

Law notes

The extent to which disciplinary proceedings involving members of the health professions are made public varies very greatly from one country to another. Major medical cases coming before Britain's Medical Research Council or the Netherlands Disciplinary Tribunals reach the pages of the professional journals; in Sweden the weekly medical journal publishes in almost every issue anonymous but detailed reports of proceedings and decisions. In Denmark by contrast, the tradition still prevails that the medical profession deals behind closed doors with disciplinary cases. Norway has in recent years chosen to follow the Swedish course, and the bulletin of the Health Inspectorate in Oslo now reports very clearly on cases involving all members of the health professions. A number of recent Norwegian cases of this type published in the course of 1998 are presented below.

Diagnosing injury in a drunk patient

A heavily inebriated man fell from a stone staircase and lost consciousness. The police failed to establish contact with him and he was taken into custody for drunkenness; the physician on duty at the police station noted a strong regular pulse of 72; cardiac function and breathing were normal. The back of the head showed a 4–5 cm long raised bruise attributed to the fall, but there was no laceration or bleeding. The physician considered hospital admission unnecessary but instructed the officers to check his breathing every half hour. Throughout the night he appeared to be asleep but at 8 a.m. it was observed that he was not breathing and an ambulance was called. Resuscitation was unsuccessful. At post mortem, injury to the cerebrum was found, as well as bleeding into the brain stem, both attributable to the injury sustained in falling.

The health inspectorate considered that the physician on duty should have instructed the police in proper observation of a patient with a head injury; in particular attempts should have been made to waken the patient at intervals, with referral to a hospital if unconsciousness persisted unduly long. A surgical consultation would also have been advisable.

In view of the circumstances however the Inspectorate decided that the physician should not be reprimanded for his failure to admit the patient to hospital (*7th January 1998*).

This is one of many such cases in which there appears to have been a misjudgement as to the cause of unconsciousness in a patient under the influence of alcohol. Visible head injury in such patients must however be a reason for particular caution, particularly since a drunk patient is likely to fall particularly heavily.

Treatment of an unclean wound

A woman tripped over a rough timber fence and incurred a cut on the thigh. She consulted a physician who cleaned the wound, applied three stitches and prescribed an analgesic. Three days later the wound was seriously infected and she consulted another physician; the latter opened the wound which proved to be 6–8 cm deep and to contain numerous wood fragments and some splinters. She received antibiotics

and tetanus vaccine. The wound required prolonged surgical treatment and the patient was absent from work for two months.

The Health Inspectorate considered the first physician's examination inadequate; particularly because some wood fragments were visible at that time there was much reason to believe that it was a deep wound which needed to be opened and examined, and which should not have been sutured. The correct means of treating unclean wounds is prescribed in an official publication on routines in emergency medical care and this standard could and should have been met. The physician received a severe reprimand (5th March 1998).

Significant in this instance is the fact that the existence of a official guideline was regarded as setting a minimum standard for treatment in a particular type of case, and not merely as a set of recommendations for practice.

Chiropraxis – and malpraxis?

A woman consulted a chiropractor because of pain and stiffness in the lower back. The latter considered that she also required treatment of the neck, although this was symptom-free; following his treatment she did develop neck pain. The woman then consulted a physician who diagnosed a cervical disk prolapse, which had to be treated surgically.

Experts consulted by the Health Inspectorate expressed somewhat divergent opinions as to whether the cervical prolapse had resulted from manipulation of the neck. One considered that there had been little reason to give such treatment but that at the time in question it had not been contraindicated. In his view, manipulation could have elicited prolapse of the disk, a known but rare complication the risk of which has to be accepted. Two other experts found a preponderance of evidence that the manipulation had caused the prolapse.

The Health Inspectorate was unable to conclude with certainty that the manipulation had indeed caused the prolapse. However, it was improper to undertake such manipulation where there was insufficient indication for it.

In the meantime a second patient independently lodged a complaint against the same chiropractor on closely similar grounds: in this case she claimed that she had explicitly requested him not to treat her neck, an allegation which the chiropractor denied. Following the treatment she had developed a stiff neck. In this case an expert declared that the chiropractor had acted according to the agreed "guidelines for proper chiropractic treatment" but that there appeared to have been poor communication with the patient.

