ARTICLE

PEER REVIEWED SUBMISSION

Is Coerced Voluntary Treatment Ever Appropriate?

Michael A. Kekewich MA
Ethics Coordinator, The Ottawa Hospital,
Ottawa, Canada

> *"All forms of tampering with human beings, getting at them, shaping them against their will to your own pattern, all thought control and conditioning is, therefore, a denial of that in men which makes them men and their values ultimate."*
>
> ~ Isaiah Berlin,
> "Two Concepts of Liberty" (Berlin, 2007)

Introduction

Prior to reflecting on a specific scenario in mental health care, my moral view of coercion was fairly dichotomous. In my mind, coercive acts were, for lack of a more sophisticated term, unethical. However, in thinking more extensively about the notion of coercion, I came to a more nuanced view of the topic. The initial question arose in psychiatry rounds, and centered on whether it would be ethical to pressure a patient into a "voluntary" action when the alternative is an involuntary treatment being forced on them. As an example, a health care provider might say to a patient that is under a legal order to be medicated, "you can take this medication on your own, but if you don't, I will have it administered by force… it would be in your best interest to take the medication yourself". Is this a free choice being offered to the patient, or is it coercive? In the provider's mind, they know that the patient will be getting their medication one way or another. Are they using that knowledge to pressure the patient? If so, is that appropriate? The initial assumption that came to mind was that it would be, for obvious reasons, inappropriate to coerce a patient into voluntary treatment. Generally, coercion is condemned as an innapropriate (Vuckovich & Artinian, 2005: 371; Newton-Howes, 2010: 218), but, contingent on the circumstances, the notion of coerced voluntary behaviour may be different. An interesting and important question to be sure, and one that will be considered in the second half of this article. Before doing so, however, a working definition of coercion must be established.

Two Concepts of Coercion

In doing a brief literature review on the ethics of coercion in the psychiatric context, one is immediately struck by what appear to be substantially different conceptions of coercion, none of which are necessarily incorrect. The first conception, which can be called the "involuntary" conception, depicts situations in which treatment is involuntarily *imposed* upon patients as coercive (see Galon & Wineman, 2010: 307; Vuckovich & Artinian, 2005: 371; Tiller et al., 1993: 679; Newton-Howes, 2010: 218). In this sense, forcefully administering medication would be *coercive*. Alternatively, the second version, which will be called the "voluntary" conception, deals with situations in which a patient is actively manipulated or pressured into doing something voluntarily (see Glick, 2000: 393; Elbogen et al., 2003: 119-127; Polcin & Weisner, 1999: 67-68; Priebe et al., 2010: 463-468). This form of coercion is characterized by elements of "persuasion, bargaining, begging, enticing, and threatening involuntary commitment" (Guarda et al., 2007: 108). In the voluntary conception, the active goal of such pressure is to get something out of the patient: agreement. Based on this voluntary conception, manipulating a patient into agreeing to take their medication, rather than administering it by force, is similarly *coercive*. While the involuntary conception is rather blunt, the voluntary conception appears more sophisticated. And so, which of these conceptions most accurately captures the spirit and meaning of what is generally characterized as coercion?

Given the complexity of the question, it's wise to start with our current lexicon. The Cambridge Dictionary provides the following definition of coercion: "the use of force to persuade someone to do something which they are unwilling to do" (see http://dictionary.cambridge.org/dictionary/british/coercion). Although there are other definitions of coercion, this definition will be accepted as accurate enough for the purpose of this paper. With this stated, and without going into an etymological infinite-regress, it appears that the operative word in this definition is "persuasion". Now, whether the imposition of treatment described by the involuntary conception can be understood as an act of persuasion is an open question. One could argue that physically imposed treatment represents the ultimate form of coercion. Alternatively, as some have suggested, coercion may be a spectrum with various forms (Guarda et al., 2007: 108; Polcin & Weisner, 1999: 64; Monohan et al., 1995: 251-252; Galon & Wineman, 2010: 308). In this sense, involuntary treatment could be at one end of the spectrum, while pressure and persuasion would be at the other. Similarly, Monohan et al., describe involuntary treatment as "Formal Coercion", and the pressuring into voluntary treatment as "Quasi-Formal Coercion" (Monohan et al., 1995: 250-251). But even within these various characterizations, the element of persuasion is lacking from whatever represents the extreme involuntary conception. As an analogy,

