SELECTED LEGISLATION AND JURISPRUDENCE: NATIONAL

Danish Medical Doctor Reprimanded for Treatment of a Four Week-old Child following Reporting from the National Board of Health*

In Denmark a health professional disciplinary tribunal handles patients’ complaints concerning the health professional performance of those with an authorization from the Danish National Board of Health. The Disciplinary Tribunal is an independent, national, court-like construction. The case process is as follows.

After the complaint has been received from the patient concerned or the patient’s relatives about one (or more) named authorised health professionals, the case is clarified by the secretariat. All the involved parties receive a copy of the complaint and are subsequently allowed to receive copies of documents during the case management. The defendant is asked to produce a statement. All health professionals involved in the complaint case have a duty to provide any relevant information, including medical records, X-ray material etc. for the case management. A proposal is made for a decision: typically, in cases not only concerning patients’ formal legal rights, this proposal is based upon evaluations made by appointed experts. For instance, complaints against nurses are assessed by nurses and complaints about general practitioners are assessed by general practice specialists. The tribunal’s decision is made by a five-person committee comprising 2 public representatives, 2 representatives of the health profession concerned (e.g. medical doctors in cases concerning medical doctors), and a chairperson who is a judge. The disciplinary tribunal has the authority to issue a reprimand to the health professional (-s) concerned because the health professional has not come up to law requirements. In this regard, it is not to be considered whether the patient has received the best possible treatment but it is clarified whether the health care

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1) Up to 1 January 2011 the disciplinary tribunal was called ”Sundhedsvæsenets Patientklagenævn” according to the previous Act on Central Administration, 397, 10/06/1987. Now the tribunal is called ”Sundhedsvæsenets Disciplinærnævn” (see Act on Complaints and Compensations, 706, 25/06/2010). The handling of disciplinary issues is separate from compensation claims.
2) See e.g. Act on Complaints and Compensations, 706, 25/06/2010 and Rules of Procedure, 1447, 15/12/2010. There have been continuous revisions of the procedure.
provision is “within the norms of generally accepted professional standards”. The latter standards are closely connected to the legal obligation of health professionals to “...act carefully and conscientiously”. The tribunal’s decision about a reprimand (with an explanation) is sent to the complainant, the health professional(s) concerned, and the National Board of Health. Similarly, the employers and others affected by the complaint may receive a copy of the final decision. It is not possible to appeal the decision to other administrative authorities, although the case can be reopened if the tribunal receives additional significant information. Decisions may, however, be brought to the Danish Ombudsman or before the Danish courts. This very rarely happens; hence, in 2007 no disciplinary decision was brought before the Danish courts.

Almost all cases brought to the disciplinary tribunal are initiated by complaint letters from patients or their relatives; the complaint case handling is financed by the municipalities and there is no fee for lodging a complaint. The option remains, however, for the Danish National Board of Health to report a case and request it to be assessed with regard to whether the issuing of a reprimand to the health professional is justified. In 2006, 70 out of 3381 (approximately 2 percent) of tribunal cases were such requests. Below is summarised the case of an infant suspected of being physically abused which was considered to have been disregarded by the medical doctor in question resulting in a National Board of Health’ reporting and subsequently a disciplinary tribunal’s reprimand.

1. The Facts

On 20 May 2007 the Danish disciplinary tribunal made public a decision concerning a medical doctor reprimanded for out-of-hours primary healthcare concerning a 4-week-old infant. The reprimand was founded in the Danish Act of Authorization of Medical Doctors, para. 6, requiring medical doctors to exercise “carefulness and conscientiousness” in connection with provision of health care.

According to the medical records, the course of events was as follows. On 4 November 2005, a 4-week-old female infant was brought to the out-of-hours services because of “rattling” breathing. She was “weedy” and additionally there were crackling chest sounds when breathing. Furthermore the girl had bruises on both cheeks and 2 cm large red spots on the chest. Her breathing was rattling,

4) See Act on the Ombudsman Institution, 473, 12/06/1996, para. 7 and the Danish Constitutional Law, (“Grundloven”), paras. 55 & 63.
8) Case 0761720, available in Danish from www.pkn.dk.
but, according to the attending doctor’s recording in the medical record, auscultation with a stethoscope was normal and there was no fever. The medical doctor recommended that the parents contact their general practitioner during daytime in case additional bruising should arise. No further precautions were taken.

Subsequently, via other means, the girl was admitted to the paediatric ward. The paediatricians considered her symptoms to possibly be due to physical abuse. The Danish National Board of Health was informed. Subsequently, by letter dated 2 June 2006, the Board brought the medical doctor before the national disciplinary tribunal.

