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Oversight of legality in health care

The Ombudsman's power

The Ombudsman oversees public health care. What is involved is above all implementation of the adequate health services that Section 19.3 of the Constitution guarantees as fundamental rights. The Ombudsman's power does not extend to her overseeing privately practising professional health care personnel, such as private doctors, nor to overseeing private producers of health care services, either, except when a municipality or joint authority outsources services from them. Involuntary psychiatric hospital treatment is an important area of oversight of legality.

Treatment is evaluated in oversight of legality also in the light of medical and dental science, for which reason the Ombudsman has before reaching her decision consulted experts, generally from the National Authority for Medicolegal Affairs and since 1.1.2009 a new agency called the National Supervisory Authority for Welfare and Health (Valvira).

In what kinds of health care-related matters do people turn to the Ombudsman?

Complaints concerning health care have traditionally related to the patient's right to good care and to be treated well, the patient's right of self-determination and right to receive information as well as to patients' medical records and their confidentiality. Complaints to the Ombudsman concerned especially these matters before the Act on the Status and Rights of Patients, the Patient Act for short, and the Patient Injury Act were added to the statute book. Because there was still no legislation on patients' rights, it is understandable that an answer about these rights was sought from not only the supervisory authorities for health care, but also from the Ombudsman. The availability of health services has come strongly to the fore in complaints in the years since the 1995 revision of the fundamental rights provisions in the Constitution.

Only the question of patients' right to have sight of their own medical records would seem to have lost its topicality. This is done now, unlike in the 1970s and still in the 1980s. It is, however, true that in some health care operational units one can still encounter the old practice of not giving patients themselves information about their mental health or psychic symptoms or restricting the provision of this information without a legal basis for doing so. Practices like this are not lawful (1783/05 and 1098/07).

By contrast, problems associated with entries in medical records are still very topical indeed. Over the years, deficiencies in the entries made in medical records by health care units and their personnel have continually been observed in the course of oversight of the legality of health care. Often, entries indicating what explanation a patient has been given about matters relating to treatment are completely absent. The same has happened with the reasons given for treatment decisions: there is no entry in the records stating why a Do Not Resuscitate (DNR) decision has been made for a patient or why the patient's medication has been changed. Consultations and discussions of treatment have also often not been entered in the records. In addition, there have been especially many shortcomings in entries relating to discussions with the patient and his or her relatives for the contingency that the patient would no longer be able to decide independently on treatment-related matters.

In some cases examined, the entries that had been made in patients' medical records were so inadequate that it was not possible on their basis to evaluate the content and implementation of the patient's treatment. Because the entries were flawed, the supervisory authority for health care was unable to give the Ombudsman the statements on medical or dental aspects that she had requested from them and she was unable to assess whether the patient had been given high-quality health care and medical treatment in accordance with the Patient Act (101/05, 995/05 and 26/06).

The purpose of medical records is to assist in planning, implementing and monitoring the advice and treatment that the patient is given. Adequate, appropriate and error-free entries clarify and strengthen the legal security of patient and staff in addition to promoting the development of trusting treatment relationships. These records are important also from the perspective of a patient's right to information. It is on the basis of medical records that the appropriateness of the actions performed by the professional staff who have participated in treatment is assessed and also whether any harm that treatment may have caused must be compensated for as a patient injury. Medical records are important also in health care-related research, administration, planning and teaching. The regulations on drafting medical records are clear,

unambiguous and precise. Complying with them ensures that the provision of adequate health services that is a constitutionally guaranteed fundamental right is implemented.

Deficient medical records have proved such a major problem that the Ombudsman has asked the National Supervisory Authority for Welfare and Health to take the measures that are essential in the matter (2828/07).

