Ethics of deliberation, consent and coercion in psychiatry

A Liégeois and M Eneman

J. Med. Ethics 2008;34;73-76
doi:10.1136/jme.2006.019695

Ethics of deliberation, consent and coercion in psychiatry

A Liégeois,[1] M Eneman[2]

[1] Faculty of Theology, Catholic University of Leuven, Leuven, Belgium; [2] University Psychiatric Hospital St-Kamillus, Bierbeek, Belgium

Correspondence to:
Professor A Liégeois, Faculty of Theology, Catholic University of Leuven, Sint-Michielsstraat 6, 3000 Leuven, Belgium; axel.liegeois@theo.kuleuven.be

Received 25 October 2006
Revised 11 January 2007
Accepted 31 January 2007

ABSTRACT

In psychiatry, caregivers try to get free and informed consent of patients, but often feel required to restrict freedom and to use coercion. The present article develops ethical advice given by an Ethics Committee for Mental Health Care. The advice recommends an ethical ideal of shared deliberation, consisting of information, motivation, consensus and evaluation. For the exceptional use of coercion, the advice develops three criteria, namely incapacity to deliberate, threat of serious harm and proportionality between harm and coercion.

The article also discusses the viewpoints of the ethical advice and of the European Convention on Human Rights and Biomedicine: is the advice in agreement with the Convention and can the advice refine the guidelines of the Convention for the particular context of psychiatry? Although the Convention emphasises the autonomy of the individual patient, whereas the advice focuses on the relationships between the partners involved, the advice enjoys a complementary and supportive function in the application of the Convention.

One of the major ethical dilemmas confronting psychiatry is dealing with freedom and coercion.[1] In former times, caregivers used to apply coercion in a self-evident manner. Nowadays, however, there is a dominant tendency to put freedom first and to consider coercion as a mostly exceptional measure. The Convention on Human Rights and Biomedicine of the Council of Europe advocates this view.[2 3] Nevertheless, in the daily care of psychiatric patients, a lot of caregivers often feel required to restrict freedom and to use coercion as a rather common practice.

Therefore, the research question of this article is how caregivers in psychiatry can deal with the following ethical dilemma: how can they respect the patient's freedom as much as possible and when are they justified in restricting the patient's freedom and in using coercion? To answer this question, we refer to the ethical advice given by an Ethics Committee for Mental Health Care of a Belgian network of 13 psychiatric centres administered by the Brothers of Charity.[4] Although this Ethics Committee has a local authority, it has expert knowledge in the particular field of psychiatry and its advice might have a broader interest. First, we describe the research method of the ethical advice. Then, we develop the two pillars of the ethical advice: the general model of shared deliberation and the criteria for the exceptional use of coercion. We also make a critical discussion of the viewpoints of the ethical advice and the European Convention with regard to consent and coercion. We make clear that the model of shared deliberation and criteria for coercion have a complementary and supportive function in the application of the Convention.

METHOD

The Ethics Committee was composed of 25 experienced caregivers, representing the various professional groups within mental health care and the 13 psychiatric centres of the network. The members opted for a methodological approach that combined ethical discussion with the study of recent literature: the moral intuitions and practices of the participants were mutually confronted with insights provided by a number of scientific publications.[4] The entire process took place within a forum that was open and free, thus allowing each participant to speak his or her mind without any form of pressure based on authority or function.

DELIBERATION AND CONSENT

The general model of shared deliberation in the advice

The ethical advice starts with an overview of the approaches of responsibility in the care relationship.[4] The traditional approach stresses the responsibility of the caregivers, based on their professional expertise and human concern. The risk of this view is that caregivers make decisions in a paternalistic way, without consulting the patient enough. To remedy paternalism and to increase the respect for autonomy, an emancipatory approach emphasises the patient's own responsibility. The patient makes his or her own decisions and should give informed consent. Now the risk is that the role of caregivers is reduced to providing information and implementing the patient's wishes.

The advice, on the other hand, maintains that both approaches are one-sided and opts for an alternative.[4] This option is based on a fundamental view on the care relationship. Both the paternalistic and emancipatory approaches consider either the caregivers or the patient to be independent individuals who do not involve others in a decisive way. The advice distinctively opts for a relational approach: men and women are not only independent individuals, however, they are also persons in relationship with others. This is a fundamental option with practical consequences. The relational dimension of human existence should be applied consequentially to the decision making. For this reason, the advice opts for a relational approach in which all the partners are involved in a process of shared decision making.