In neither case was the Health Inspectorate able to ascertain the content of conversations between the chiropractor and the patient, but there was evidence that communication had been poor. It was the chiropractor's responsibility as therapist to ensure that sufficient information was given and that it was understood.

Beyond this, the Inspectorate considered it striking that the chiropractor had in both cases treated the neck region despite the fact that patients had no symptoms in this area; this was bound to raise doubts as to his professional competence in dealing with such cases. He received a "warning" under the Health Professionals Act for indefensible behaviour (30th March 1998).

Where "alternative" professionals have obtained recognition under the law, as in Norway, they become subject to disciplinary rules analogous to those binding physicians. The difficulty, evident in

these two cases, is that a disciplinary body is likely to be dependent on the advice of experts, some of whom represent "official" medicine and others complementary medicine, and there is every likelihood that their views on the competence of a complementary practitioner will differ.

Patients – and friends

A qualified physician "C" prescribed narcotic analgesics to two persons both of whom were severe drug addicts, but neither of whom were his own patients. One was registered as a recognized addict; the other had his own physician from whom he normally obtained drugs. "C" claimed that he had prescribed the drugs in order to reduce the subjects' excessive use of illegal "hard" drugs.

The Health Inspectorate considered it particularly reprehensible that the prescriber had issued drugs to a person who had his own regular physician; this could only complicate the latter's treatment. It also appeared that the prescriptions had been used for personal rather than medical reasons. Such an admixture of medical and personal relationships is entirely unacceptable and contrary to fundamental principles of sound medical practice. He was issued with a "warning" under the Medical Practice Act (3rd February 1998).

The old principle that a physician should normally only treat those who are his patients, and should avoid confusing professional and personal services, is one with a sound basis in logic. Especially where drug addiction is concerned, it is vital that a patient receive medicines only from a single prescriber in order to avoid confusion and abuse.

Sterilization unwanted?

A woman who had recently undergone detoxification after a period of drug addiction became pregnant. She was admitted briefly for therapeutic abortion; a note in her hospital records at this time read: "Is applying for sterilization". A week later she was readmitted because of retention of foetal material and evidence of uterine inflammation. Another month later she was once again admitted for abdominal pain; a right ovarian cyst was found and laparoscopy was decided upon. The surgeon concerned was aware of the earlier note in the records indicating a desire for sterilization, and after consulting the physician who had made the entry he performed laparoscopy, in the course of which he carried out sterilization. He had not consulted the patient to determine her wishes, and there was no signed request from her asking that she be sterilized.

The Health Directorate issued the surgeon with a severe "warning" under the Medical Practice Act for failure to observe the rules with respect to sterilization (30th March 1998).

It may be noted that the Norwegian Law, like that of many other countries, requires that a woman desiring sterilization sign a declaration to this effect. The treating physician should ensure that she is fully informed as to the nature, effects and risks of such treatment. The surgeon performing the act must ensure that these requirements have been met.

Compulsory medication of children

Utah court orders children to take psychiatric drugs against the will of their own parents. ICSP News, Spring/Summer 1998, 6.

A “special report” issued by the American human rights group Support Coalition International in July 1998 provides a summary account of proceedings brought in the State of Utah against David and Teresa Rodriguez for both “educational neglect” and “medical neglect” of their four children, aged between 8 and 15. The “educational neglect” was stated to comprise the home schooling which the children were receiving, while the “medical neglect” was described as comprising the parents’ failure to ensure treatment of the children with the stimulant drug methylphenidate (Ritalin[®]). They were found guilty of both offences in April 1997; thereafter they moved of their own volition to the state of Arizona.

On March 7th 1998, following a nocturnal police raid on their new home, the children were taken into custody by the authorities and sent to foster care in Utah. On June 16th 1998, the State of Utah held an expedited hearing brought by the State’s Division of Child and Family Services before the Juvenile Court for the purpose of putting the two oldest children on psychiatric medication, claiming that the second eldest, a girl of 13, had attempted to commit suicide. A psychiatric expert witness called by the parents was not allowed to give evidence, and a Court order was issued requiring the children to be treated with Ritalin[®]. Proceedings before the Juvenile Courts of Utah are held *in camera* and no official account of the proceedings has been issued.

