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Doctors, coercion and the law

EDITORIAL

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Giving the population better healthcare is contingent on effective regulation. This work cannot be left to the legal profession alone.

Doctors are educated and trained in assessing patients' health and in making decisions about the investigation and treatment of illnesses on a medical basis. However, many young doctors find that decision-making processes in health care are often also based on a number of factors other than the purely medical. For example, questions about resources are becoming increasingly relevant. Do we have beds? Do we have staff? Can we afford it? Likewise, the legal and regulatory framework is also part of the puzzle. Patients may disagree with the doctor's assessment or may not want to cooperate.

Some patients' family members make demands that are not compatible with what we believe is the right choice. Our employer may be subject to special directives that do not always accord with what we want to do. What obligations and rights do we have in such contexts?

A classic example of such a problem is those situations where we consider treatment without the patients' consent. According to basic clinical ethics, the patient's autonomy is crucial (1). The legislation also generally requires patient consent for the provision of health care (2). Nevertheless, situations can arise where health care must be provided without the patient's consent, for example if the patient does not have the capacity to consent or does not want to consent.

Treatment without consent should and must be clearly regulated and clarified in professional guidelines. This has already been done in some areas, such as mental health care in the specialist health service. There are laws, comprehensive regulations, professional guidelines, clinical frameworks, established support schemes for discussing clinical ethics, and legal control schemes for how the treatment should be given when the patient does not consent and coercion is needed.

In other areas, the situation is considerably less clear. An illustrative example is pre-hospital services, as described by Thorvaldsen et al. in this issue of the Journal of the Norwegian Medical Association (3). The ambulance service frequently deals with patients with undiagnosed conditions, often without direct access to a referring doctor and occasionally by forcible means in the case of aggressive patients. To further complicate the situation, there is no clear set of regulations for pre-hospital services that can clarify the handling of patients without consent. The regulations largely assume that treatment takes place in defined clinical settings, as in the case of the rules on coercion in psychiatry and somatic health care. They also assume that staff have the opportunity to discuss the situation with colleagues and the time and resources to document a decision. These assumptions are not the reality in pre-hospital settings, which means that pre-hospital services sometimes operate without a clear set of regulations or clearly defined professional guidelines.

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The issue shows the gap between everyday life in clinical practice and theoretical law. The rules are often designed under specific hypothetical scenarios and, unfortunately, sometimes with little insight and understanding of the complexity of medicine. The example from pre-hospital services is not unique. Similar challenges occur every day in many other places in the health service, including nursing homes, GPs' offices, emergency clinics and hospitals.

Some of these problems have been identified, such as the challenge of fragmentary legislation on the use of coercion, and efforts have been made to resolve them. In a white paper on coercion limitation, the Østenstad Committee proposes closer coordination of these rules (4). Other problems remain unresolved, as exemplified by the ongoing discussions between the health service and the police in Oslo about who should be able to use forcible means on uncooperative patients (5).

Healthcare personnel are increasingly having to deal with a complex health service in which several factors influence our decisions about health care. The introduction of ever more rules and stronger calls for legal protection for patients in the health service is one such example. If health service rules are to be effective, or at least applicable, we as doctors must also be involved in developing our legal rights in this area.

So what exactly can we doctors do? Some measures are already available to us and, in practice, only require greater commitment and participation. This could relate to legal policy work in the form of consultative papers, where our trade

unions and occupational groups can exert influence. Other measures require more effort and resources, such as targeted efforts to build competence and joining the right decision-making forums.

The push for a better health service also includes good regulations, and this should not be left to the lawyers alone. We need a mutual exchange of specialist knowledge between healthcare personnel and lawyers to make it happen. The legislation on interventions for patients who do not give consent is, unfortunately, one example of how the regulations are not always sufficient. Human rights, constitutional provisions and legal protection rules require such health care to be clearly and concisely regulated. In some areas, this is still not the case. We should get involved and take our share of the responsibility for improving healthcare provision.

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