According to the Patient Act, a patient has the right to receive, without discrimination, the high-quality health care and medical services that his or her state of health requires and to be treated well. It has been observable on the basis of complaints that a patient's state of intoxication has affected his or her access to treatment and the way that he or she has been treated (1147/04 and 632/06). Intoxicated patients with mental problems have not been admitted to psychiatric hospitals for examination despite having been referred for observation. Patients like this have been refused entry to the hospital and told to go home or else to the police cells to sober up. However, intoxication must not prevent appraisal of a person's need for treatment or the arrangement of treatment. Nor may intoxication prevent a person from receiving good treatment and being accorded courtesy and fairness. Intoxicated patients' right to care and equitable treatment often becomes a critical issue in the actions of emergency response centres. It emerged in the course of investigation of one complaint that emergency response centres do not have a set of guidelines issued by a health care authority to assist in evaluating the risk to the health of an intoxicated person and the need for help (529/06).

In oversight of the legality of health care, the question in the only case to date that has led to a prosecution concerned consent and the right of self-determination. The Ombudsman ordered a state prosecutor to lay a charge against a dentist specialising in oral surgery in a central hospital for negligent breach of official duty. The specialist had in the course of performing his official duty extracted all of a legally incompetent person's teeth while the patient was under an anaesthetic without hearing the views of the person's legal representative or family and obtaining the consent of such a person for the procedure. Taking the nature of the dentist's action into consideration, it was not possible to be content with a reprimand by the Ombudsman as the only sanction in the matter. The extraction of all of a patient's teeth meant an irrevocable measure for the patient. Assessed on the whole, the deed was not minor considering the inconvenience and damage it had caused and other factors associated with it (2447/04).

Availability of health services has assumed prominence in recent years

The availability of health services, a patient's right to treatment and a municipality's obligation to arrange health services are questions that the Ombudsman has in recent years repeatedly had to respond to in individual cases, but also on a more general level. Health is an important matter and obtaining treatment when it is needed can be a question of life or death. Health services inspire popular discussion and their implementation in accordance with law prompts questions. People have become increasingly aware of their rights also as patients.

One reason why questions concerning the availability of health services have assumed central prominence in oversight of legality is that they involve fundamental rights. Economic, social and educational rights were enshrined in the Constitution when its fundamental rights provisions were revised in 1995. Section 19.3 of the Constitution obliges the public authorities, i.e. the State and municipalities, to provide, in accordance with what is set down in an Act, everyone with adequate health services and to promote the health of the population.

Another matter that makes growing numbers of people turn to the Ombudsman in these questions is the fact that treatment decisions are not of the kind that leave open the possibility of appealing against them. However, treatment decisions are doctors' decisions in the meaning of Section 22 of the Act on Professional Health Care Personnel: it is a doctor who decides a patient's need for treatment, how it is examined as well as diagnosis and treatment of the illness.

On the basis of complaints, the Ombudsman has adopted positions on questions that include the following: Is it up to a municipality to arrange odontological treatment for children? Have people in the municipalities participating in the Helsinki Uusimaa Hospital District received the special medical care in the way that the law requires? Do the solutions that various municipalities have made with respect to medical rehabilitation equipment safeguard people's right to treatment? Have municipalities arranged dental care in the way that the law requires now that the obligation to arrange it covers the entire population? Should a patient with Fabry disease be treated in public health care? Are the obligations of the Treatment Guarantee (which sets limits for treatment waiting times) being fulfilled?

In complaints concerning the availability of health services, a solution has been sought to also such questions as those in which clear and contentually correct statements of position from the administrative sector and guidance in accordance with them would have been

essential and appropriate. One example of this is implementation of the dental treatment reform, something to which I shall return later. However, the Ombudsman cannot as an overseer of legality assume the task of directing health services (Comment by the Ombudsman in the 2003 Annual Report).

Odontological treatment for children

It was observed in the course of investigating complaints concerning odontological treatment that there was uncertainty and divergent views as to whether arranging it was included in a municipality's statutory tasks. It was also obvious that there were big differences from one municipality to another in the availability of this treatment.