we can apply coercion in the financial context. If one attempted to have someone give them money by pressuring them, this would be coercive. Alternatively, flat out stealing from them would not seem to be coercive in the same active sense. When stealing from someone, active coercion seems to be bypassed in favour of directly obtaining what is sought. I would propose that the same applies to our understanding of the involuntary coercion. Physically administering medication wouldn't appear to be coercive in any active sense. There is no pressuring or persuading. In fact, aside from a patient's body being the subject of the administration, the patient isn't meaningfully involved in the interaction at all. Granted, it is perhaps the case that, in the involuntary conception, the notion of 'compulsion' simply replaces the element 'persuasion' that is present in the voluntary sense. But is compulsion coercion, or is persuasion? Are both? Is one *more* coercive than the other?

Consider the voluntary conception, which more accurately capture the meaning of the term 'coercion'. In this instance, the attempt is made to persuade a patient to take their medication, with the alternative being the administration of the medication by force. Here, the patient is actively involved. We can see, at this point, that the tables are somehow turned in the voluntary conception. With the involuntary conception, a provider is looking to do something, and the patient is somewhat irrelevant to that process. In the voluntary conception, a provider is still looking to do something, but the patient and their decisions are much more relevant to how the end goal is achieved. Granted, the outcome of not being successful in having a patient accept voluntary treatment may well be imposition of treatment in the involuntary sense. This begs the question of just how voluntary one's actions are when they are forced. As a result, it may be the case that the two conceptions represent a distinction without a difference - perhaps similar to the oft cited distinction between killing and letting die. This may or may not be true, depending on the circumstances. This point will be elaborated on in the second half of this article. However, before moving on to a discussion of forced voluntary treatment (i.e. the voluntary conception of coercion) in the mental health setting, another point should be made.

Like other frequently cited terms in health-care ethics – paternalism comes to mind – coercion has a strong connotative dimension. Paternalism, for example, is for all intents and purposes an ethically dirty word. The word paternalism is informed by a history of arrogance and injustice. When the term paternalism is used, it is frequently as an example of what not to do in health-care. This strong connotative aspect is equally present in the use of the word coercion. When we speak of coercion, we are almost always referring to something done unjustly, inappropriately, without justification, and for ends that are not good. As an example, the phrase "having a gun to your head" is often used to describe coercion as an experience characterized by a lack of freedom at the hands of another. In a sense, the persuasion or manipulation that is characteristic of voluntarily conception seems to fall in line with this connotation. When someone is persuaded in a coercive sense, it is not often imagined to be pleasant. This is certainly not to say that coercion is never justifiable or inherently unjust. Instead, it's simply to say that, as with other ethically loaded words, coercion must be placed in what appears to be its normative context. In this case, that context is mostly negative. This is important for the following reason. For an act to be characterized as coercive in the morally controversial sense that we usually intend when using the term, it could be argued that the act must meet the connotative criteria referred to above in some minimal way. Without meeting these criteria, a purely descriptive or procedural account of coercion loses its substantive meaning.

Coerced Voluntary Treatment: Is it Ethically Justifiable?

We can now return to the initial question with an accurate understanding of the two conceptions of coercion. According to that understanding, the voluntary conception with its element of active persuasion or pressure is more meaningfully coercive than the involuntary conception. Both have strong ties to one another, but the definition and connotation of coercion falls more strongly in line with the voluntary conception. And so, is it ever appropriate to coerce a patient through pressure or strong persuasion? My suggestion will be that this type of action, if done properly, is *not necessarily* coercive at all.

The main argument against pressuring a patient into voluntary treatment is that this type of act is coercive, and that coercion is, *prima facie*, unethical. When a health-care practitioner holds a proverbial gun to the patient's head in the form of imposing treatment, the patient is not free in any meaningful sense. This opinion of coercion is represented quite firmly in Ontario's *Health Care Consent Act* (HCCA), which explicitly states that consent is not valid if it is not given "voluntarily" (see the Health Care Consent Act, 1996: s. 11). In this case, the argument would be that the consent given to agree to a treatment is not voluntary in any meaningful sense because it is the only choice being offered, and failure to agree to that choice will result in the same treatment being physically imposed on the patient regardless of their initial wish. In this sense, the patient is coerced into voluntary treatment, which disrespects their autonomy and invalidates the consent given. Thus, the freedom of choice presented to the patient is fundamentally called into question as superficiality.

