A CARE PERSPECTIVE ON COERCION AND AUTONOMY

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ABSTRACT

In the Netherlands there is a growing debate over the possibility of introducing ‘compassionate interference’ as a form of good psychiatric care. Instead of respecting the autonomy of the patient by adopting an attitude of non-interference, professional carers should take a more active and committed role. There was a great deal of hostile reaction to this suggestion, the most commonly voiced criticism being that it smacked of ‘modern paternalism’. Still, the current conception of care leaves us with a paradox. On the one hand patients are regarded as individuals who have a strong interest in (and a right to) freedom and non-interference; on the other hand many of them have a desperate need for flourishing, viable relationships. In fact, part of their problem is that they cannot relate very well with other people. This creates a dichotomy, because respecting patients’ autonomy often means that they cannot be given the help they so desperately need. In this respect current care practices do not answer the caring needs of these patients. The criticism on care practices is to be considered as important. It invites us to reexamine and reevaluate the current conception of caring relationships and its main values. In line with this reexamination an alternative perspective on care is introduced in this paper, a perspective in which ‘compassionate interference’ is not so much a threat to autonomy, but a means of attaining autonomy. For this we need a different definition of autonomy than that commonly used in current care practice.

INTRODUCTION

In 1993 a nurse working as a specialised practitioner in social psychiatric care in the city of Rotterdam in the Netherlands caused a controversy when he pleaded for the introduction of
‘compassionate interference’ in health care relationships. (Henselmans, 1993)

Most of the patients he and his colleagues treat are homeless drug addicts, living on the streets and marginalised by society. Many have a long history of psychiatric care. Some survive by learning the ‘language’ of their professional carers. They often act in a manipulative way, abusing the help that is offered. Others, perhaps out of anger or bitterness, simply refuse care. The situation of these patients is the worst of all, because the professional carer can do nothing but stand on the sidelines. Patients have a right to self-determination and professional carers are not allowed to intervene. It was against this background that the plea for ‘compassionate interference’ was made.

In making this plea the nurse was stressing the need for a different outlook on what good care should mean. He was suggesting that instead of respecting the autonomy of the patient by adopting an attitude of non-interference, professional carers should take a more active and committed role. They should not stand aside. On the contrary, they should keep an eye on their patients, look them up and provide advice and help where necessary. There was a great deal of hostile reaction to this suggestion, the most commonly voiced criticism being that it smacked of ‘modern paternalism’. ‘Compassionate interference’ does not appear to be the politically correct approach in caring relationships today. It seems that a professional attitude of attentiveness and commitment does not go hand in hand with respect for patients’ autonomy.

The nurse pointed out, however, that the current conception of care leaves us with a paradox. On the one hand patients are regarded as individuals who have a strong interest in (and a right to) freedom and non-interference; on the other hand many of them have a desperate need for flourishing, viable relationships. In fact, part of their problem is that they cannot relate very well with other people. This creates a dichotomy, because respecting patients’ autonomy often means that they cannot be given the help they so desperately need. In this respect current care practices do not answer the caring needs of these patients.

I consider the criticism on care practices to be important. It invites us to reexamine and reevaluate the current conception of caring relationships and its main values. In line with this reexamination I will introduce an alternative perspective on care, a perspective in which ‘compassionate interference’ is not so much a threat to autonomy, but a means of attaining autonomy. For this we need a different definition of autonomy.
than that commonly used in current care practice. I will begin by investigating what respect for autonomy means in today’s medical setting.

RESPECT FOR AUTONOMY

In the last thirty years we have witnessed a development towards more patient autonomy in health care. The principle of beneficence has been replaced by the principle of autonomy. According to the ethicist Pellegrino this change can be considered the most radical in the long history of the Hippocratic tradition. The relationship between the professional carer and the patient has become more honest and open, and shows more respect towards the dignity of the patient. (Pellegrino, 1990)

The concept of autonomy recognises the human capacity for self-determination and puts forward the principle that the autonomy of the individual ought to be respected. This general description of autonomy still allows for different interpretations. Like many other moral concepts, such as justice and equality, autonomy derives its meaning in the context of a particular theoretical perspective. Many contemporary and leading philosophers and ethicists seem to construe autonomy as a capacity of individuals. For instance, Bruce Miller in the *Encyclopaedia of Ethics* distinguishes three elements of the capacity for autonomy: agency, independence and rationality. Agency is awareness of oneself as having desires and intentions and of acting on them. In short, it is an account on how a person is able to act. Independence, as the second element, refers to the absence of influences which so control what a person does that it cannot be said that he or she actually wants to do it. Autonomy requires that individuals have an adequate range of options. The third element of the capacity of autonomy is means-end rationality. There are several ways to understand rationality as an element of autonomy, but it certainly requires that persons are able to reflect critically on their desires and beliefs.

