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A brief history of empowerment: response to discussion with Julianne Cheek

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Empowerment has gained prominence in health care as an ideal to underpin practitioner – client/patient relationships. Its advocates see it as preferable to paternalistic or authoritarian models and practices, partly because of the humanistic values that shape it and partly because it is believed to improve efficiency in health care delivery because it makes compliance to treatment regimes and to health promoting advice more likely. However, as Cheek notes in her paper, there are plenty of situations in which it is difficult to find anything approaching empowerment in practice. This paper, which develops Cheek's arguments further, examines some of the historical and philosophical origins of empowerment, traces its trajectory through post-World War II societies into health and welfare values and finally asks whether nurses and other health care workers face significant contradictions if they are to take seriously the call to 'empower' their patients.

Key words: patient empowerment; modernity; civil rights

Introduction

According to policy analyst Theodore Marmor, one of the weaknesses of international comparative policy analysis is its lack of criticality. Marmor argues that many analysts merely take on the 'language of the agents' (and by agents he means government departments, or health providers). Simply to use a term like 'managed care' is to be implicated in a profit-motivated rhetorical sleight of hand. Analysts have thrown away the opportunity to critically examine policies and practices by unthinkingly adopting such language (Marmor, 1994; 2000). This, in a sense, is what the agents are hoping for: that if they simply use a term like 'managed' or 'modernized' often enough, many people will forget how this entity was conjured into apparent existence through language use. As linguistic philosopher John Austin, would argue, these terms are 'performatives' no less than the more conspicuous naming of ships and pronouncements of marriage that he used in his examples in the early 1960s (Austin, 1962). In their very speaking they achieve something. Such is the power of language.

Julianne Cheek, in her paper, has noticed the rise within policy and professional literature of the notion of patient empowerment. She argues that patient empowerment is widely pictured as practice which respects patients' abilities to make decisions, values their input into such decisions and features practitioners who are able to allow their patients the space to reject their advice. However, she goes on to argue that sometimes, when actual examples of practice are examined, a different picture emerges: one where patients' views are not valued, situations where patients feel they have experienced a dehumanizing passivity before clinicians who appear to have their own concerns and priorities at the fore.

Cheek notes that there is a difference between the 'rhetoric' of empowerment and the apparent 'reality' of practice and summarizes the problem in three ways:

- 'Empowerment' is only conceived of and

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enacted within a limited space, closely defined by the professional.
- To be a recipient of empowerment is to remain passive, i.e., there is an inherent contradiction.
- The positions of the empowered and the disempowered are not separate or stable; an individual practitioner can be simultaneously understood as having power with respect to a client and very little power within the system of state healthcare.

In response, in this paper I want to explore three questions that correspond approximately to these three problems:

1) What are some of the philosophical and political forerunners of the notion of empowerment?
2) Through what routes has this notion travelled into western welfare and health care over the last 20 years?
3) How far can we understand the healthcare professional as manager of scarce resources and, inevitably, agent of state control?

Philosophical and political forerunners of 'empowerment': Freedom, empowerment, false-consciousness and liberation

Where does the idea of empowerment come from?

It is important to understand the historical and philosophical development of the notion of 'empowerment' because, rather than being a timeless, universal good, because it arises within a narrow context, there are quite specific understandings of the individual within society.

For part of this history I draw on Zygmunt Bauman's examination of the concept of freedom (Bauman, 1988).

From early times, freedom was something granted to one person or group by another powerful individual. The earliest example was manumission of slaves in classical antiquity. Freedmen had to be *made free* by their master but they never became fully human. The medieval Church chose to reject the theological and spiritual equivalent of manumission to prefer instead St Augustine's doctrine of original sin. For the Church of this period, freedom was on the side of evil, a mark of humankind's turning away from God's law. Socially too during these centuries, right up to the birth of modernity in the seventeenth and eighteenth centuries, it made no sense for someone to claim to be autonomous, unattached or master of their life, because society knew no other way of preserving social cohesion than through the role of master over man. The only concept of freedom remained as something given or granted, and then often in a heavily conditional way. Freedom was a privilege, offered sparingly.

In England, it was the unrelenting financial pressure put upon his subjects by King John, to pay for the Crusades, among other things that led to one of the first rejections of the power of mastery in the form of Magna Carta – the 'great charter of freedom'. In it, John agreed to a series of 'freedoms' which his barons were to have, to the legalized status of freedmen, and to trial by peers. The absolute and arbitrary power of the monarch was transformed at this period into the law. The charter included the right of the barons, and other freedmen, to take up arms, even against the king if necessary, in order to protect their freedom. Freedom, however, was nevertheless enjoyed by only a narrow privileged class of society.