2. Legal Procedure

In the medical doctor’s own defense, he stated that he remembered the patient because of the unusual bruising. He did not find that there was an acute need for treatment and therefore concluded that any further treatment should be carried out by the child’s own general practitioner.

The disciplinary tribunal maintained that bruising in a 4-week-old infant is very unusual and likewise that puffing respiration should raise the suspicion of lung disease. The tribunal maintained that the sequence of events from the primary symptoms until serious illness in infants is often very short, and that unusual symptoms, although the diagnosis cannot be made, should justify considerations as to whether acute hospitalization for observation is needed, even though the child is not deeply affected.¹⁰

By way of conclusion, it was the tribunal’s opinion that the medical doctor in view of these observations should have admitted the infant to hospital for monitoring in the paediatric ward. The tribunal therefore decided to issue a reprimand because the medical doctor had not come up to Danish legal requirements in the emergency medical service, thereby concluding that the medical doctor on 4 November 2005 “performed below the level of generally accepted professional standards”. The decision was not brought before the courts.

3. Perspectives Regarding Medical Doctors’ Legal Obligations

The case maintains the intensified attention which is associated with the provision of health care to children presenting with unusual and perhaps acute illness

¹⁰ It was, however, not explicitly mentioned in the published decision that the Danish National Board of Health had issued an Announcement concerning Assessment and Triage of Acutely Ill New Born Infants (Copenhagen, 2002). According to the latter announcement, “…acutely ill children, particularly during the first year, should on broad indications be seen by a medical doctor and during the first months additionally should be referred to pediatric hospital on wide indications”. 
which in addition could indicate suspected physical abuse. In case of health professional disregard, disciplinary proceedings might be commenced on the health care authorities’ own initiative.

Under the Convention on the Rights of the Child,11 countries are bound to address child maltreatment. This is clearly stated in Article 19. In this connection measures should be implemented to, e.g., treat, investigate, and report instances of child maltreatment. Accordingly, in most countries, notification of the municipality services is mandatory when suspicion of child maltreatment is raised. Denmark ratified the Convention in 1991 implying an adjustment of Danish national rules of law and administrative practice in conformity with the Convention. Below are discussed the duties of general practitioners and other medical doctors in cases of suspected child maltreatment in context of the decision mentioned above.

3.1. A Three-Step Approach to Child Maltreatment

Due to the nature of the profession, health professionals and not least general practitioners have particular obligations when children present with various signs of troubles for which they need help.12 Hence, the regular interaction between parents and children on the one hand, and the general practitioner on the other provides a particularly indispensable opportunity to detect and intervene in child maltreatment.13 The protection from maltreatment may be described in terms of a three-step process: a) assessing whether e.g. acute health care provision is necessary, b) detection of maltreatment, and c) deciding whether a notification should be made (immediately or later).

3.1.1. Provision (of Health Care)

Providing the health care necessary should be a top priority. In this regard, the health professional should rely on professional knowledge, practical skills, and sound reasoning. With regard to the 4-week-old girl, a thorough physical examination allegedly had been performed, yet the conclusions drawn by the medical doctor were deficient. The assessment of whether further health care should be (e.g. acutely) provided must be carried out with a wide margin of safety in favour of the child’s well-being.14 This requirement was not fulfilled in the case presented. Indubitably, the unusual bruising in a newborn infant with puffing respiration should result in referral to the paediatric ward in order to rule out any acute, potentially life-threatening situation. Referral might be based upon e.g.,

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12) See the introduction of Danish Ministerial Order (DMO), 9350, 18/04/2006.
14) See the abovementioned Announcement concerning Assessment and Triage of Acutely Ill Newborn Infants (2002).
suspected fractures of the ribs, an imminent complicating pneumonia, a suspicion of disordered haemostasis or, simply, an impending respiratory failure. Principally, in this situation, the provision of necessary and perhaps life-saving health care in connection with clarification of the nature of the illness comes first.\textsuperscript{15}

3.1.2. Detection
Different algorithms, flowcharts, and checklists have been created in order to operationalise the detection of child maltreatment. One example is suggested by Benger and Pearce.\textsuperscript{16} "The latter suggestion implies a flow chart according to which cases suspected of child maltreatment are stratified into high and low suspicion injuries based upon information on treatment-seeking delay, history consistency, injury explanation, and objective clinical findings (behaviour and interaction). Such instruments might possibly help improve detection and help to children suspected of intentional injuries and maltreatment — not least in cases of physical abuse."

