered by others. His renowned principle of freedom/liberty holds that an individual is sovereign in directing his own life, as long as his actions do not hurt others. Notable authors in the field of health care ethics have emphasized that respect for autonomy means that the health care professional should avoid meddling in the decision making of the patient or client (Beauchamp & Childress, 1994). When the client is attracted to criminal behavior, one should not intervene unless his safety or that of others is at stake/in jeopardy.

Non-intervention is stressed in this view of autonomy. The individual is to rule about his own life without interference from others. This is considered negative freedom/liberty. The concept of positive freedom/liberty can be distinguished from that of negative freedom/liberty (Berlin, 1969). It deals with an increase in freedom/liberty in the actions or choices of people. Positive freedom/liberty focuses on a person's ability to be the source of his own decisions and to lead his life in accordance with his own value-commitments, goals, and plans. In the positive notion of freedom/liberty not only the question whether people can make their own decisions, but the content of these choices is also taken into account. From the standpoint of autonomy as positive freedom/liberty one does not have to respect every choice. A choice that is in accordance with the life-plan of the individual has greater importance than a choice based on a random impulse (Dworkin, 1988). The ethical value of the continuation of one's life path and personal history can also be found in the work of Ricoeur (1992). People become incredible, untrustworthy and irresponsible when they step outside their life history, and cannot keep up the promises they made to others. So when someone engrosses himself in criminal activities this does not signify/exemplify autonomy, because the choice is not an expression of what the person truly values in his or her life (unless the person made a clear and informed choice to engage in illegal activity). Yet, even such a deliberate choice becomes questionable if it, for instance, implies that the client can no longer be responsible for his family. Think of a patient who is addicted to alcohol or drugs and can no longer care for his son.

Care ethicists adhere to the notion of autonomy as positive freedom/liberty (Verkerk, 2003). They stress that autonomy is not the same as independence. Autonomy can only be developed in relationships with others, so in situations/states of dependence. Hence care ethicists speak of relational autonomy (MacKenzie & Stoljar, 2000; Verkerk, 2001a). From a deliberative perspective people require support to gain insight into what is important in their lives and how to arrange their lives accordingly (Oeseburg & Abma, 2007). It is not always simple to choose friends. Sometimes one needs to be warned not to be tempted into an (seemingly) alluring situation. When one lets people in vulnerable circumstances choose

their own company, this does not prove of respect for their autonomy but of neglect. By helping them guard themselves against 'wrong friends' their autonomy is actually reinforced. Help and support will not be limited to this. The client's criminal activities afforded him a particular role and might even have given him a certain status level. Besides money and material goods, criminal activities in itself are valued in certain communities. Therefore, finding alternative ways to a respectful life are crucial in the cessation and prevention of illegal activities. From a positive view on freedom/liberty, care professionals should help their clients (or refer them to others who can help the client) to discover better ways to participate in society and live a meaningful life. This implies an active search for pursuits or pastimes that fit his personal wishes and abilities. In addition to developing a daytime program, care professionals should also assist their clients in attaining a different social network. Lastly, clear and achievable agreements should be made based on joint discussion (such as no longer socializing with certain people or frequenting certain meeting places). Informing the healthy network of the client may be helpful/effective in this. Family members and acquaintances can remind the client of the arrangements. Care professionals can also check regularly whether or not clients have kept their promises, and if not, why not, and try to adjust/improve the situation accordingly. In this way care professionals help to empower their clients.

According to Agich (1993), individuals are never fully formed but they are part of a dynamic process of development, in interaction with their environment. Only for a person without an identity does freedom/liberty mean absolute independence. Dependency need not impair anyone's freedom/liberty as long as that person can develop and mature. The same holds true for the mutual influence that care professionals and clients have on each other. As stated by Agich, it is more important to help clients to live with their vulnerabilities and to accept their limitations (for isn't this what it means to be human?) than it is to offer them freedom of choice (Agich, 1993). This means that it is more important to guard people against the temptations of criminal activity, then to let them do whatever they want.

4. Inducement and coercion

From the perspective of care ethics, respect for autonomy constitutes more than not interfering in the decisions of the client (Verkerk, 2001b). Sometimes it is necessary to influence the behavior of the client, especially to be able to add to their autonomy as self-development (as opposed to autonomy as self-determination). One can execute inducement and persuasion in an attempt to change the client's mind or even employ coercive measures to prevent negative consequences. We speak of inducement when a client still has the freedom to make a choice (e.g. if you do not stop growing marijuana plants, then I will have to report it to the police). In the case of coercion the client has no choice (e.g. I will get the police involved now).