In the late Middle Ages, 'freedom' could be granted, not just to individuals, but to whole corporations or towns. Freedom in this case, importantly, enabled a freedom from the jurisdiction of the land estate. This marked the beginning of the end of the power of land wealth over individuals. Up to this point, social hierarchy and power relations were based on land ownership and obligations, and share in its produce, but now moveable wealth became autonomous. The world in which human interdependence was based around land ownership and use, and hence seen as 'natural', began to be replaced by a largely urban, modern social order which began to be conceived: 'not as a natural condition of mankind, but as a product of human wit and administration … dictated by human reason … (Bauman, 1988: 35).

The modern notion of freedom of the individual has become linked with fundamental ideas about the self and individualism. This individualism starts from the psychological sense of distinction between 'my being and that of other people' but:

> The significance of this experience is greatly increased by our belief in the value of human

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> beings in themselves (Colin Morris cited in Bauman). Once the stamp of special – indeed, supreme – value had been impressed upon the otherwise mundane experience of doing one's things and thinking one's thoughts, an 'acute self-awareness followed' – an impulse to look on one's 'own self' as an object of tender care and cultivation.
>
> (Bauman, 1988: 36).

Prior to the modern era, to follow the call of individualism was for the few, for philosopher-beggars, or religious devotees, but after that time, it is seen as the most fundamental and universal characteristic of human beings. For example, for the Greek Aristotle (384–322 BC), it seemed natural to start thinking about human existence from the starting point of the polis, the collective, but nineteen hundred years later, one of the founders of modern thought Thomas Hobbes (1588–1679), starts with ready made presocial individuals and the problem then is how they can associate with each other to form some kind of society or state.

With this starting point, one of the difficulties of any state would be the ambivalent status of individuality because on the one hand, the individual had the capacity for judgement, recognizing interests and making decisions, characteristics which could aid the cohesion of a society, but at the same time the capacity to act out of self-interest could endanger this same cohesion. Society would have to develop ways of keeping such anti-social forces in check. So with modern society, gone is the single, unified source of authority. In its place is a plethora of partial, mutually unrelated authorities all behaving as if the other authorities did not exist, and all demanding sole loyalty to themselves.

So, we can sum up the characteristics of modern individualism:

- Individuality as value;
- Intense preoccupation with individual distinction and uniqueness along with the 'everyday' experience of the individual;
- The poignant experience of being a 'self' and 'having' a self and being obliged to care for and defend one's self as one would any of one's possessions.

Let us now return to the question of patient empowerment and see what light this brief history has shed on the issue.

Firstly, it is possible to detect a number of quite exquisite tensions. Most developed western societies value humanistic principles: i.e., that the safety, welfare and self-fulfilment of the individual is of paramount importance (Taylor, 1986), hence the state provision of housing, education and welfare, including health care. Yet there will always, inevitably, be a tension between any single person, or group's understanding of what they require for self-fulfilment and what powerful groups who are in control of decision-making about these provisions think is appropriate and in the best interests of the stability of the society as a whole. Perhaps we could characterize this latter position as reflecting utilitarian values. For example, it is possible to think of state education as involving a tension between a system that develops critically minded challengers of authority and one that provides a 'human resource' to enable industry and commerce – capitalism – to function in the most efficient way possible (Traynor and Rafferty, 1998). It is possible to think of healthcare provision as involving a tension between the economically justifiable maintenance of a healthy workforce and fighting force on the one hand and the humanitarian ideal of providing any treatment which could alleviate suffering to any individual at any cost on the other (Seedhouse, 1993). How education, or health care, is actually delivered is probably the result of a great deal of pragmatism, but somewhere within these actions are embedded not only policy priorities but more general societal values – as well as tensions, like those just mentioned.

So, it is possible to argue that at the broadest level, the notion of empowerment in health care arises because there is an inevitable tension between our humanistic valuing of the individual and his or her optimum experience and the utilitarian and bureaucratic basis of state health care provision.

Empowerment and Identity

The idea of empowerment involves some fundamental beliefs about human identity which have their own genealogy. It is perhaps only in the last 300 years that an idea of the human individual as needing and, importantly, having the capacity to liberate itself from delusion or irrational beliefs has

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developed. The notion of 'empowerment', I suggest, is a notion which is central to the European Enlightenment (Foucault, 1984; Taylor, 1989).

'What is Enlightenment?'

