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The doctor as an administrator of legislative rules

EDITORIAL

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Is it possible for health personnel to comply with all legal requirements? Yes, provided that the regulations are based on sound medical knowledge.

Law is a field of expertise whose basic principles we as non-lawyers should be reluctant to challenge. The respect for expert, discipline-based knowledge so indicates. Nevertheless, clinical work these days is not only a matter of medical knowledge and interaction with the patient. In clinical practice, many decisions are in fact legal ones.

When the hospital doctor decides that the patient is entitled to necessary health care on the basis of a referral from the regular general practitioner, this decision has legal force for the patient. The general practitioner's assessment of what type of drug should be used for treating hypertension will often end in a decision that will give the patient a legal claim for reimbursement of certain costs associated with the treatment. The choice of what information to enter in the patient's record is based on the health workers' understanding and interpretation of the relatively detailed legal requirements for record-keeping. Not least, in every encounter with a patient, health workers must act in accordance with the legal requirements for professionally defensible conduct. This indicates that health workers in general, and especially doctors, must possess a certain modicum of knowledge about legal matters.

As academic traditions, law and medicine have a shared ground in facing practical problems. However, they face these problems in very different ways. Olav Molven refers to the lawyer's approach as *normative rationality* (1). In this case, the practical challenge is held up to pre-defined legislative rules, and an appropriate decision is

reached through reasoning. On the other hand, Molven refers to the health worker's approach as *purposive rationality*. The doctor's decision is based on what is best for the patient. Occasionally, these two logics of decision-making may come into conflict.

This issue of the journal contains an article that elucidates this point (2). By using constructed case histories, the authors have investigated how various groups of medical practitioners apply the guidelines for ultrasound examinations during pregnancy (3). Furthermore, they have compared the doctors' assessments with assessments made by a smaller group of executive officers in the Directorate of Health. The authors document that the doctors only comply with the guidelines to a limited extent. They also report that these guidelines are interpreted differently by doctors and administrators. Even though these findings are not unexpected, and do not originate in actual practice, there is ample reason to subject them to a closer discussion.

In recent decades we have seen a huge increase in legal claims to the provision of health services. In some ways this is a good thing, because it has clarified the patients' rights and resulted in increased predictability. However, the increased legal demands have served to restrict the discretionary judgement that health workers may exercise in their encounter with the patient (4). Out of concern for the legal protection of patients, including an intention to prevent unwarranted inequality of treatment, the authorities have added a sprinkling of guidelines and manuals in various forms. It is consequently interesting to take a closer look at the legal status of these documents, that is, how binding they are with regard to medical practice and the exercise of discretionary judgement by doctors. In a letter to the Norwegian Association of Regional and Local Authorities (KS), the Ministry of Health and Care Services has provided a statement (5). Here they point out that the claims embedded in the legal acts, meaning laws and regulations, as a matter of course will have a binding effect. Furthermore, however, they point out that national professional guidelines will constitute a natural basis for any assessment of what should be deemed professionally defensible in each individual case. Further on, the letter states that *national professional guidelines establish professional norms, while a manual contains advice and guidance*. It is ascertained that in cases where service providers choose a practice that significantly deviates from what the guidelines and manuals propose, this should follow from a specific and amply justified assessment.

With regard to clinical practitioners, I am of the opinion that this boils down to the following mini-course in legal methodology:

- Wherever the rules proclaimed by the letter of the laws or regulations define specific solutions, the doctor should abide by these. Then, the doctor needs to make a decision on the basis of normative rationality. Examples include the rules for record-keeping and the duty to report.

- Wherever the rules allow for expert medical assessments, the doctors can base their decision-making process on purposive rationality. The challenge will be to demonstrate that this purposive rationality has a solid medical foundation. Furthermore, in a public service one must be certain not to provide unequal treatment by offering the service to some but not to others without having a professionally sound reason for doing so. The requirement for defensible practices is the best example of such rules.

The study undertaken by Kjerstine Røe and collaborators indicates that more professional guidelines alone will be insufficient to ensure proper compliance with key legal requirements. In their decisions, doctors place great emphasis on the consequences for their patients. Good health legislation must therefore be based on realistic medical and social assumptions. In this way the regulations can provide a good framework for the provision of services and ensure predictable conditions for the patients as well as the service providers. It is self-evident that the legislative acts must be supplemented with good examples of how they can be complied with in practice. This is where the guidelines and manuals come in. To have an effect in practice, it may be worth investigating whether such documents could constitute a meeting-point for decision-making forms of logic based on normative rationality and purposive rationality. If so, the documents must be prepared on the basis of health science and not only appear as legal interpretations of the regulatory framework. In the letter from the Ministry of Health and Care Services referred to above, the authorities are heading in exactly this direction by saying that *the Ministry further presumes that key academic communities as well as users such as the municipal sector should be actively involved in the preparation of these documents*.

In its elaboration of the guidelines for prioritisation the Directorate of Health has also taken the same approach in recent years. It will be intriguing to see whether this approach will ensure compliance with professional guidelines issued by the central authorities.

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