It was noted in decisions on these complaints that odontological treatment, when it is done for health reasons, belongs to oral hygiene care in the same way as care of hard dental tissues and connective tissues and that the ground for receiving odontological treatment must be the need for treatment reasoned in the light of dental and/or medical science that the patient's state of health requires. Thus what is involved is a statutory task belonging to those that a municipality is obliged to arrange. To ensure the availability of these services on an equitable basis, the Ombudsman believed it would be desirable to issue a decree regulating the measures, including odontological treatment, that are necessary from the perspective of good dental care of especially children and adolescents. What she saw as the minimum requirement was a set of national recommendations for odontological treatment. She informed the Ministry of Social Affairs and Health of this opinion (2150/98 and 1155/01).

Uniform principles for non-urgent odontological treatment in basic health care were drafted in conjunction with the legislative amendments concerning the Treatment Guarantee that entered into force on 1.3.2005. Preventive oral treatment for children and adolescents is regulated under a Government Decree (380/2009) in force since 1.7.2009.

Helsinki Uusimaa Hospital District (HUS) decision

A complaint was made to the Ombudsman that the municipalities participating in HUS were continually under-budgeting for special hospital care.

On the basis of reports received, a suspicion seemed to exist that the participating municipalities had not appropriated sufficient funds to ensure that residents would have received, in addition to urgent treatment, also other necessary special medical treatment. The appropriations available at any given time appeared to be intended to regulate waiting periods for non-urgent treatment. The Ombudsman found it clear that people's fundamental right to

adequate health services can not generally be implemented when waiting lists are unreasonably long, with some people waiting for as much as over a year. The municipalities should therefore make adequate appropriations for, in addition to urgent, also non-urgent special medical treatment. The Ombudsman pointed out that the Rule of Unity in financial planning applies to also hospital districts.

The Ombudsman underscored that the mention of resources in Section 3 of the Patient Act does not limit the obligation to arrange health care and hospital treatment to the resources available at any given time. A municipality's statutory duty to arrange health care and medical treatment has not been intervened in through the Patient Act. This duty is imposed on municipalities by the Primary Health Care Act and the Act on Specialised Medical Care, under which services must be arranged in such a way that all municipal residents are provided with, in addition to urgent treatment, necessary non-urgent treatment. The Ombudsman informed HUS and its participating municipalities of her opinion that they are obliged to arrange both the urgent and the non-urgent special medical treatment that residents of the participating municipalities need within a period that is on a regionally equitable basis and reasonable.

In addition, the Ombudsman informed the Ministry of Social Affairs and Health of her view that the responsibility that hospital district authorities and their participating municipalities bear with respect to treating patients should be regulated with greater clarity and in finer detail than at present. The shortcomings in the legislation on arranging special health care are conducive to making implementation of fundamental rights – adequate health services safeguarded on an equitable basis – more difficult. In the view of the Ombudsman, a more precise definition in the Act of the extent and standard to which basic health care services must be made available to all on a basis of equality everywhere in the country would help better ensure that people's rights regarding equitable and adequate health services are safeguarded (488/00).

Legislation on health care was indeed explicated to safeguard availability of treatment through amendments that entered into force on 1.3.2005. Time limits for access to treatment, the obligation when they are exceeded to procure treatment elsewhere without change in the charge the client must pay as well as the requirement that treatment be provided on uniform medical and dental grounds were enshrined in the Primary Health Care Act and the Act on Specialised Medical Care. The responsibility that a hospital district authority bears for a patient's treatment was written into the Act on Specialised Medical Care: When a patient has been sent to receive special medical treatment, the responsibility for the patient is transferred to the hospital district authority. The legislative amendments concern-

ing the Treatment Guarantee have helped explicate the obligation to health services that municipalities and hospital district authorities bear and thereby implemented the obligations that Sections 19.3 and 22 of the Constitution imposes on the public authorities.

Auxiliary equipment for medical rehabilitation

In one complaint, the Ombudsman was asked to examine whether municipalities were complying with the legislation on medical rehabilitation. According to the complaint, the practices adopted were disparate and the availability of services varied greatly from one municipality and one hospital district to another.