Alternatively, the argument supporting this type of action suggests that it is conditionally appropriate, and emphasizes the setting in which the action occurs. In the psychiatric context, patients are frequently required by law to comply with certain forms of treatment that have been deemed necessary to protect themselves and others from serious harm. In this instance, when a health care provider says to a patient, "You have two choices, you can do X on your own volition, or X will be imposed on you…I suggest you do X on your own volition", it is not the provider that is delimiting the freedom of choices. Rather, the circumstances are naturally coercive for the patient in question at that moment. They have a mental illness, are symptomatic, and meet legislative criteria that require them to accept treatment one way or another. Offering a patient the choice to participate in their treatment voluntarily is, in this light, not coercive at all. Rather, it is a simple presentation of the facts. If done properly, the provider is transparently stating that the patient, by virtue of their circumstance, has two options are free, to the extent possible, to choose which one of those courses of action is more suitable for them. The provider is not, in this sense, coercing the patient into one form of action by creating a threatening and intimidating alternative. The alternative is already threatening and intimidating, and the health care provider is sim-

ply describing it transparently to the patient. Even if the provider were to suggest one form of action over another, this wouldn't meet the connotative criteria for coercion. It is entirely appropriate for a health care provider to make recommendations for treatment, and this continues to obtain in difficult circumstances.

One could even take the argument in favour of this type of perceived coercion one step forward by asking what the alternative would be to giving a patient the choice to do something voluntarily. Would it not be completely unacceptable to impose a treatment on a patient without giving them even the smallest opportunity to have a say in how that treatment will be administered? Is it not actually a moral obligation to respect whatever constitutes a patient's autonomy by providing choice, no matter how small that choice might be? To be sure, a patient might scoff at the proposal that they do something themselves when they know full well that they will be receiving that treatment one way or another, but some patients may well find it preferable to control even small portions of their treatment in very difficult circumstances. One can note here that perceived coercion is not the same thing as actual coercion. Although perceived coercion should be reduced to the extent possible (Priebe et al., 2010: 463), patients may still, understandably, feel coerced. At the end of the day, with the help of their provider, it's up to an individual patient to decide what the available choice means to them. An analogy to this would be the firing of a person from their job. Perhaps security comes to a person's office and says to them, "You can either walk out of the building on your own with us behind you, or we can carry you out…it's your choice". I would think that most individuals would prefer to have that option given to them, rather than having security show up, pick them up, and bring them outside. Evidence suggests that allowing involuntary patients to participate in their care increases feelings of being respected (Johansson & Lundman, 2002: 645), that patients would agree to voluntary treatment if given the opportunity (Monahan et al., 1995: 252-253), and that feelings of procedural justice are increased when patients are given a voice in their treatment (Galon & Wineman, 2010: 314). This indicates that the presentation of extremely limited options is by no means superficial.

With all this being said, it is still important to note that the type of action in question is only appropriate if done correctly. Persuading a patient could easily become coercive if done in a certain manner. As an example, it would not be appropriate to misrepresent alternative options so as to push a patient illegitimately towards one option over the other. By doing so, the emphasis is taken away from the patient and their choice to what the provider wants them to do. This would be coercive, and it would not be appropriate. It would be persuasive in the same dubious sense that is referred to above. Recall that coercion has a substantively connotative dimension that implies power being used inappropriately, rather than a simple set of circumstances playing out procedurally. When a health care provider has made the choice for the patient and is manipulating or persuading them to make that same choice, it is no longer appropriate.

In this sense, the only circumstances that appear legitimate for this type of action would be: (1) That the patient meets standard criteria for restraint or imposition of treatment in their jurisdiction[1], and (2) That the health care provider offers the choice to the patient in a fully transparent manner without illegitimately pressuring the patient into one of those choices. When these two conditions are met, it does not make sense to describe the action as coercive. The connotative dimension of coercive acts is completely lost under these circumstances. This action is an appropriate presentation of actual options, however minimal, in a highly unpleasant context. Questions certainly remain around what would constitute legitimate and illegitimate pressuring or persuasion, but those questions are beyond the scope of this article and should be subjects of further study.

Conclusion

Based on the above, two things are clear. First, there are multiple ways to understand coercion. According to some, coercion might only be understood in the involuntary sense. Others might define it as something like the voluntary conception above, and still others might take the view that coercion is a spectrum with multiple forms. Depending on which understanding one accepts, the appropriateness of actions that might be described as coercive will vary. This article argues that the voluntary conception most accurately captures the meaning of coercion through the operational element of pressure.