Care is a process of negotiation and corresponding perspectives. In this context, Moody (1992) coined the term 'negotiated consent.' According to him, care does not merely consist of offering information and waiting for consent, but reaching a joint understanding through negotiation. Care professionals cannot simply sum up the risks and wait for whatever the client decides to do. This is unfair, especially when clients are missing the cognitive or emotional intelligence to value and weight various alternatives and to oversee the consequences. By being involved with client the professional should (attempt to) encourage

the client to handle risks in a responsible way. This means that they should enter negotiations with the client by actively offering and discussing their options.

Moody (1992) points out a number of ways in which health care professionals can intervene during the process of negotiation. He discerns four types of intervention. The first is *representation of interest*. The professional works as an advocate for the interests of the client and tries to defend these. For this their interests must be understood. And if necessary the care situation should be adjusted, for example when a client does not want to be helped by a certain professional, but only by another. The second form of intervention is *stimulation*. Here, the objective is to encourage the client to look at himself differently. For example, start to see again that one is a father with responsibilities for a family instead of just being a alcoholic and patient. The third intervention is *persuasion*. The professional tries to persuade the client to comply/be cooperative by offering convincing reasons. These must be tailored to the client's circumstances. The fourth and final intervention is *deciding for the other*. In this situation the client no longer plays an active role. According to Moody, though, even in this case is there communication and negotiation, for example with the family, or between professionals.

What does the approach of Moody mean for the care professionals at MEE? First of all, they need not accept every form of conduct from their clients. They can try to convince their clients to show more responsible behavior. This could consist of modifying the situation they are in (for example by giving someone a daytime activity or removing them from a certain environment) or through the strategy of stimulation. A client is then confronted with his own healthy and positive behavior and motivated to see himself as someone who, despite limitations, is mature and takes the possessions and interests of others into account (as opposed to being a thief and/or taking advantage of others). The next step would be to seriously debate with the client and discuss behavior that is inappropriate and may call for sanctions such as fines or prison sentences, and offering alternatives instead. If these interventions/forms of persuasion are not beneficial, (then) care professionals can alert other institutions such as the police or justice system. However, whether or not this effectively changes the clients' actions remains questionable. Often, the involvement of police will actually lead to (increased) resistance on the part of the client. In that case it may be advisable to explore other options (such as alerting social work or people from the healthy environment of the client). The tendency not to rush to the police can (easily) be defended because an exaggerated intervention may result in negative reactions from the client and thus damage the basis of trust that is essential for a good professional relationship. Nevertheless, in some cases there is no other way as the client systematically ignores well-intended advices. In a selected group of patients clarity and an active stance can help to break the cycle of negativity.

5. Carefulness

From the viewpoint of care ethics, action may indeed be indicated when looking out for the client's autonomy. This does not purport that every form of intervention is always justified. First of all, the intervention should have a result. Will the intervention modify the client's behavior, end the criminal activities, and help the client to find pursuits that are more compatible with his abilities? An ineffective intervention will inevitably be problematical. Secondly, the intervention should be appropriate, and specifically not more grave than necessary. For example, a minor incidental offense demands a straightforward but small

correction and some form of agreement to prevent repetition. When a client is structurally involved in unlawful activity the care professional may consider applying some restrictions (for instance taking away certain privileges) or alerting other institutions and authorities. To be able to answer these questions it is vital to pay attention to the client's reactions. Herein, observation and communication are essential.

A care ethical attitude requires the willingness of care professionals to take on responsibilities, but also to be open to the reactions of the recipient/client, and, if necessary, to amend their own opinions about giving good care. Openness demands that one does not ignore possible negative reactions from others. Conversely, it also does not mean that every negative response or refusal should be considered to be just. To be able to modify one's opinions there needs to be trust and a firm, but not inflexible belief in one's own standpoints and perceptions. Adequate help constitutes the ability to find a middle ground between determination and resoluteness on the one hand and acquiescence and flexibility on the other hand. Adhering too strongly to your own beliefs impairs the capability to hear the negative reactions of others. However, following every suggestion of another person could result in a decreased value of one's own ideas and beliefs. It also makes one incredible and untrustworthy. According to Aristotle, the capability to determine the right means and course of action in a given situation is characteristic of wise and intelligent people (Widdershoven, 2000). The type of wisdom that is of concern here is primarily practical in nature. This is therefore called practical wisdom. Rather than pointing out the middle ground through reasoning, what matters is demonstrating this through (one's) actions, situated in time, place, and circumstances.

Practical wisdom implies one is capable of shaping behavior in such a way that extremes are avoided. In care, this means that care professionals know when and what kind of coercive measures are indicated and appropriate in the situation, but also when they should hold back (in these) and find alternatives which are less restricting. Only on the basis of practical wisdom can you responsibly realize the interventions that Moody (1992) proposes. After all, the question of whether a certain intervention is justified in the situation and whether or not it is too severe or too light keeps repeating itself. This does not only include the consideration of whether the type of intervention will be successful or not, but also whether the intervention is appropriate in answering the question of what good care is and how this can be answered in cooperation.