Compulsory medication is as a rule ordered by courts only in highly exceptional circumstances, e.g., to restrain certain violent psychiatric patients or to suppress fertility in institutionalised individuals who are both mentally subnormal and promiscuous. Even in such instances, a meticulous assessment of the situation is required. The incomplete account of the above case which is available from the human rights group concerned does not allow a complete evaluation, e.g., of the suitability of the Rodriguez’ to care for their children properly. However, the very notion of requiring adolescent children to receive compulsory Ritalin[®] medication must be viewed in the light of the facts adduced in a recent issue of this Journal [1]. The use of such drugs in children for the treatment of “Attention deficit-hyperactivity disorder” is widespread in North America, but elsewhere there is much doubt as to the existence of the disorder, and certainly as to the propriety of giving stimulants in this connection. If the facts in this brief report are correct, the use of legal powers to enforce such controversial treatment would appear gravely inappropriate, as would the manner in which the court order was obtained.

Malpractice liability of Health Maintenance Organizations

Oulette v. Christ Hospital, 942 F. Supp. 1160 (Ohio, SD, 1996).

On September 30th 1994 a women entered an Ohio hospital to have her ovaries removed. Her insurer, ChoiceCare Health Plans, was a Health Maintenance Organization (HMO) which employed “utilization management” in order to ensure efficient and economical use of resources. One of the policies developed in this framework was the imposition of a two-day limit on hospital stay in connection with ovariectomy, though exceptions could be made for individual medical reasons. The specialist in obstetrics who examined the patient on October 2nd authorized her discharge from hospital in accordance with the two-day rule. Later that same day, while still in hospital, she began to experience pain, fever and haematuria. The nursing staff failed to inform the specialist of these complications and demanded that she leave the hospital that evening in accordance with the insurer’s two-day rule. The patient continued to suffer complications and brought civil proceedings in a state court against the hospital on grounds of malpractice, but also against the HMO, arguing that the malpractice was a consequence of the latter’s relationship with the hospital.

The defendants removed the proceedings to a federal district court on the grounds that the claims related to the enforcement to benefits and therefore fell under the Federal “Employee Retirement Income Security Act” (ERISA). This piece of benefits legislation contains no specific provisions relating to the provision of proper health care, and its application has sometimes in the past protected HMO’s from malpractice claims [2]; if a defendant can show that the plaintiff has received benefits under ERISA (e.g., by securing hospital care of some sort) the claim will fail. In the present case, however, the federal judge ruled in effect that this federal legislation only pre-empted state legislation in proceedings to enforce a patient’s rights under an employee benefit plan, and that malpractice claims against the health provider and insurer did not fall under this heading. For reasons which are not clear from the law report, the judge distinguished this case from an earlier one [3] in which the Sixth Circuit held that claims for medical malpractice indeed did fall under the Federal legislation. The ultimate result was thus that the Ohio case was remanded to state court, where the plaintiff was free to pursue her claim against both parties.

Although the legal technicalities differ across the world, an increasing number of countries have in recent years restructured their health financing systems and created bodies analogous to the Health Maintenance Organizations of the USA. Such bodies may or may not themselves own hospitals or clinics but irrespective of this they are commonly in a situation where they can influence directly and in detail the type, quality and quantity of health care for which an insured individual is eligible. It would be patently absurd if, where such provisions directly deprive an individual patient of proper, safe and reasonably necessary care, the HMO and its dependent institutions were to be shielded from malpractice claims. Although the law in the US is still being developed by the courts and is not homogenous [4], this Ohio judgement is one of a series which now appear to be opening the door to such actions in the USA.

References

- [1] Editorial: Medicating for a mirage, *Int. J. Risk and Safety in Medicine* **11**(1) (1998), 1–8.
- [2] *New York State Conference of Blue Cross and Blue Shield v. Travelers Insurance Co.*, 115 S.Ct. 1671 (1995).
- [3] *Tolton v. American Biodyne*, 48 5.3d 937 (6th Cir. 1995).
- [4] *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350 (3d Cir.), *cert. denied*, 116 S.Ct. 564; also *Rice v. Panchal* 65 F.3d 637.