

This issue of the Journal of the Norwegian Medical Association presents two articles based on data from the Norwegian System for Patient Injury Compensation – a resource for learning that could be better utilised.

What can we learn when the government pays for our errors?

The Norwegian System for Patient Injury Compensation (NPE) is a government agency ensuring that patients may receive compensation for errors committed in the health services. The error must have caused injury to the patient, who must also have sustained a financial loss. In some cases patients may be granted compensation even when no error has been committed, provided that the injury is especially unexpected or substantial (1).

This issue of the Journal of the Norwegian Medical Association presents two articles that raise the question of how data from the NPE may also provide knowledge about medical practice. The article by Alfsen and collaborators discusses diagnostic errors in the field of pathology (2). Kongsgaard and collaborators investigate neural injuries in anaesthesiology (3).

Both articles show low figures for claims upheld in relation to the total number of pathology tests and blockades. There is reason to believe, however, that a considerable number of cases go undetected. Data from the NPE provide a limited basis for drawing conclusions regarding the real frequency of errors that cause patient injuries. Effective diagnostics and treatment of serious conditions may only be proven after the fact to have been undertaken on an incomplete basis or to have given rise to an unpredictable injury – meaning that no error was committed at the time. Most of these cases will not be relevant for the NPE. When errors have been committed, an application will only be accepted if the patient has sustained a loss in excess of NOK 10 000 (NOK 5 000 before 1 January 2016). The effect of this may vary when it comes to what injuries are reported and the size of the compensation for different patients with the same injury.

The NPE is a low-threshold option that is free of charge. The therapist's duty to inform about the NPE was reaffirmed in 2014 – information must be provided to anyone who has sustained an injury or an uncommon, serious adverse effect (4). Cases will nevertheless occur where the patient is unaware that an injury has been caused by an error, the injury becomes evident only after completion of the treatment, or the patient chooses not to apply.

Alfsen and collaborators have studied summaries of de-identified cases from the NPE's casework (2). The material provides a good indication of the types of errors that entail especially serious consequences in pathology, although it may be difficult to draw any conclusions regarding the relative frequency of the different types of errors. Errors associated with false-positive diagnoses or overdiagnoses will rarely be reported because they tend not to result in injury, even though they may entail extra inconvenience and worry.

Human error must primarily be combatted at the systemic level, with the aid of better routines, new technology and more double-checking, if appropriate. Alfsen and collaborators point out that each case in which the claim for compensation was upheld cost society approximately NOK 1 million (2). Some of this money could have been spent on hiring more pathologists in our laboratories – not only with a view to reducing the number of cases and compensation payments, but primarily to reduce the ensuing disease and suffering.

When it comes to cases processed by the NPE involving neural injury after spinal or epidural anaesthesia or peripheral nerve blockade (3), we also need to take sources of error into account. Sparse documentation may complicate a decision on whether or not an error has been committed. Afflictions associated with muscular, neural or skeletal pain and minor outcomes may be uncharacteristic and part of normal and variable conditions in the general population. Neural injuries may be a result of the surgical procedure itself – instruments and tissue oedemas in the area may cause compression injuries, and some damage to small and sometimes even large nerve fibres may occur. Lying still on an operating table for many hours may in itself cause nerve compression injuries, despite comprehensive routines for prevention.

Although the NPE data have some limitations when it comes to interpretation of frequency, degree of seriousness and tendencies, nearly every case will represent a lesson to be learned. Simplified routines and regulations for the protection of privacy might improve the opportunity to investigate especially serious cases in greater depth. Strict Norwegian requirements for consent are a clear hindrance in this respect, thus having the effect of turning the NPE into one of many underutilised sources of data for Norwegian research (5). In addition, the epidemiological aspects need to be seen in a critical perspective, preferably by including data from other sources: academic literature, reporting of adverse events, and statistics from the Knowledge Centre for the Health Services, the Norwegian Board of Health Supervision, the Norwegian Patient Registry and others.

There is every reason to encourage others to elucidate safety and quality in treatment and diagnostics by delving into the abundant records of the NPE. The two reports in this issue of the Journal of the Norwegian Medical Association may serve as an inspiration for such efforts.

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