Because the Ombudsman's tasks do not include conducting, upon request, studies that have all municipalities as their focus, she examined on a general level the oversight authorities' perceptions of the operational practices and guidelines adopted in municipalities and hospital districts with respect to the provision of medical rehabilitation services, and in this case especially equipment and other aids. She further looked into the measures that the supervisory authorities had taken to change any operational practices and guidelines that might be unlawful. The Ministry of Social Affairs and Health and the State Provincial Offices were urged to intervene in individual instances of unlawful operational practices and guidelines when necessary.

It emerged from reports furnished by the State Provincial Offices as well as from one supplied by the National Institute for Health and Welfare that in some health care operational units clients were still having to pay charges for the loan of equipment and aids, fitting them, replacing them when necessary, and maintenance. The reports revealed that some units also limited their lending of inexpensive and/or expensive items of equipment, or listed items that were never lent as well as limited the number of items of equipment or their replacement. Some or other category of patients could also be excluded from equipment services.

The Ombudsman pointed out that guidelines in which no room to take the individual needs of the person requiring a service into account is left are contrary to legislation. Guidelines that schematically exclude some categories of patients, such as persons of a certain age, or certain devices or those above a specified price level, from medical rehabilitation services in advance are unlawful. Likewise unlawful are guidelines that make it possible for clients to be charged for the loan of equipment and aids, fitting them, replacing them when necessary, and maintenance. Guidelines under which the number of equipment items or their replacement are limited are in conflict with legislation if they do not allow for the individual needs of the person requiring them.

According to the reports, the principal means of oversight used by the State Provincial Offices had been a variety of forms of information guidance, such as arranging or participating in training events and visits to municipalities.

It emerged from the reports that the health care operational units in question had changed their unlawful practices and guidelines if the State Provincial Offices had intervened in them through concrete guidance and oversight measures. On the other hand, the reports did not indicate whether all State Provincial Offices that, in conjunction with investigation of the complaint now in question, had become aware of the unlawfulness of operational practices or guidelines had taken appropriate guidance and oversight measures to correct them. In the view of the Ombudsman, oversight by these State Provincial Offices had been deficient and inadequate in these cases.

There was no indication in the report from the Ministry of Social Affairs and Health that it had given the State Provincial Offices guidance in the matter. Only in late October 2000, in connection with investigation of the complaint, did the Ministry ask the State Provincial Offices to report how they had complied with the order issued by the Ministry in June 1995 and what kinds of guidance and oversight measures they had taken. The Ministry had then urged the State Provincial Offices to monitor compliance with the legislation on equipment and aids within their area and to take whatever guidance and oversight measures were necessary. Thus also the Ministry of Social Affairs and Health's oversight had been, in the Ombudsman's assessment, defective and inadequate.

The Ministry of Social Affairs and Health's general duty of guidance and oversight and the same duty on the part of the State Provincial Offices are especially accentuated when decision making concerning loans of auxiliary aids and equipment follows unlawful guidelines or practices and the patient has no means of changing a treatment decision. Therefore it is important that the oversight authorities intervene concretely in unlawful operational practices and guidelines. On 5.6.2003 the Ombudsman informed, for their enlightenment and future reference, the Ministry of Social Affairs and Health and the State Provincial Offices of the deficiencies that she had observed in the arrangement of auxiliary equipment services and in guidance and oversight of these services (1803/00).

Reform of dental treatment services

The duty of municipalities to arrange dental services has featured often in complaints in recent years. First there were complaints to the Ombudsman that municipalities were not discharging their duty to arrange dental care, the scope of which was extended to cover all

residents from the beginning of December 2002 onwards, in the manner that the law requires, but had continued to prioritise certain groups only. When this matter was rectified, complaints concerned the fact that treatment was provided for only those in urgent need of it; patients needing non-urgent treatment were not even put on a waiting list. At the moment, complaints concerning dental care are coming from patients who have been on a waiting list for longer than six months.