Discussing incidents after they have occurred with care professionals, clients, and other involved parties is part of good care. This enables the care professional to calmly explain the measures that were taken, why they were taken, the dilemma's experienced, the emotions and feelings the intervention evoked among professionals, how this affected the client, and whether he understood the care professional's motivation. Evaluation offers the client the chance to share experiences and feelings, to ask questions and raise concerns. It does not occur often, but the participants generally appreciate talking about such matters. It helps the client to hear that the care professional saw no other way out and also felt concerned and bothered by it. Voicing these feelings promotes understanding (Widdershoven & Berghmans, 2005). Not only can such an evaluation be an opportunity to exchange views on the situation and express emotions and experiences (often feelings of powerlessness on the side of the care professionals, and anger and resentment on the part of the clients), but it will also serve to advance learning and generate ideas how to prevent crises in the near future. Why was an intervention needed? Could looking out for certain behaviors earlier on have

prevented the intervention? What does this mean for the future? Based on the findings it is frequently possible to create early intervention plans and make appointments with the client. In this way communication, evaluation, and prevention go hand in hand (Abma et al., 2005).

6. Conclusion

Societies are less tolerant toward criminal and strange behavior of certain patient populations than several decades ago. It is therefore nowadays more or less expected that care professionals report certain behaviors to each other, the police or the authorities. This article raised the issue how to deal with these new sets of responsibilities from a care ethics perspective.

Commonly care professionals tend to not to interfere in the lives and privacy of clients referring to the value of autonomy. Respect for autonomy can, however, be explicated in a number of ways. From the viewpoint of negative freedom/liberty one should give people the space and opportunity to make their own decisions and not interfere. Here, the contents of their choices are irrelevant. People are seen as individuals who, ideally, live their lives independently of each other. From a care ethical perspective, the idea of positive freedom/liberty is propagated. People are free when they are allowed to develop and are able to handle the situation they are in. This requires an inter-subjective context of care and support. Giving direction to his own life does not mean that a client can do whatever he wants without hindrance or impediment. It does mean that a client is able to structure and build his own life supported by the attention and involvement of others and that he learns how to handle his disabilities and cope with his limitations.

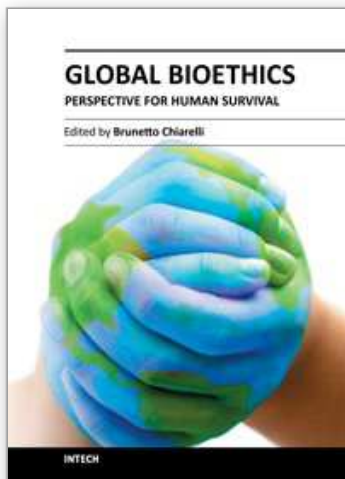
Based on the care ethical view of autonomy it would be useful if care professionals keep each other informed of problematic behavior in their clients. Alerting police or the justice system may also be indicated. Such forms of intervention should, however, be subject to certain requirements. Firstly, all parties involved should aim to enhance the autonomy of the client. This will enable him to get more control over his situation. Secondly, the least severe intervention should be employed. Stimulation and persuasion are preferable to coercion. Lastly, the intervention should be evaluated with all parties.

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Two new factors have been added to the ideological change in the second half of the past century: the “ecological impact” of humankind on the environment due to the population increase; and the “innovative impact of science, first with atomic physics, which introduced the scission of the fundamental unit of matter, the atom, and then with molecular biology, which led to the decoding of genetic information and intervention of biological engineering that annihilate our concepts of individual and species as fundamental units in biology. This stage of fundamental rethinking is however overshadowed by the threat of ecological disaster and catastrophic population increase, which not only impose limits to development, but undermine the very survival of Humankind. The future survival of our species in fact depends on the interaction between its reproductive characteristics and the productivity of the territory, which, even if increased by the intellectual capability of the human brain, has intrinsic limits. The adaptive choices (which are also biotechnological and biomedical) of the interaction between human population and the natural ambience is the conceptual basis of the new discipline “Global Bioethics”.

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University Campus STeP Ri
Slavka Krautzeka 83/A
51000 Rijeka, Croatia
Phone: +385 (51) 770 447
Fax: +385 (51) 686 166
www.intechopen.com

InTech China

Unit 405, Office Block, Hotel Equatorial Shanghai
No.65, Yan An Road (West), Shanghai, 200040, China
中国上海市延安西路65号上海国际贵都大饭店办公楼405单元
Phone: +86-21-62489820
Fax: +86-21-62489821

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