This leads to the second point. If one accepts that the voluntary conception most closely represents coercion, one can still observe that persuading a patient to accept treatment voluntarily is not necessarily coercive. Rather, a health care provider may be making a sincere recommendation based on the facts at hand, which they don't control. This is not inappropriate. In fact, it should be encouraged. Patients should be offered the choices that are available to them, even when the circumstances are difficult. Health care providers should tell patients that involuntary treatment is self-evidently unpleasant, and that voluntary treatment is a much more desirable option.

Although coercion is an ambiguous concept, health care providers should not be afraid to strongly recommend certain forms of voluntary treatment, particularly when involuntary treatment is the only viable alternative. For patients suffering from mental illness, any modicum of control should be offered without fear of being coercive in the process. Certain difficult circumstances naturally constrain patients' choices, and do not render the actions of health care providers coercive as a result.

Notes

1. Implicitly, this also requires, as Vuckovich and Artinian argue, that "the action to be taken must be considered beneficent and failing to take action grossly maleficent" for the coercion to be justifiable. See Vuckovich, et al, p. 373-374.

References:

Berlin, I. (2007). Two Concepts of Liberty. In I. Carter, M.H. Kramer & H. Steiner (Eds.), Freedom: A Philosophical Anthology. (pp. 39-58). Malden MA: Blackwell.

Cambridge Dictionaries Online (2010). Coercion. Retrieved February 16, 2011. http://dictionary.cambridge.org/dictionary/british/coercion.

Elbogen, E.B., Swanson, J.W. & Swartz, M.S. (2003). Psychiatric Disability, the Use of Financial Leverage, and Perceived Coercion in Mental Health Services. International Journal of Forensic Mental Health, 2, 119-127.

Galon, P.A. & Wineman, N.M. (2010). Coercion and Procedural Justice in Psychiatric Care: State of the Science and Implications for Nursing. Archives of Psychiatric Nursing, 24, 307-316.

Glick, S.M. (2000). The morality of coercion. Journal of Medical Ethics, 26, 393-395.

Guarda, A.S., Pinto, A.M., Coughlin, J.W., Hussain, S., Haug, N.A. & Heinberg, L.J. (2007). Perceived Coercion and Change in Perceived Need for Admission in Patients Hospitalized for Eating Disorders. American Journal of Psychiatry, 164, 108-114.

Johansson, I.M. & Lundman, B. (2002). Patients' experience of involuntary psychiatric care: good opportunities and great losses. Journal of Psychiatric and Mental Health Nursing, 9, 639-647.

Monahan, J., Hoge, S.K., Lidz, C., Roth, L.H., Bennett, N., Gardner, W. & Mulvey, E. (1995). Coercion and Commitment: Understanding Involuntary Mental Health Hospital Admission. International Journal of Law and Psychiatry, 18, 249-263.

Newton-Howes, G. (2010). Coercion in psychiatric care: where are we now, what do we know, where do we go? The Psychiatrist, 34, 217-220.

Polcin, D.L. & Weisner, C. (1999). Factors associated with coercion in entering treatment for alcohol problems. Drug and Alcohol Dependence, 54, 63-68.

Priebe, S., Sinclair, J., Burton, A., Marougka, S., Larsen, J., Firn, M. & Ashcroft, R. (2010). Acceptability of offering financial incentives to achieve medication adherence in patients with severe mental illness: a focus group study. Journal of Medical Ethics, 36, 463-468.

Service Ontario (1996). Health Care Consent Act. Retrieved February 16, 2011. http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_96h02_e.htm.

Tiller, J., Schmidt, U. & Treasure, J. (1993). Compulsory Treatment for Anorexia Nervosa: Compassion or Coercion? British Journal of Psychiatry, 162, 679-680.

Vuckovich, P.K. & Artinian, B.M. (2005). Justifying Coercion. Nursing Ethics, 12, 370-380.

Acknowledgements: *I'd like to thank Drs. Thomas Foreman, Jacky Parker, Margaret DeCorte and Elda Lansfield (Ottawa Hospital) for reading this article and providing their insights.*

Competing Interests: *None.*

Address for Correspondence:
The Ottawa Hospital, Civic Campus
1053 Carling Avenue,Ottawa ON K1Y 4E9

e-mail: *mkekewich@ottawahospital.on.ca*

Published: *November 30, 2011*