Philosophers of the eighteenth and nineteenth centuries saw their period in history as a new stage in the evolution of humanity. According to Kant, humans could claim a new confidence, a new authority through the operation of reason and its principles. Enlightenment was an emancipatory project (Foucault, 1984). It promised emancipation from the primitive forces of unreason in its various forms, superstition or religion. It asserted the autonomy of the human subject rather than the subject's relationship of dependence, upon God, for example. It is a project that still consumes a vast amount of energy and its heritage offers perhaps one reason for the persuasiveness of the New Right vision of the freedom of the individual (Hayek, 1967; Nozick, 1974) which will be considered later. Autonomy is also central to the claims of the modern professional (Freidson, 1994).

Lather contrasts a radical understanding of empowerment with its use within:

> … the current fashion of individual self-assertion, upward-mobility and the psychological experience of feeling powerful … I use empowerment to mean analysing ideas about the causes of powerlessness, recognising systemic oppressive forces, and acting both individually and collectively to change the conditions of our lives … empowerment is a process one undertakes for oneself; it is not something done 'to' or 'for' someone …
> (Lather, 1991: 3–4)

In this light, it is possible to see the term 'empowerment' used in the health care context, which Julianne Cheek discussed in her paper, as a weakened form of a more radical concept. Though a more radical understanding of the term has origins in Enlightenment thinking and Marxism, it has travelled a certain path to get to where it is today via the strange bedfellows of liberation theology and new right politics. Marx believed in: '… the drama of the forward march of human productive capacities via class conflict culminating in proletarian revolution' (Fraser and Nicholson, 1990: 86).

The oppression which the working class experienced was not only material, but was acted out within their very consciousness. They were blinded by the fog of ideology, which called them to accept an image of the world and their own place within it that worked to the benefit of those who owned the means of production. Liberation involved, of necessity, an escape from the lies of ideology, from false consciousness, into a vision of the truth of the world and then, importantly, doing something drastic to bring about revolutionary change.

However, there is one problem with the theory of ideology and liberation: how is it that some groups are able to gain genuine knowledge of social reality rather than being deceived by appearances like everyone else (Harding, 1990; Hammersley, 1995)? Marxists may argue that Marxism's scientific basis ensures that it can be relied upon, however over the last few decades Marxism has had to face critiques, from some postmodernists and feminists amongst others. These critiques centre around a number of issues, among them:

- the question of the authority of the knowledge of any group which claims to be able to help oppressed people to liberate themselves: (science as an assurance of trustworthiness and objectivity has been questioned by many)
- and how far we can really understand anyone as an 'autonomous individual capable of full consciousness and endowed with a stable 'self' …?' (Lather, 1991: 5).

So, I would like to argue that even at a basic, theoretical level, the notion of empowerment is not without its problems and contradictions.

Recent history of empowerment in health care

The horrors of World War II brought some quite profound social changes to all of the nations involved. Among such changes in the UK was the setting up, in 1948, of the Welfare State with its humanistic ambition of overcoming ignorance, poverty and ill health for the whole population (Klein, 1989). In the same year the newly formed United Nations formulated its Universal Declaration of Human Rights. The declaration was described as 'a Magna Carta for all humanity' (Office of the High Commissioner for Human Rights, 1997).

Article 1 boldly states that: 'All human beings

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are born free and equal in dignity and rights. They are endowed with reason and conscience' (UN, 1948, art. 1).

Mrs Eleanor Roosevelt who chaired the UN Human Rights Commission in its early years emphasized the valuing of 'everyday life' which we noted earlier is an important feature of modern conceptions of the self and of freedom:

> Where, after all, do universal human rights begin? In small places, close to home – so close and so small that they cannot be seen on any maps of the world. Yet they are the world of the individual person; … Such are the places where every man, woman and child seeks equal justice, equal opportunity, equal dignity without discrimination. Unless these rights have meaning there, they have little meaning anywhere.
> (Office of the High Commissioner for Human Rights, 1997)

In the wake of this new concern with equality and justice the American Civil Rights movement emerged. Black civil rights campaigner, Martin Luther King claimed that: 'All over the world like a fever, freedom is spreading in the widest liberation movement in history. The starting point is our objective situation as oppressed and dependent peoples.' (Atkinson, 1998).

The mood was also expressed in folk and popular culture, encapsulated in the following interview from American folk singer Woody Guthrie who sang in the 1930s and 1940s:

> I am out to sing songs that will prove to you that this is your world and that if it has hit you pretty hard and knocked you for a dozen loops, no matter what color, what size you are, how you are built, I am out to sing the songs that make you take pride in yourself and in your work.
> (Empowerment Resources.com, 1997)

Woody Guthrie had a huge influence on a whole generation of protest singers including, most notably, Bob Dylan.

