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Coercion in the service of society

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Doctors are supposed to protect their patients, but sometimes societal considerations must take precedence.

Photo: Sturlason

It was night-time, and I was on duty in a small municipality along the E6 motorway. Standing in front of me were two police officers with a tight hold on a man. The man had been brought in for erratic driving, and the officers wanted him to be examined by a doctor. The man was unwilling, but the police had their warrant in order. A quarrel ensued before the patient agreed to be examined. While the police looked on, I drew two small vials of blood and noted how the patient staggered in an uneven line across the floor. In the aftermath, doubt crept into my mind: Was it ethical of me to take part in this?

In a normal clinical context, coercion is usually associated with the mental health service and treatment of patients who lack insight into their illness – a last resort to do what is presumably best for the patient (1). But coercion is not always related to mental illness or an incapacity to give informed consent. The aim of a patient encounter is not always to help the patient. As Skipenes of the Medical Ethics Council wrote in the Journal of the Norwegian Medical Association earlier this year, the doctor acting in an official capacity as expert authority must serve the interests of society – also when this goes against the interests of the individual patient (2).

Section 22 of the Norwegian Road Traffic Act sets out provisions on driving while intoxicated. The job of the police is to ensure compliance with this section of the law, if necessary with the use of physical force. If society's need for traffic safety on the E6 motorway conflicts with an individual's desire to drive while intoxicated, the interests of society take precedence. The Control of Communicable Diseases Act (Sections 5–2 and 5–3) and the Mental Health Act (Section 4–4) also contain provisions that permit the use of force against individuals in order to protect the interests of society. Patients who are a threat to society, due to a communicable disease or mental illness, can be admitted and treated without their consent.

When the doctor acts in an official capacity as expert authority, a high level of professionalism and ethical behaviour is required (2). It is the doctor's job to assess whether the examination is suitable for answering the questions raised. Is it possible to present the results in a way that can be interpreted by the entity ordering the examination? Do the conclusions have an acceptable margin of error? Can the risk to the patient be defended?

Most people would probably not think it is controversial for a doctor to assist the police by taking a blood sample to assess an individual's degree of intoxication. We trust the quality of the test and adhere to the boundaries society has set for when it is safe to get behind the wheel. Expert age determination of refugees is more controversial, which is reflected in the debate following the conclusion of the Medical Ethics Council of the Norwegian Medical Association that it is unethical for doctors to use current methods of determining the age of asylum seekers (3). The main reason for this is the uncertainty of the method. The margin of error is too great. In addition, the Council raises the question of whether the informed consent entails genuine freedom of choice.

We cannot rely on the decisions of the authorities alone. The Nuremberg trials after World War II established that each person is responsible for the consequences of his or her own actions (4). In modern times, colleagues in

Syria are facing a cruel dilemma in which they must balance their own convictions and government demands, as well as take their own health and safety into account (5). Doctors who participate in war also have an obligation to comply with the Geneva Convention and uphold human rights (6).

Ultimately, each of us must reflect on the ramifications of the job we do. We should tread very lightly when our actions are not motivated by what is in the immediate best interest of the patient or when our conclusions have consequences for minors or other especially vulnerable individuals. At the same time, we must remember that if the threshold is too low for putting one's own political views ahead of solutions that are decided on in a democratic society, we risk undermining our democratic principles. We also risk polarising the health service so that vulnerable patient groups only meet healthcare personnel who share certain political views. This will serve neither the individual nor society at large. There is no denying that the use of coercion and withdrawal of freedom of choice are necessary evils when protecting the interests of society.

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