Tidsskriftet
DEN NORSKE LEGEFORENING

# Fatal mistakes

FROM THE EDITOR

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## Where is the demarcation between institutional responsibility and individual responsibility for mistakes made in the health service?

Photo: Sturlason

An A&E doctor in the county of Trøndelag has violated the legal requirements for professional standards and compassionate care. This is the conclusion of Trøndelag's County Governor in a case where a young man died, probably as the result of a heart attack (1). The doctor had not examined the patient himself, but had spoken on the phone with ambulance personnel who were in the patient's home. The decision was made not to take the patient to A&E. The case attracted a great deal of attention following publication of an article in the *Adresseavisen* newspaper entitled 'The A&E doctor who made a mistake at Støren could have been me' (2). In contrast to the doctor, the A&E department and St Olav's Hospital in Trondheim had, in the County Governor's opinion, maintained professional standards in the care of this patient.

The case highlights the demarcation between individual responsibility and institutional responsibility in the health service. Despite A&E doctors often receiving phone calls like the one above during their shift, the division of responsibilities in emergency health care outside the hospital setting is not clearly defined. In a letter to all health trusts in Norway in 2019, the Norwegian Directorate of Health stipulated that patient responsibility in such a setting will depend on a concrete assessment and cannot be defined in a general sense,

but should be 'clarified in the service's protocols' (3). This institutional responsibility became clear in a regulatory investigation in 2015 where a 16-year-old boy with a hydrocephalus shunt died as a result of shunt failure. The violation of the law in this case was placed at the door of the health trust due to the unclear distribution of responsibilities and a communication failure between doctors and ambulance personnel (4). In a case from Denmark, with the hashtag #detkuhaværetmig, a man in his 60s with diagnosed diabetes died as a result of severe hypoglycaemia. The doctor had given oral instructions for his blood sugar to be measured, but this was not done. Doctors throughout Scandinavia felt that the doctor was being blamed and convicted for a type of incident that is commonplace in clinical practice. She was eventually acquitted of gross negligence in the Danish Supreme Court by four to three votes (5). The doctor no longer works with patients. In retrospect, this fundamental issue has highlighted the need for a change of focus from the individual to the structure in Danish health legislation and administration, but no concrete changes have yet been made.

*«Doctors often have to make decisions without knowing all the facts»*

Doctors often have to make decisions without knowing all the facts. Lack of access to a complete medical record can mean that the doctor is unaware of important background information. Establishing details about a patient's relevant medical history can be particularly challenging in emergency situations. Sometimes the medical history is conveyed by someone other than the patient, for example in a phone call with other healthcare personnel. The doctor nevertheless still has clinical responsibility and must make a decision based on the information available.

Under the Health Personnel Act, all doctors are subject to a requirement for professional standards (6), which is a legal minimum standard for all health services, and is one level below 'good practice', as described in national recommendations and guidelines. A legal standard is dynamic and can vary over time. What is regarded as professional practice will therefore follow norms and developments within the field and will not be fixed. This leaves considerable room for interpretation and discretion. The legislation also stresses that the work must be carried out in accordance with what 'can be expected on the basis of the healthcare personnel's qualifications, the nature of the work and the situation in general' (6). The 'nature of the work', and the 'situation in general' in particular are factors that must be viewed as complex, changing and unpredictable. Most regulatory investigations in Norway concern GPs and violations of the requirement for professional standards (7). A study reviewing the 953 administrative sanctions meted out by the Norwegian Board of Health Supervision in the period 2011–18 revealed that GPs are eight times more likely to be subject to sanctions than hospital doctors (8).

The Health Personnel Act requires health and care services to be organised in a way that enables healthcare personnel to comply with their statutory obligations (6). This creates a number of grey areas. As doctors, we work in a system that is highly pressured at times, and where we have relatively little agency to influence patient flows and workloads. Nevertheless, we have a major personal responsibility. Doctors are known for their enormous professional pride, and many go above and beyond the call of duty. The threshold for bringing issues to light or whistleblowing is high for many. We can therefore end up in work situations that are not justifiable. The overarching objective of both the Health Personnel Act and the Health Supervision Act is to ensure high quality and safety in the health and care service, and to maintain the population's trust in healthcare personnel and the service as a whole (6, 9). The decision of the County Governor in Trøndelag has not contributed to this.

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Publisert: 22 March 2022. Tidsskr Nor Legeforen. DOI: 10.4045/tidsskr.22.0196