This period, the 1950s and 1960s saw a new focus in the West on the individual and the quality of his or her experiences. It was a period that struggled against the deadness of bureaucracy, vested interest, racial prejudice and authoritarianism. The community development movement and post-colonial movements also grew out of this period. In the field of organized religion, the Second Vatican Council (1962–65) committed the Roman Catholic Church to an active role in the promotion of justice, human rights and freedom.

Latin American liberation theology also emerged in the 1960s in the midst of profound economic, cultural and religious upheavals in that part of the world. It was a movement of Christians who understood their religious commitment as intimately bound up with the struggles of the oppressed for liberation. Those who argued its cause were prepared to admit the influence of Marxism on its thinking, for example, in its understanding of history as the process of liberation of oppressed classes, but emphasized strong differences as well.

Brazilian theologian Archbishop Helder Camara said, 'When you give food to the poor, they call you a saint. When you ask why the poor have no food, they call you a communist' (Atkinson, 1998).

The 1970s and 1980s also saw the rise of feminist movements, gay rights and disability rights movements. The WHO's Ottawa Charter on Health Promotion (World Health Organization, 1986) and the same organization's Health for All by the Year 2000 (World Health Organization, 1978) also emphasize the participation of communities in the design of health promotion and health care services. The spirit of these documents formed some of the foundational principles of the Healthy Cities and New Public Health Movements and set the scene for the increased involvement of lay people, in many countries, in decisions about health care or at least the appearance of this involvement.

Uneasy bedfellows

There has been a range of quite different forces behind what we take today as 'patient empowerment' and one powerful force has been the rise of New Right politics since the late 1970s in both the US and the UK (Brown and Sparks, 1989). The thinking and policies of New Right governments were based, to some extent, on the Liberal economic thinking of eighteenth century political theorist Adam Smith and his investigations into the necessary conditions for state prosperity (Smith, 1904). Such thinking is strongly individualistic and understands, or tries to understand, the state as a loose collection of free individ-

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uals each with the ability to make choices, often economic choices, that maximize their utility. The state's role is seen as minimal, providing a stable currency and minimum structures for a market to operate (Wolff, 1991). Intermediary groups between the government and the individual, such as trade unions or professional bodies do not fit into this schema and the decades of Thatcherism in the UK saw a systematic challenging of these groups. The introduction of general management and then the 'internal market' into health care are two good examples of such policies (Griffiths, 1983; Harrison and Pollitt, 1994).

One motivation for these policies in the UK was a desire to dismantle the collectivist and supposedly paternalistic welfare system that had developed since the inception of the welfare state after the Second World War (Brown and Sparks, 1989). The attempt was made to transform 'patients' into 'customers' or 'consumers' or at the very least 'clients' and picture the health care transaction as little different from any other market place activity. Some groups of health care providers, for example health visitors had already started to refer to the members of the public that they dealt with as 'clients' in a way that was intended to reflect a change of thinking: these clients were no longer the passive recipients of professional expertise, but partners in planning their care (Luker and Orr, 1985). The 'Patients' Charter' which was published by John Major's government in 1991 (Department of Health, 1991) carried on this tendency and there was a sense that the public did indeed have raised expectations of health care and that unconditional gratefulness was only felt by the over-sixties who could perhaps still remember the pre-NHS days.

However, the new emphasis on consumerism cut both ways: perhaps some groups of the public did experience greater responsiveness to their preferences in health care, but at the same time an individualistic emphasis on personal responsibility for health and illness reflected governments' reluctance to examine structural impediments to health, such as poverty, pollution, poor housing or inadequate transport. Whether all these policies have really reduced the power of professionals vis-à-vis their patients and managers is open to question (Harrison *et al*., 1992; Harrison and Pollitt, 1994).

Now it is time to ask how far health professionals are in a position to 'empower' their clients and patients vis-à-vis the bureaucratic state. Are they, by virtue of the fact that they are health professionals, agents of state control?

The health professional and state control

Much attention has been paid to the relationship between professional status and power, and writers have reached two quite different conclusions. The first is that the professions – and experts in general – exercise enormous power over both state policy and the personal lives of individuals by creating an artificial dependence. They do this partly by 'controlling the way that people perceive their problems and decide how to cope with them' (Freidson, 1994: 31). It is possible to think that the health professions are, to a greater or lesser extent, implicated in this exercise of power over the consciousness of the public because they, for the most part, take on and perpetuate the categories of health and ill health. The social view of health does attempt to escape this narrow medicalization, but it is not clear to what extent this influences structures of health care provision. Writers such as Ivan Illich and Ian Kennedy have explored this theme (Illich, 1977; Kennedy, 1981).