Consequently, shared deliberation is the ethical ideal of the advice.[4–7] It goes without saying that the most important partners in this process of deliberation are the patient and the caregivers. A third partner, however, is constituted by the patient's family, bearing in mind that the latter represents an essential element of the natural environment and social network of the patient. The term "family" is understood in an inclusive sense, extending beyond immediate blood relationships to include all the persons involved with the patient to a significant degree, especially the legal representative. The involvement of the family remains, however, an object of discussion between the patient and the caregivers. Indeed, it is possible that the patient wishes to exclude the family from the process of deliberation, albeit temporarily. When the patient is not able to participate in the deliberation and to give consent, the caregivers are to consult with the patient's legal representative.

The process of shared deliberation consists of four pillars: information, motivation, consensus and evaluation. It is important that each element is characterised by an express mutual exchange and dialogue between the partners involved.

Information

The provision of information begins with the patient and the family who are experts in the patient's life story. The caregivers gather information from the patient and family on their desires and expectations. If the patient and the family fail to provide such information spontaneously, then the caregivers invite them to do so. For their part, the caregivers are experts in concern and good care. For this reason, they inform the patient and the family of the various available options. They provide information in an objective and an understandable manner to both the patient and the family. The information regards to the various options in care, their goals and characteristics, advantages and disadvantages, consequences and risks.

Motivation

Based on this exchange of information, caregivers, patient and family endeavour to arrive at a motivated choice. Caregivers, patients and family, all of them, listen to one another's opinions and arguments, sensitivities and emotions. They all account for one another's observations and wishes. They question one another and themselves in a critical way. Together, they weigh up the pros and cons of their preferred option and endeavour to motivate their choice.

Consensus

This mutual process of information and motivation is very important for well-considered decision making. Therefore, caregivers, patient and family encourage one another to reach common consensus on a particular decision. Consensus remains an essential element of shared deliberation. While this process may take a considerable amount of time, it increases the chances that the preferred option will be adhered to effectively by caregivers, patient and family.

Evaluation

Once the caregivers, patient and family have implemented the decision, they evaluate it together after a period of time. The evaluation may in turn serve as the point of departure of a renewed mutual exchange of information and motivation, leading to a new preferred option and decision.

Discussion with the Convention

After developing the ethical advice, we make a comparison with the European Convention on Human Rights and Biomedicine. The documents are of a very different nature and have another purpose. The advice focuses on the specific context of psychiatry. It is an ethical and practical document of a regional ethics committee. The Convention, on the other hand, deals with a wide range of biomedical topics without focus on psychiatry. It is a juridical and political document of an international organisation.

The Convention

To compare the content of both documents, we should first explain the point of view of the Convention on consent. The Convention affirms the already well-established rule of informed consent. It states that "an intervention in the health field may only be carried out after the person concerned has given free and informed consent to it" (art. 5).[2] Beforehand, the caregivers give "appropriate information as to the purpose and nature of the intervention as well as on its consequences and risks" (art. 5).[2] The Explanatory Report adds that informed consent can take various forms: implicit or express, the latter being either verbal or written (no. 37).[8]

When an adult patient does not have "the capacity to consent to an intervention because of mental disability, a disease or similar reasons", the Convention provides the following protection: the intervention may only be carried out "for his or her direct benefit" and "with the authorisation of his or her representative or an authority or a person or body provided by law" (art. 6).[2] The patient is not ruled out, however, since he or she shall "as far as possible take part in the authorisation procedure" and shall consent again, once the mental capacity is regained (art. 6).[2]

Discussion

We will not make a detailed comparison of the guidelines in the ethical advice and in the Convention. From an ethical point of view, we prefer to put forward two questions.

First, is the ethical advice in agreement with the Convention? This question is important because it would be unethical to give advice that, in general terms, contravenes a well-considered juridical document. When caregivers, patient and family follow the ethical advice and have a shared deliberation, they are most likely to come to an appropriate decision and to a consensus. In this consensus, an informed consent is undoubtedly given. The Convention requires informed consent, but not any particular form of consent. Through the process of deliberation, the patient or the representative give their express or implicit consent. Because of this consent, the relational approach of the advice guarantees the protection of the patients' rights.

The second question is the following: is the advice an ethical complement to the Convention? Or is the advice a refinement of the Convention in the particular context of psychiatry? This is an interesting question because the advice has a specific ethical perspective and an exclusive focus on psychiatry. A fundamental difference between both documents is that they are founded in different basic assumptions. The Convention opts for an emancipatory approach, based on respect for the patient's autonomy. The Explanatory Report remarks explicitly that the rule of informed consent "makes clear patients' autonomy" and "restrains the paternalist approaches which might ignore the wish of the patient" (no. 34).[8] The advice opts for a relational approach, based on the mutual relationship between all the partners concerned. It stresses the interaction between caregivers, patients and family through a process of shared decision making.