Respect for autonomy as capacity can be shown in several ways. The minimum content for the principle of respect for autonomy is that persons should have independence, that it be free from coercion or other similar interferences. Respect for autonomy also brings with it the idea of self-determination. An individual’s right to make his own decision can be seen as a right against other individuals or against the state, but the point in either case is that others would be wrong to use coercion or manipulation, to
interfere with an individual’s efforts to make and carry out these decisions.

In these interpretations autonomy is mainly understood in political and legal terms. The concept of individual autonomy is often suggested by the analogy with autonomous states which have the right to govern their own internal affairs. Individuals are seen as ‘sovereign authorities’ over a wide range of matters concerning their lives.

This dominant interpretation of autonomy is also shown in the context of health care. The principle of respect for the autonomy of persons in terms of respect for the right of self-determination has been expressed in several medical laws. For instance, in the last eight years seven separate laws on patient autonomy have been accepted in the Netherlands. The two most important ones are the Law on Contracts of Medical Treatment (WGBO) in 1995 and the Law on Special Admission of Psychiatric Hospitals (Wet bopz) in 1994. The WGBO defines patients rights in professional health-care situations, such as the right of informed consent and the right to refuse medical treatment. The Wet bopz defines the legal position of the psychiatric patient who faces possible coercive institutionalisation. In contrast to the past, coercive institutionalisation and coercive treatment is no longer justified for paternalistic reasons. The right of self-determination overrules considerations of protecting the well-being of patients. Coercive interventions are legally and morally justified, only in cases of severe risk or danger to society and patient.

But this dominance of the right of self-determination is now being questioned, particularly in the context of psychiatric health care. In fact, reservations about the view that the right of self-determination should always prevail unless society or the patient himself are at great risk were already being raised in 1995, shortly after the Wet bopz came into force. In 1997 the Dutch government asked the National Council for Care for advice as to whether coercive interventions for reasons of protecting the well-being of patients could not be justified under certain circumstances. In posing this question, the government began a revaluation of the Wet bopz. This revaluation was all the more pressing when certain recent developments in health-care policies are taken into consideration. In the Netherlands, a process of de-institutionalisation has been taking place. Patients with chronic diseases increasingly remain outside the institutionalised forms of care. Care is becoming more socially integrated and the patient becomes more emancipated. A side effect of this process of deinstitutionalisation is that sometimes
patients do not receive the care they need. This applies particularly to patients who have developed a deep mistrust of the care system and because of this avoid or refuse care.

In 1997 the National Council for Care published its report. In the report it was suggested that under certain circumstances coercive treatment and coercive admission for reasons of the well-being for the patient could be justified. The perspective of respect for autonomy is maintained in this justification. Paternalistic reasons simpliciter are not acceptable. The moral justification is concentrated on the discussion of questions of competence and voluntariness in decision-making and choice-making. The moral justification made use of a so-called ‘balancing strategy’. In line with what the proposal Buchanan and Brock had made in their book *Deciding for Others* in 1989, a what is known as a risk-related standard was introduced to strike an appropriate balance between respect for autonomy and concern for patient well being. If the risks are high, a strong standard of competence is required. If the risks are low, a weaker standard of decision-making capacity is appropriate. The implication of this balancing strategy is that a standard of competence should vary in significant part with the effects for the patient’s well-being of accepting his or her choice.

At this point I want to make two brief comments on the outcome of the discussion as it was presented by the Council on Care. First of all, in the report the emphasis on autonomy as the main moral value in caring relationships is maintained and because of that the moral discussion is restricted to criteria of autonomous decision-making and choice-making. The perspective on autonomy itself is not questioned and what is more, respect for autonomy as the dominant moral value in caring relationships is not questioned either. And so, secondly, other interpretations of good caring practices are not put forward in the discussion. For instance, very little attention is paid to the issue of how the need for coercive interventions can be prevented or, to put it another way, how a situation in which only two strategies remain — leave the patient as he is or use coercion — can be avoided. It was to prevent such situations that the Rotterdam nurse, in 1993, pleaded for a different conception of care.

Finding solutions to the above mentioned problems in psychiatric health care, we need a different perspective on care and a different interpretation of the role and status of the value of autonomy in caring relationships. To this end I want to make use of a perspective on care in which the discussion is not forced
into balancing respect for self-determination and paternalism. In developing a more relational model of autonomy, interventions in care can be shown to be in the interest of patients, that is, they can be seen as interventions for attaining autonomy, instead of threatening autonomy. In developing this alternative perspective it can be shown that some of the problems which have brought about requests for more coercion are, in fact, the result of a particular conception of care in which autonomy is the main value and in which other values and ways to relate are neglected.