In the case presented above, the failure to thrive manifested itself in very clear-cut ways (signs of battered child and impending respiratory failure). As concluded by the disciplinary tribunal, this required immediate action to be taken through an acute referral for specialised assessment by paediatricians. Needless to say that health care workers are not appointed 'detectives' with regard to discovering child maltreatment but at least medical doctors ought to be familiar with particular indicators of child abuse (e.g. bruises are rare in infants until they start to crawl).\textsuperscript{17}

3.1.3. Notification
It follows from Danish law that all citizens are obliged to inform the municipalities if obtaining knowledge about children being subject to neglect or humiliation or living under circumstances which put the child's health or development into risk.\textsuperscript{18} In addition, a public employee or health care worker has a particular duty to notify the municipalities in case he or she, in connection with provision of health care, obtains knowledge of — or has grounds for — suspicion that a child under the age of 18 needs support or being subjected to e.g. violence or other

\textsuperscript{15} Cf. UNCRC, Convention on the Rights of the Child which was adopted by the United Nations General Assembly in 1989, Article 24.


\textsuperscript{18} Act on Social Service, 904, 18/08/2011, para. 154. It explicitly follows from Danish Ministerial Order (DMO), 9350, 18/04/2006, subsection 1 that the provision concerns “very serious matters including physical or psychological violence, sexual abuse, maltreatment, neglect etc”.

kinds of abuse.19 The duty to notify comes into force when there is no reasonable possibility through means of the medical doctor’s own measures in due time to satisfactorily solve the child’s problems through, e.g., guidance of the parents or the child concerned.20 In those instances where report is necessary, consent to notification should be obtained in advance if possible.21 In accordance with a previous disciplinary case decision a medical doctor cannot rely on the possibility of the troubles being managed by other persons or by, e.g., referring the child concerned to the police or the patient’s daytime general practitioner.22 In that case, the obligation to report received specific attention from the National Board of Health.

The grounds for suspecting and subsequently reporting suspicions of abuse rest on a thorough evaluation which probably requires more than just a “gut feeling”. On the other hand, no exact lower limit can be established.23 The aforementioned algorithms might provide some guidance. However, any benefit of doubt should be weighted in favour of the child thereby applying a burden on health professionals to safeguard the welfare and protection of the child rather than protecting, e.g., the parents.24

It is acknowledged that the duty of health professionals (and other officials) is more far-reaching than the common obligation of citizens to report.25 The magnitude of the duty is, however, not clearly demarcated and, as maintained above, rests on a concrete assessment. Certainly a grey zone exists between just ‘imperfect’ upbringings, “simple” manifestations of neglect, “domestic quarrels”, and the absolute terrible childhood marked by neglect, violence, sexual abuse etc. Anyhow, instances where the situation has resulted in treatment-seeking

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19) Act on Social Service, 904, 18/08/2011, para. 153. See also Danish Ministerial Order 1466, 16/12/2010. According to the previous Danish Ministerial Order 1092, 08/12/2000, mandatory notification both concerns cases were physical or psychological functioning is threatened.

20) Danish Ministerial Order, 9350, 18/04/2006, subsection 2.2.

21) Ibid.

22) Ibid., see also case 0340408, published 20 October 2003, www.pkn.dk; and commentary in Mette Hartlev, Fortrolighed i sundhedsretten et patientretligt perspektiv (Confidentiality in health care — a patients’ rights perspective) (Thomson, Copenhagen, 2005) p. 574. A residential doctor was brought by the Danish National Board of Health to the disciplinary tribunal and criticized for not reporting parents’ physical assaults on a 16-year-old daughter to the municipalities according to the former Act on Social Service, 755, 09/09/2002, para. 35 (now Act on Social Service, 904, 18/08/2011, para. 153) and the former Act on Medical Doctors, 272, 19/04/2001, para. 11. The girl presented in the emergency unit with bruises in her face, on her arms, ribs, and hip. The residential doctor considered that the bruises might have been traumatically caused and ordered a chest x-ray which revealed no fractures. The doctor considered that the girl should seek her family doctor the next day and contact the police. The disciplinary tribunal maintained that “...the girl had numerous traumatic bruises and the residential doctor should have notified the municipalities about his observations and the information he had during the consultation”.

