Tidsskriftet Tidsskrift for Den norske legeforening

Medicine is debate

FRA REDAKTØREN

ERLEND HEM

Erlend Hem (born 1970) MD, PhD, is the Deputy Editor of the Journal of the Norwegian Medical Association.

In the trial following the 22 July attacks, the experts reached different conclusions. This is not a problem.

Photo Einar Nilsen

Over the last year, no single issue has had such an impact on us as the tragedy that struck the nation on 22 July 2011. The effects of the case have reverberated through society. Norwegian medicine was also put to the test, both the emergency life-saving treatment and the psycho-social follow-up of the survivors and their next of kin. However, it was forensic psychiatry that became the focal point. The expert report prepared by the psychiatrists Synne Sørheim and Torgeir Husby and submitted on 29 November 2011, reaching the conclusion of insanity, spurred an intense and lengthy debate. Oslo District Court subsequently appointed two new experts, the psychiatrists Agnar Aspaas and Terje Tørrissen, who submitted their report on 10 April 2012 – with the opposite conclusion. The main issue during the trial focused on this single question: Was the defendant of sound mind or not?

There appears to be a consensus that Norwegian forensic psychiatry came out of the trial with its reputation tainted. The forensic commission showed itself in a not very trustworthy light, but the most difficult issue to reconcile oneself with, was the fact that the two pairs of experts reached opposite conclusions. In the comedy show *«Nytt på nytt» («Have I got news for you»)* on NRK1, Knut Nærum described the problem very succinctly: «If I'm lying on the operating table and someone says «That liver must come out», I wouldn't want another

surgeon to come in and say «It's healthy, leave it there.»» (1). Anders Giæver, commentator in the *VG* daily, wrote: «The defenders of the profession speak warmly of the necessity for professional disagreement and academic dissent. This may be all well and good in scientific discourse and articles in medical journals, but we cannot let it determine the issue of guilt in Norwegian courts of law» (2).

Several others explained the alleged mishap by referring to how psychiatry is not an exact science (3). «Exact sciences» is a designation often applied to sciences where the problems can be addressed mathematically – such as mathematics, mechanics, physics, informatics and modern chemistry (4). Although this lexical list is not exhaustive, medicine as a science is not mentioned. Of course not. Medicine is not an exact science, and psychiatry is no exception.

The example of the diseased liver in *Nytt på nytt* was meant as a joke, but it could just as well have been taken from reality. However, there is no tradition of exposing doubt and disagreement on medical issues. Fair enough, one might say, as it would seem confusing and frightening to patients if doctors openly demonstrated all their doubts concerning diagnosis and treatment. In the old, patriarchal medicine there was no room for such things. The doctor decided, and he left little room for uncertainty and discussion. Nowadays, the patient's preferences should be given weight, but the patient will often tend to want a recommendation and a clear answer. A good colleague of mine says that being a clinician means making a number of decisions on a shaky basis every day. Well stated.

In one of the communication courses towards the end of their medical studies at the University of Oslo, the students have the opportunity to see how difficult it can be to relate to uncertainty and doubt. «A mother calls on you, a house officer in a rural community. She has a daughter who is eighteen months old, her first child.» The mother is anxious, she has a limited network, and there has been a case of meningococcal infection in an adjacent municipality. The case history indicates that most likely the child has a viral infection, and the house officer therefore sees no reason to hospitalise the child, which would mean a three-hour journey to the local hospital or five hours to the nearest paediatric department. Nevertheless, the doctor remains somewhat uncertain and worried as to how the situation might develop. Many students would want to hospitalise the child just to be sure, others point out that in this case the hospitals would soon be filled with children with conditions that are not serious. Good discussions often ensue, and valuable lessons are learned.

When we as doctors are in doubt, we often ask a colleague for advice. Oddly, we tend to use the English expression «second opinion» in this context. In reality, in appointing the second pair of experts, that was exactly what Oslo District Court did. So why did the opposing conclusions of the forensic psychiatrists cause such an outcry? In my opinion, the problem is the opposite: Our profession often allows too little room for discussion and disagreement. In law, disagreement has been institutionalised through three levels of jurisprudence: district courts, courts of appeal and the Supreme Court. Nobody thinks it is a scandal if the Court of Appeal reaches another conclusion than the District

Court. On the contrary, it tends to be regarded as a sign that the system is sound and working well. Even when no new information has emerged in a trial, the facts may be assessed differently than during the first hearing, and the balance of the arguments may have shifted. In law, debate has been made part of the system. The case should be elucidated to the greatest possible extent, and good documentation and argumentation are required to come out on top.

Of course, diagnostics may often provide a clear result: This is an obvious fracture, a definite infection or an unambiguous psychosis. But there may still be disagreement when it comes to treatment: Should we choose surgery or conservative treatment, should the patient receive antibiotics or not, should she be hospitalised or not? Medicine is full of such questions. Unfortunately, we often fail to address this disagreement very well, and often resort to rigid positions. The positions turn especially rigid when the documentation – and the argumentation – are weak. In my opinion, professional disagreement ought to be made part of the system to an even greater extent than today in medicine as well, as in law and the other non-exact sciences. This is the very essence of medical journals. There should not only be a discourse – there must also be a conclusion. Whoever documents and argues best comes out on top.

LITERATURE

1. Nytt på nytt. NRK1 13.4. 2012. www.nrk.no/nett-tv/klipp/840121/ (24.4.2012).

2. Giæver A. Psykiatrien i sentrum – igjen. VG 24.4.2012: 10. www.vg.no/vgpluss/article/CLxG10D (6.9.2012).

3. Madsen PA. Rapporten som åpner saken. Aftenposten 11.4.2012. www.aftenposten.no/meninger/kommentarer/Rapporten-som-apner-saken-6802303.html (6.9.2012).

4. Eksakte vitenskaper. I: Store norske leksikon. http://snl.no/eksakte vitenskaper (6.9.2012).

Publisert: 18 September 2012. Tidsskr Nor Legeforen. DOI: 10.4045/tidsskr.12.1007