For my argument I will make use of the ‘care perspective’ as developed in some feminist writings.

A SHORT OUTLINE OF CARE PERSPECTIVE

In the bioethics literature the terms ‘care’ and ‘caring’ are often used interchangeably to describe a form of moral reasoning, a care practice or a feminist theory of ethics. This has led to the criticism that care ethics is a hopelessly vague and ambiguous term. To a certain extent some of these criticisms are justified and a clear definition of what care ethics amount to is needed. In a recent article in the *Journal of Philosophy and Medicine* Margaret Olivia Little understands correctly, in my view, care ethics first and foremost as an orientation or perspective on the moral world. The care orientation is defined ‘in terms of emphases of concern and discernment (to notice and worry more, say, about the dangers of abandonment rather than about the dangers of interference), habits and proclivities of interpretation (the proclivity, say, to read “the” moral question presented by a situation in terms of responsibilities, rather than rights) and selectivity of skill (to have developed, say, an attunement to difference more than an ease of abstraction’ (Little, 1998, 195).

In the care perspective a relational account of moral agency and an idea of interdependency as characteristic of human existence are emphasised. In the care perspective the ideal of independency as self-sufficiency is fiercely criticised. That is, the idea that a good life is a life in which we do not need help or support from anyone in meeting our needs and carrying out our life plan is criticised. Instead, the value of depending on others and being depended upon is then recognised. The idea of the self as ‘disembedded and disembodied’ that has played a prominent role in moral and political theory, is also rejected in the care perspective. Instead, the self is conceived as a relational and embedded self. Besides these more or less fundamental anthropological insights, care often denotes an epistemic
attitude, understood as a moral ideal of attention. In this, the care perspective emphasises an alternative moral epistemology, in which attention, contextual and narrative appreciation and communication are considered as elements of moral deliberation (Walker, 1992). In short, care as an orientation can be seen as a practice, in which the concerns and needs of the other are taken as a basis for action and in which attentiveness and responsiveness are seen as epistemic virtues.

Understanding care ethics as a different perspective on the moral world, also asks for a rethinking of the place and status of some of the concepts in the moral scheme. For instance, some have pointed to the importance of trust and self-trust in moral life (Baier, Govier), others, such as Robin Dillon, have developed a care perspective on the notion of respect. And there are those who have insisted on a different interpretation of autonomy. For that, they have developed a relational or dialogical conception of autonomy. (Keller, 1997) In developing this relational account of autonomy, the idea of autonomy in terms of self-governance has not been deserted in care ethics. Only, the individualistic account of human nature that seems to underlie the liberal conception of autonomy is criticised. An account of the moral agent as an ‘encumbered self’, in which the self is always already embedded in relationships with flesh-and-blood others and is partly constituted by these relationships is developed. By developing a relational concept of moral agency, care ethicist’s stress the necessity of having relationships in order to see oneself as autonomous. Relationships are of importance in developing autonomy in at least two senses. First, instead of defining autonomy in opposition to social relationships, autonomy is made possible by our social relationships. That is, to become autonomous, an individual must receive the appropriate kind of social training.

Secondly, the self is relational in the sense that one of the fundamental ways a person conceives himself and thinks about the world around him is in terms of the relationships in which he is involved (Keller, 1997). An autonomous person asks himself questions such as ‘can I take responsibility for this or that action while retaining my self-respect?’ or ‘could I bear to be the sort of person who can do that?’. The self that is consulted in these questions is a self that is constituted in a dialogical process with — as Charles Taylor would say — significant others. In this dialogical process notions of self-trust, self-esteem and self-respect are being developed. These very same notions can be seen as necessary conditions for autonomy and autonomous
decision-making (Govier, 1993). Whether someone is involved in making autonomous decisions is not only a question of having the adequate capacities, but also, and more importantly, a matter of his having a sense of his ‘self’ that would support a full sense of flourishing. And this last also depends on the social institutions and the forms of socialisation one is subject to. In other words, the social and cultural context one is in, has a profound influence on self-respect and thereby on autonomy. (Verkerk, 1998, 125)

In short, the care perspective in developing a relational account of autonomy puts emphasis on how to achieve autonomy. It thereby considers autonomy as an empirical notion, to be achieved by an empirical self and not by a transcendental self, who rises above the material world. In stressing autonomy as something to be attained, it distinguishes itself from the more or less political and legal interpretation of autonomy in terms of non-interference. The next question is, how does a care practice look in which the target of achieving autonomy is central?

