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When may people be protected from themselves?

Today, on Thursday, the German Ethics Council is publishing its Opinion "Help through coercion? Professional Caring Relations in Conflict Between Welfare and Autonomy".

Coercive measures justified on the grounds of beneficence and care are widespread in many areas of the social and health care system. These include measures involving deprivation of liberty, such as the involuntary commitment of people in hospitals and other inpatient facilities or the attachment of bed rails or restraint belts, as well as medical treatments or care measures against the will of a patient or so-called intensive pedagogical measures in child and youth services. If a person threatens to seriously harm him- or herself, such coercive measures can serve the welfare of the person concerned. Nevertheless, every instance of such "benevolent coercion" represents a serious infringement of the fundamental rights of the person concerned and is therefore in particular need of legal and ethical justification. This has repeatedly led to critical discussions about corresponding practices in medicine, in institutions of child and youth services as well as in nursing homes and homes for the disabled. With its Opinion, the German Ethics Council takes up these discussions with the aim of pointing out deficits in regulation and implementation in the complex and problematic area of professional help through coercion and of proposing solutions to politicians, legislators and members of health and social professions.

In principle, the Ethics Council holds the opinion that the use of coercion in the context of professional caring relations can only be considered as a measure of last resort. This means, first of all, that framework conditions, structures and processes should be designed in such a way that coercion is avoided as far as possible. If, however, situations arise in which a person is at risk of suffering serious harm, for example because he or she opposes a necessary medical measure, then persistent efforts must be made through persuasion to obtain the voluntary consent or cooperation of the person concerned. Also, before a coercive measure is taken, all less intrusive means available to achieve the same objective must be exhausted.

Coercive measures may only be considered in situations in which the ability to self-determination is so severely restricted in the recipient of care that he or she is unable to make a free and autonomous decision. Conversely, this means that the free will of a fully autonomous person must even be respected if he or she is exposed to serious risks to life and health. The ability to self-determination is thus the central normative point of reference in dealing with coercion, even though assessments of competence can be difficult to make in practice.

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Every coercive measure ultimately means heteronomy of the coerced. This makes it all the more important to plan and handle them in such a way that respect and esteem for the individual person and his or her autonomy are guaranteed as far as possible. This means, among other things, that the concerned person's claim to participation must be recognised by including him or her in the planning, implementation and in the follow-up process of any coercive measure.

When weighing up the advantages and disadvantages of a coercive measure, the possibility of secondary harm such as humiliation, traumatisation or loss of confidence must always be taken into account. The duration of coercive measures should be as short as possible. In order to ensure this, it must be reviewed regularly at appropriate intervals whether the prerequisites for the use of coercive measures continue to exist. Due to their exceptional character, coercive measures must be carefully documented and regularly evaluated. Quality assurance measures including error reporting systems and complaint management should also include coercive measures.

Personnel involved in coercive measures should be specially trained. The intercultural competence of professional caregivers should be promoted. Furthermore, structures should be established that minimise cultural and language barriers. Professional caregivers who are involved in coercive measures should receive support and supervision in order to cognitively and emotionally process their own experiences in exercising coercion. Advisory bodies among peers should be established to deal with the use of coercive measures prospectively as well as retrospectively.

The public should be made aware of the ethically and legally problematic aspects of coercive measures in caring for the mentally ill in crisis situations, for children and adolescents in difficult family and social situations and for dependent elderly and disabled people. In this context, the media have the important task of providing differentiated and appropriate reporting.

In addition to these (and other) general recommendations for the responsible handling of coercion in professional caring relations, the Ethics Council puts forward a large number of specific recommendations for the three practice fields of psychiatry, child and youth services as well as for services for the elderly and disabled, which can be read in the Opinion.

The Opinion was adopted without counter-voices by the German Ethics Council. In a dissenting vote, however, one member expressed reservations regarding the central concept of free responsibility. In order to carry the normative load imposed on it, the term should have been defined more clearly in the Opinion.

The full text of the Opinion (in German) can be accessed on https://www.ethikrat.org/fileadmin/Publikationen/Stellungnahmen/deutsch/stellungnahme-hilfe-durch-zwang.pdf.
A translation of the Opinion will be available in due course.