A different conclusion is that the professions are almost entirely powerless, and are the passive instruments of the state and of capitalism, and have little influence of their own. Any power that they do have needs to be legitimated by the state which grants them the specific and limited autonomy that they have through legislation (Freidson, 1994). The actual practices that have or have not been granted state approval have changed over time, e.g., some 'alternative' practices can become 'mainstreamed' by state regulation.

In fact, these two apparently opposite conclusions are quite similar so it is difficult to place the ideas of French historian, Michel Foucault into either category. Foucault finds links between the power that the eighteenth century monarch wielded over the life and death of his subjects with what he terms the biopower exercised by states in the modern era. He sees biopower as made up of disciplines of the body on the one hand – such as schooling, or army training – and regulations of the population on the other – techniques and institutions developed to control new movements

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of population and rising birth rates. As he says: 'The old power of death that symbolised sovereign power was now carefully supplanted by the administration of bodies and the calculated management of life' (Foucault, 1984 cited in Rabinow, 1984: 262).

Foucault argues that capitalism could not have developed without the bodily organization that biopower could achieve by means of new techniques and powerful new instruments of the state. Biopower could segregate a population and reinforce hierarchies and because of this make it easier to govern. Growing populations along with the growing organization of capital, he argues, gave rise to a new need for surveillance and classification of the healthy and sick, the rich and poor, those more or less amenable to profitable investment, those with greater or lesser prospects of survival. But the development of the institutions of surveillance like medicine, led to more than a simply economic concern, so that a controlling surveillance penetrated deeper into the individual lives of the population. For example, the problem of high birth rate coupled with problems of infant mortality and the question of the investment needed to produce the optimum number of children turned into a more detailed attention to the correct management of this age of life. This gave rise to a new regulation of the relationships between adults and children and obligations on both: care, contact, hygiene, suckling of children, physical exercise. Foucault also notes the large number of medical texts giving advice about childcare and family life that emerged in the second half of the eighteenth century (Foucault, 1973; 1985). The family became a new moral arena created and sustained by medicine and today policed by a range of state officials, including health visitors, school teachers and social workers.

From this perspective, one in which medical attention to the family arose in a particular historical and economic context, 'empowerment' becomes a much more problematic idea, no matter how sincere the individual health worker may be, because he or she is already implicated in a project which is about encouraging individuals to fit into patterns of behaviour in which the state and capitalism have a strong interest – the good health of the social body for reasons of social stability, a fit and flexible workforce and reduction in health and welfare costs. Their job is to inculcate a private ethic of good health and practices into the individual parent.

There are some clear examples of this emphasis. Some nurses writing about empowerment describe it as 'a process in which clients participate with nurse facilitators to assist them to develop proactive healthy behaviours' (Rafael, 1995) or when empowerment is seen as an effective strategy to assist clients in making behaviour changes, which are health promoting. Or again, when the outcomes of the empowerment process are given as 'self-determined, independent health promoting behaviours' (Ellis-Stoll and Popkess-Vawter, 1998: 65). As Cheek notes in her paper, governments in the UK and Australia have emphasized how patient involvement and empowerment can lead to the more efficient operation of health services by encouraging compliance (quite the opposite to empowerment) and perhaps reducing unnecessary use.

Conclusion

So it could be argued that there is a powerful contradiction at the heart of some notions of 'empowerment'. 'Empowerment' is in danger of placing such emphasis on personal responsibility that it can perpetuate the status quo by failing to give attention to massive, but taken-for-granted, structural constraints on the life and consciousness of the individual. 'Empowerment' in the hands of state professionals can involve a manipulation of the consciousness of the individual into believing that their own health status is largely a result of conscious decisions and individual behaviours rather than less visible, but none the less effective structural forces. So, ironically, 'empowerment' can perpetuate ideology. After all, this is what the most effective ideology does – it tells the individual subject that he or she is free while at the same time constructing the possibilities for thought and action. This is probably why western individualistic capitalism is so successful, and state health care can be seen as serving its best interests.

Following on from Cheek's paper in which she discusses empowerment and its frequent failure, I have not offered a checklist of how to make sure health care workers are empowering their patients. This is because we as health care workers need a sophisticated understanding of where this – and

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other notions – come from, and of some of their inherent contradictions. Otherwise any actions on our part may well be confused themselves.

If health workers want to take the notion of empowerment seriously there is no way to avoid asking radical questions about the functions of state agencies and their place within them. There are encouraging signs that some involved in health care have asked some of these questions and movements like the New Public Health, Healthy Cities and various aspects of Community Development are evidence of this. However, many of these and other movements involve uncomfortable challenges to the power of professionals.

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