THE CARING RELATIONSHIP

At least two perspectives on care can be distinguished. There is the concept of care relationships as some form of contractual relationship between the care giver and the care receiver. In care as a contract, care is mainly seen as a product or as some sort of contractual agreement between two equal parties. The care giver offers his help and if the care receiver does not want it, then that is the end of the story. We cannot force him to accept the offer. I don’t think that care can be understood in this way, although the dominant perspective on care seems to underline this concept of care. In contrast to this perspective and in line with the writings of the political theorist Joan Tronto, I would like to define care as an ongoing process, which consists of four, analytically separate, but interconnected phases: caring about, taking care of, care-giving, and care-receiving. (Tronto, 1993)

Caring about. Caring about involves in the first place the recognition, that care is necessary. It involves noting the existence of a need and making an assessment that this need should be met.

Taking care of. Taking care of assumes the responsibility for the identified need and determining how to respond to it. Rather than simply focussing on the needs of the other person, taking care of involves recognition that one can act to address these unmet needs.
Care-giving. Care-giving involves the direct meeting of needs for care. It involves physical work and almost always requires that care-givers come in contact with the objects of care.

Care-receiving. Care-receiving recognises that the object of care will respond to the care it receives. It is an important element of the caring process because it provides the only way of knowing that caring needs have actually been met.

Those four phases of care describe an integrated, well-accomplished, act of care. Moreover, care as an ongoing process, is to be considered as a moral practice. That is, care requires specific moral qualities and the four ethical elements of attentiveness, responsibility, competence and responsiveness are related to the four phases of care as a process. Again, good care implies that the four ethical elements of caring are to be integrated into an appropriate whole. Tronto warns us that such an integration of these parts of caring into a moral whole is not simple. Care involves conflict; to resolve this conflict will require more than an injunction to be attentive, responsible, competent and responsive. In short, care as a practice involves more than simply good intentions. It requires a deep and thoughtful knowledge of the situation, and of all of the actors’ situations, needs and competencies. (Tronto, 1993, 137).

From this perspective on care, it is clear that respecting the autonomy of the patient involves more than simply not interfering. The care of a good carer requires that he or she is attentive, responsible and competent. Central to the care perspective are motifs such as the fundamental particularity and interdependence of individuals, the attention and understanding as modes of moral response and the insistence on active sympathetic concern for another’s good. In the care perspective, respecting autonomy involves coming to understand individuals in the light of their own self-conceptions and trying to see the world form their point of view. But respect for persons also involves taking account of both our connectedness and interdependence. Again respect requires not so much refraining from interference as recognising our power to make and unmake each other as persons and exercising this power wisely and carefully. (Dillon, 1992, 115) Compassionate interference can be seen as an expression of this kind of caring behaviour. Compassionate interference is an expression of caring behaviour as well as being regulated by a particular caring respect for persons.

In conclusion I want to address one criticism concerning the care perspective. Sometimes the care perspective is criticised...
because the very structure of the caring relationship invites the marginalisation of those who are dependent and in need of help. It would threaten an even more oppressive paternalism than any other previous relationship. The philosopher Anita Silvers has put this criticism in the following words:

‘Helping relationships are voluntary, but asymmetrically so. Help-givers choose how they are willing to help, but help-takers cannot choose how they will be helped, for in choosing to reject proffered help one withdraws oneself from being helped as well as from being in a helping relationship. To relate to others primarily by being helped by them, then, implies subordinating one’s choices to one’s caretakers, at least insofar as one remains in the state of being helped.’ (Silvers, 1995, 40)

Silvers’ criticism is an important one, for if she is correct in her argument, it would mean that the care perspective would be of no use in developing good caring relationships, particularly for those patients who are already marginalised in society. In fact, Silvers states that socially devalued people — those perceived as defective or deviant — cannot help but occupy inferior positioning when drawn into such asymmetrical associations (Silvers, 1995, 41). Silvers’ criticism cannot only be considered important, but history also proves her to be partly right. The dominant social and health care practices throughout history show one fundamental negative side-effect: they put the receiver of care in a position in which he or she eventually has less self-respect and dignity.

Silvers’ criticism can be answered by stressing once again the goal of good caring relationships. Care should always be related to enhancing the capacity of people to define who they are, to understand themselves and to direct their lives. As I said before, care should not undermine autonomy, but should facilitate autonomy. This is why the fourth dimension of the caring process is of such an importance. Responsiveness requires that carers remain alert to the possibility for abuse that arises with vulnerability. Therefore I want to conclude by quoting Robin Dillon, who wrote about the care perspective in the following words:

‘Care respect is a matter of relationship, with all, including all the effort, which that involves. While Kantian respect — say the respect for self-determination and non interference — might be thought to distance us from one another, both in hiding our particular selves from one another and in erecting protective barriers of rights against each other, care respect can be seen to involve a determination to discover, forge, repair, and strengthen
connections among persons in ways that benefit all of us. Care respect joins individuals together in a community of mutual concern and mutual aid, through an appreciation of individuality and interdependence.’ (Dillon, 1992, 129).

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