23) Ibid., subsection 2.1.


behaviour might strongly indicate that the point has been reached where notification should be considered.\textsuperscript{26}

Within the grey zone, factors pertaining to either the child itself or factors pertaining to the surroundings (namely parents) may speak in favour of considering a notification. Children’s manifestations of failure to thrive are various. Among the more special cases, it has been recommended that guidelines should be made for medical doctors to seek assistance from the municipalities in cases of, e.g., severe childhood obesity thus considered as a sign of severe parental neglect. Alexander et al. previously reported on an Australian case of extreme child obesity with secondary arterial hypertension and obstructive sleep apnoea, where intensive voluntary measures had no effect.\textsuperscript{27} Subsequently, the child protection authorities were notified and the child had intensive community-based support which proved beneficial in terms of — not least rapid weight reductions. It might be argued that when developing for example serious obesity-related disorders, e.g. the child convention’s requirement for safeguarding “The development of the child’s . . . mental and physical abilities to their fullest potential”\textsuperscript{28} is substantially violated and such extreme cases might possibly fall within the area of the Danish Act on Social Service. Correspondingly, with regard to parenthood factors indicative of a need for notification, a previously published decision made by the Danish disciplinary tribunal confirmed a psychiatric senior registrar’s notification of the municipalities about a schizophrenic mother’s presumed neglect in relation to her 8-year-old daughter.\textsuperscript{29} The mother was considered not to have any insight in her illness while, more generally, the family resources where limited and so was their social network. Hence, according to an overall evaluation, notifying the municipalities was not a violation of the legal confidentiality claim.

4. Perspective Regarding Ethics

Confidentiality is considered of major concern in the patient-doctor relationship.\textsuperscript{30} Generally, according to Article 8 of the European Convention of Human Rights (ECHR), “Everyone has the right to respect for his private and family life.”\textsuperscript{31} Likewise, in the Council of Europe Convention on Human Rights and

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\item \textsuperscript{26} Cf. the case 0340408 mentioned above.
\item \textsuperscript{28} See UNCRC, Convention on the Rights of the Child, resolution 44/25 (1989), Article 29.
\item \textsuperscript{29} The notification was carried out in accordance with the former Act on Social Service, 755, 09/09/2002, para. 35 (now Act on Social Service, 904, 18/08/2011, para. 153). See case 9914203, www.pkn.dk.
\item \textsuperscript{31} Council of Europe: The European Convention on Human Rights, Rome 4 November 1950.
\end{itemize}
Biomedicine, the right to private life and private information is explicitly stated in Article 10. Anyhow, specifically, according to e.g. the Council of Europe Recommendation R (97) 5 on the protection of medical data, section 7.3.b., health care information may be communicated without an explicit consent if “...permitted by law for the purpose of... safeguarding the vital interests of the data subject.” Correspondingly, according to Danish law, patients have the right to confidentiality and consent must be obtained before disclosure of private information in connection with health care. Information may, however, be communicated in specific cases if permitted by law. This pertains to for example the situation of mandatory notification.

It is not a big problem when the child and its parents consent to notifying the municipalities, yet specific issues may arise with regard to e.g. whether the child and parents realize the possible consequences of this type of consent. When there is no consent to notifying the municipalities, patient-doctor confidentiality especially comes under pressure. Mandatory notification might have drawbacks if wider categories of children needing health care, due to the risk of a notification, refrain from visiting their general practitioner or, perhaps even more importantly, do not seek emergency health care. Correspondingly, in addition to the risk of harming the patient-doctor relationship, there is also the risk of harming the relationship with family members and the risk of misjudging the situation. Likewise, the health professional may fear that referral for paediatric intervention or notification may only worsen the situation for the involved parties and that there are no appropriate measures available for the municipalities to follow-up on a notification. Mandatory notification especially may clash with the interest of providing the health care necessary and there is certainly no guarantee that a notification will always improve the child’s situation.

5. Conclusion

In the disciplinary decision presented, a medical doctor was considered to have disregarded a 4-week-old girl presenting with physical signs which should at least have resulted in an acute referral for hospitalisation. Acute assessment by paediatric experts was needed and the absolutely most reasonable (and least intrusive measure) was to refer the infant for acute investigation and treatment at the paediatric health care unit. Referral could be reasoned in a suspicion of acute

33) Council of Europe, Recommendation R (97) 5 on the protection of medical data.
disorder of breathing. It is likely that, sooner or later, the municipalities should be informed.

Current regulation and guidelines both provide health professionals with directions on how to manage suspected child maltreatment and warrant action to be taken when necessary. Focus is directed towards the matter-of-fact management of crucial and sometimes acute signs of failure to thrive and the importance of taking such signs seriously. In many cases, the very first step implies the child to be more or less acutely referred to professional assessment (typically during hospital admission) in order to further clarify the child’s health situation. Such clarification may also provide important evidence if notification of the municipalities is required. In any case, in such situations the health professional’s fulfilment of duties, including safeguarding of crucial health care in due time, should be expected to receive an intensified attention from the health care authorities.

S.F. BIRKELANDa) and D.E. JARBØLb),* 

a) Research Assistant, Research Unit of General Practice, Institute of Public Health, University of Southern Denmark 
b) Associate Professor, and General Practitioner, Research Unit of General Practice, Institute of Public Health, University of Southern Denmark, Odense, Denmark