Tidsskriftet Tidsskrift for Den norske legeforening

It could have been me

LIV-ELLEN VANGSNES

Liv-Ellen Vangsnes (born 1972) is editor of the Journal of the Norwegian Medical Association. She is a specialist in anaesthesiology and senior consultant at Østfold Hospital.

A young doctor in Denmark has been found guilty of gross negligence. She asked a nurse to measure a patient's blood glucose level, but failed to enter her request in the medical records.

Photo: Sturlason

A young doctor is on primary on-call duty one night in August 2013. A patient is admitted with abdominal pains which have been recurring over several months. On arrival the pains have subsided, and the man is fully conscious. The doctor reviews the patient's records and sees that he has insulin-dependent diabetes mellitus 2. She determines that his blood glucose level has not been measured on admission and asks a nurse to do this. It is not entered in the patient's records, and the nurse forgets to take the measurement.

The doctor fails to follow up on whether the blood glucose measurement has been taken, as it is normal practice to be contacted by the nurses if the result is *abnormal*. She emphasises in the records that the patient has diabetes and must receive his usual medication, which includes insulin before meals. The procedure is that nurses measure the blood glucose level before insulin is administered. The doctor does not discuss the patient with the backup surgeon on call, but before she goes off shift, she sees that he has prepared a treatment plan for the abdominal pains. The patient is transferred to a ward. The nurse in attendance there does not look at the doctor's notes from which it is apparent that the man had diabetes, and therefore the blood glucose measurement is not taken at that point either. The next morning the patient is found unconscious with a blood glucose level of 1.8 mmol/l. He remains in a coma and dies almost exactly one month later. The autopsy concludes that the cause of death is assumed to be severe brain injury as a result of hypoglycaemia (1).

Both the doctor on primary on-call duty and the backup surgeon on call were charged with 'gross or repeated negligence or carelessness in the exercise of their duties'. At the district court in Svendborg both were found not liable, but in the appeal case heard at the Eastern High Court in Copenhagen, the backup surgeon on call was found not liable, while the doctor on primary on-call duty was found liable. She resigned afterwards from her job as a hospital doctor.

The Danish Medical Association supports the woman, who has applied to have her case heard in the Supreme Court (1). Many doctors believe that this could have happened to them, and the Facebook campaign #Det KuHaVæretMig [#ItCouldHaveBeenMe] has also spread to Norway.

Everything possible must be done to learn from this event, so that nothing similar can ever occur again. However, choosing one individual as a scapegoat without rectifying the underlying causes does not make for a safer health service. It is alarming that this case, which shows that responsibility is laid upon the individual employee, comes at a time when healthcare personnel frequently feel themselves brushed aside when they warn of structural conditions that are a threat to patient safety. In this case it transpired that the hospital management had decided that nurses should no longer read patient records for *reasons of time-saving* (2). Three nurses were involved, but none of them had read the patient's records. The doctor on primary on-call duty, who was found liable for carelessness, was the only person who had actually read and acquainted herself with the patient's disease history before dealing with him. During the court hearing, the doctor therefore pointed out that the missing entry in the records was in reality irrelevant as none of those involved would have seen it (2).

This case is a tragic example of the possible consequences of 'efficiency measures' when employees' warnings go unheard. Paradoxically, at the time of writing an employment tribunal case is being heard in Norway in which doctors are fighting against being forced to work in broad contravention of the rules in the Working Environment Act.

In the Danish case it is essential to obtain an unequivocal legal assessment of whether the doctor's actions can be considered gross negligence or carelessness. If the judgment stands and the healthcare personnel are to comply with it, it will be difficult for them to perform their work in an appropriate manner and in the patient's best interest. Their daily work will be overshadowed by fear of making mistakes. Health personnel *must* be anxious not to make errors, but nothing is to be gained if the anxiety becomes overwhelming. Mistakes can also be made for fear of making them.

Also, it will in practice be impossible for doctors and nurses to collaborate in the manner to which they are accustomed. The doctor on duty may be responsible for several dozen patients. In the course of a shift we receive many telephone calls from nurses about patients that we do not know. We are often busy with an acute case and cannot leave, but much can be resolved there and then through verbal communication. This happens frequently and is crucial for rapid and appropriate patient treatment. If a doctor can be found liable for gross negligence for having given a verbal message without an entry in the patient records, we cannot continue to work as we do today. We must insist on relating to one patient at a time, in order for the smallest action to be immediately entered in the patient records. Patients and nurses will suffer, as they may need to wait for several hours for the doctor to attend in order to resolve a simple problem that might easily have been dealt with over the telephone.

Healthcare personnel are accustomed to thinking of the patient's best interest, but given the risk of being found liable for gross negligence, doctors and nurses may feel it necessary to turn the spotlight *away from* the patient onto themselves and their own security in the eyes of the law. What effect will this have on acute, life-threatening conditions when every second may count? In such cases nurses receive numerous verbal messages from the doctor in the attempt to save the patient's life. Will they dare to carry out anything that is not ordained in writing, even if it is urgent? Doctors cannot be continuously documenting in such situations. Saving the patient's life must take precedence over patient record entries.

We are in the same boat as our Danish colleagues, and this case does not only concern doctors, but everyone working in a hospital. Next time, it could be you.

LITERATURE

1. Ugeskriftet guider dig igennem Svendborgsagen. Ugeskr Laeger 2017; 179: 1609–700.

2. Svendborgsag HJ. Dømt læge var den eneste, der læste patientens journal. http://www.fyens.dk/modules/mobile/article?articleid=3194002

(19.10.2017).

Publisert: 30 October 2017. Tidsskr Nor Legeforen. DOI: 10.4045/tidsskr.17.0906