This basic assumption of the ethical advice creates some qualities that can complement and refine the Convention. First of all, shared deliberation is a wider concept. Informed consent, as prescribed by the Convention, consists of two elements: information and consent. Shared deliberation adds two important pillars: the motivation before and the evaluation after the deliberation. Secondly, information and consent, as prescribed by the convention, should not be a mutual process: providing information is an action from the caregivers towards the patient or the representative, while giving consent is an act from the patient or representative towards the caregivers. In shared deliberation the four pillars of information, motivation, consensus and evaluation are all mutual processes among all the partners concerned. Because consensus is a mutual process, consent is substituted for consensus in shared deliberation. Finally, there are more partners concerned in shared deliberation than in informed consent. While informed consent, as described by the Convention, is given by the patient *or* the representative to the caregivers, shared deliberation happens between all partners concerned: patient *and* family *and* caregivers.

THE USE OF COERCION

Criteria for the exceptional use of coercion in the advice

Shared deliberation is the ethical ideal for decision making in the advice. Situations exist, however, in which deliberation is no longer possible or in which the caregivers involved are obliged to take urgent measures and introduce coercive procedures. It is extremely important that caregivers do not take coercion as a matter of course. For this reason, it is imperative that they critically question every form of coercion and introduce as much as possible into the discussion with the patient and the family. Three criteria were elaborated in the advice, all of which are considered essential prerequisites in the justification of coercive procedures: incapacity, harm and proportionality.[3 4 9 10]

Incapacity

The first criterion insists that the patient should lack sufficient capacity to deliberate or to exercise control with respect to his or her behaviour. Coercion under such circumstances should promote, where possible, the restoration of the said capacity. In this criterion the value of autonomy is at stake.

Harm

The second criterion determines that the physical or mental health or the integrity would be seriously harmed without the use of coercion. Here the value of inviolability is at stake. Two sub-criteria need to be explained. According to the first sub-criterion, serious harm would be inflicted on the patient's physical or mental health should coercion not be used. For this reason, the coercive measures employed should focus on the treatment of the patient's psychiatric problem. According to the second sub-criterion, serious harm would be inflicted on the patient's physical or mental integrity or that of other persons should coercion not be used. For this reason, the coercive measures employed must focus on the protection of the patient's integrity or that of another.

Proportionality

The third criterion means that there should be a "right" proportion of, or a reasonable relationship between, the use of coercion and the harm that would otherwise be inflicted on the health or integrity. Caregivers have to assess the values of autonomy and inviolability. This assessment implies that there should be a right proportion between the harm and the coercion, and hence that the coercion should not be more severe than necessary to avoid the harm. They are obliged to explore the possibility of employing the less coercive measures during the shortest time yet still guarantee health or integrity. Consequently, they should restrict the use of coercion to the degree and duration that is really necessary, no more and no longer.

The formulation of these three criteria leaves caregivers room for interpretation. Indeed, it remains impossible to determine strict boundaries between situations in which caregivers, patient and family would be best advised to continue the process of deliberation and situations in which coercion is justified. Caregivers should be careful not to opt for coercive procedures too quickly, but they should also take care to avoid situations in which the use of coercion to mitigate the threat of harm is too late.

Discussion with the Convention

The Convention

Now we can move on to the Convention. Scattered over the whole text, we can distinguish four instances in which the use of coercion can be justified. Firstly, as we pointed out, the representative can consent to coercive measures when the patient lacks the capacity to consent and when these measures are for the patient's direct benefit (art. 6).[2]

Secondly, there is an explicit article on the protection of psychiatric patients. The Convention prescribes that, subject to legal protective conditions, "a person who has a mental disorder of a serious nature may be subjected, without his or her consent, to an intervention aimed at treating his or her mental disorder only where, without such treatment, serious harm is likely to result to his or her health" (art. 7).[2] We remark that that the patient should suffer from a serious mental disorder and that intervention should be specifically necessary to treat the mental disorder. If not, serious harm will occur to the patient's health.

Emergency can be a third justification of coercion. The Convention stipulates that, "when because of an emergency situation the appropriate consent cannot be obtained, any medically necessary intervention may be carried out immediately for the benefit of the health of the individual concerned" (art. 8).[2]

Fourthly, there are some general restrictions on the exercise of the patient's rights (art. 26).[2] The Explanatory Report applies this explicitly to psychiatric patients. When a patient is a "possible source of serious harm to others", he or she may be "subjected to a measure of confinement or treatment without his or her consent", and this "in order to protect other's people's rights and freedom" (no. 151).[8]

Discussion

We can now compare the guidelines of the advice and the Convention and evaluate if the advice is in agreement with the Convention. The first criterion, capacity to make choices with respect to one's behaviour, is not explicitly formulated as criterion in the Convention. Nevertheless, it is implicitly present each time the Convention refers to the incapacity to give consent or to a mental disorder with an express serious nature (art. 6—8).[2] The second criterion concerning serious harm is twofold. The first subcriterion of the patient's own health and the second subcriterion of the patient's integrity are evident when the Convention argues in terms of the patient's own health or benefit (art. 6—8).[2] The other element of the second subcriterion concerning other person's integrity is taken up when the Convention protects other people's rights and freedom (art. 26).[2] Proportionality as in the third criterion is not found in the Convention. From an ethical perspective, nevertheless, it is an extremely important criterion. Coercion can be justified, but only when there is a right proportion between the harm and the coercion.

Finally, we can answer the question as to whether the ethical advice complements the Convention and can refine the guidelines in the context of psychiatry. In the Convention the rules for the use of coercion are scattered over several articles, namely articles 6—8 and 26. In the ethical advice, on the other hand, the criteria are developed in a clear, systematic and coherent way in order to allow for greater precision and nuance in the field of psychiatry. This merit is of course linked with the other nature and purpose of both documents. The Convention deals with a wide range of biomedical topics without focus on psychiatry, while the ethical advice is specifically limited to psychiatric care.

CONCLUSION

Both documents differ in their basic assumptions: the Convention emphasises the autonomy of the individual patient whereas the advice focuses on the relationships between the partners involved. It is for this reason that the Convention and the advice make different formulations of the guidelines with respect to the consent and coercion.

On closer inspection, however, both options are not so different and the possibility of reconciling them is realistic. In order to arrive at shared deliberation, the advice insists that all the partners involved should be included in the process of information, motivation, consensus and evaluation, and that the process should be as reciprocal as possible. The advice also insists that clear and coherent criteria be used in the exercise of coercion. The Convention does not reject such ethical recommendations with respect to shared deliberation and criteria for coercion. The advice thus has a complementary and supportive function with respect to the application of the Convention.

The complementary and supportive function also has its limits, nevertheless. Ethics is rooted in the ideal of shared deliberation and sets out to help men and women in the tensions they experience between the said ideal and reality. As a consequence, ethics makes its primary appeal to personal voluntariness, which those involved are not always prepared to exercise. Where the process of shared deliberation becomes impossible or the application of the criteria does not lead to a consensus for reasons related to the patient or the caregivers, then it is important that those involved are able to appeal to available legal rules. Ethics and law thus complement and support one another in a reciprocal relationship.

Competing interests: None.

REFERENCES

1. **Liégeois A,** Van Audenhove C. Ethical Dilemmas in Community Mental Health Care. *J Med Ethics* 2005;**31**:452–6.
2. **Council of Europe**. Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine. Brussels: European Treaty Series—No 164, 1996.http://conventions.coe.int/treaty/en/treaties/html/164.htm (accessed 12 Nov 2007).
3. **Tannsjo T.** The convention on human rights and biomedicine and the use of coercion in psychiatry. *J Med Ethics* 2004;**30**:430–4.
4. **Liégeois A,** Eneman M. Omgaan met vrijheid en dwang in de geestelijke gezondheidszorg: een ethisch advies. *Tijdschr Psychiat* 2004;**46**:369–78.
5. **Beauchamp TL,** Childress JF. *Principles of Biomedical Ethics*. New York: Oxford University Press, 2001.
6. **Charles C,** Gafni A, Whelan T. Shared decision-making in the medical encounter: what does it mean? (or it takes at least two to tango). *Soc Sci and Med* 1997;**44**:681–92.
7. **Hamann J,** Leucht S, Kissling W. Shared decision making in psychiatry. *Acta Psychiat Scand* 2003;**107**:403–9.
8. **Council of Europe**. Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine. Explanatory Report. Brussels: European Treaty Series—No 164, 1996.http://conventions.coe.int/Treaty/EN/Reports/Html/164.htm (accessed 12 Nov 2007).
9. **Bloch S,** Chodoff P, Green SA. *Psychiatric Ethics*. Oxford: Oxford University Press, 1999.
10. **Kallert TW,** Glöckner M, Onchev G. The Eunomia project on coercion in psychiatry: study design and preliminary data. *World Psychiatry* 2005;**4**:168–72.

Correction

doi: 10.1136/jme.2006.019281corr1

There was an error in the October issue of the journal (Molyneux D. ''And how is life going for you?'' – an account of subjective welfare in medicine. *J Med Ethics* 2007;**33:**568–82.) The last line of the article was repeated. A corrected version is available online at http://jme.bmj.com/supplemental

---

Correction

doi: 10.1136/jme.2006.017251corr1

There was an error in the November issue of the journal (Liao SM, Goldschmidt PJ, Sugarman J. Ethical and policy issues relating to progenitor-cell-based strategies for prevention of atherosclerosis. *J Med Ethics* 2007;**33:**643–6.) The correct name of the second author is PJ Goldschmidt-Clermont.