The starting point in a Government proposal introducing a bill to restructure the dental care system was that there would be no significant shift from private to municipal dental care after the reforms had been effected, because an expansion of the health insurance system's coverage would be implemented at the same time as the scope of municipalities' obligation to arrange dental care services was broadened. The assessment in the preparatory work leading up to the restructuring was that private-sector patients would in the main continue the care relationships that had earlier been established. Calculations of the cost of the expansion of the health insurance system were also based on the assumption that the number of private dental care patients would not change.

Because the Ombudsman's oversight does not include assessing questions relating to the sharing of funding responsibility between the State and municipalities, she did not adopt a stance on the adequacy of the increase that had been made in the State's contribution to funding. In her opinion, however, assessment of the effects of the legislative amendment had not matched the reality well. Forecasting the effects had had significance for how preparations had been made in municipalities for the broadening of the obligation to arrange dental care.

According to the Government proposal introducing the bill to restructure the dental care system, the reform did not mean that a separate subjective right for municipal residents to receive municipal dental care would come into being. Therefore persons born in 1946 or later would not, according to the Government proposal, even from now on be entitled to receive municipal dental care contrary to the resources limit provided for in Section 3 of the Patient Act.

The resources limit in the Patient Act cannot be coupled to a municipality's obligation to arrange health care and medical treatment. Thus, in the Ombudsman's opinion, the assumption according to which the expansion of the statutory obligation to arrange dental care would not, because of the provisions of the Patient Act, require increased resources was incorrect and based on a wrong legal interpretation. On the contrary, inter alia the provisions of the Constitution require that implementation of the broadened statutory obligations relat-

ing to dental care be done by increasing resources if necessary. Section 22 of the Constitution states that the public authorities must safeguard implementation of fundamental and human rights. Allocation of resources is one of the key means by which the public authorities must fulfil their obligation to safeguard these rights.

It was stated in both the Government proposal and the report of the Eduskunta Social Affairs and Health Committee that the reform of the dental care system should not be implemented to the detriment of the services with which persons already receiving care were provided. Partly on the basis of these statements, there had been a tendency in municipalities to stick to their habits in the prioritisation of special groups.

Irrespective of the positions stated in conjunction with the legislative drafting, the dental care reform applied to all municipal residents who had a need for examination and treatment. Under the Act, care must be provided with the need for it, its urgency and its effect taken into consideration. With effect from 1.12.2002, the patient's age or the category to which he or she belongs are no longer in themselves the determining factors. A division in accordance with the entry-into-force provision of the Act applied only to the various stages of implementation of the reform. Thus a municipality could not, in the opinion of the Ombudsman, have been able to limit its statutory obligations by invoking the views expressed when the Act was being drafted.

Thus the principles according to which dental care was arranged in the municipalities that were the subjects of complaints were not in all respects lawful. However, the municipalities had drafted these principles in a situation where their decisions had been influenced by, in addition to the obligations imposed in the legislation, a demand for services that had grown faster than forecast and partly incorrect information about their obligations with respect to arranging care. Although these considerations did not obviate the municipalities' responsibility for a prioritisation that was unfounded in law when deciding who had access to care, the Ombudsman nevertheless took them into consideration when evaluating the blameworthiness of the municipalities' action (e.g. 1044/02).

Treatment of patients with Fabry disease

With regard to exceptionally expensive treatments, the Ombudsman has, arising from a complaint, adopted a position on the care of patients with Fabry disease. Something that can not be deemed lawful is that when there is a dearth of appropriations, a university hospital has to prioritise the treatments given so that Fabry sufferers can not be given the expensive medicines that this disease requires, because so much more would then be left undone.

Under the law, categories of patients suffering from certain diseases cannot be excluded from the scope of responsibility for arranging specialist medical care. In treatment decisions, the prohibition on discrimination is of key importance as a question of the fairness in health care that is associated with implementation of fundamental rights. The ground for access to health care services must be the medically founded need for treatment that the patient's state of health calls for (921/04).

Obligations under the Treatment Guarantee

It emerged in the course of investigating one complaint that a child had received the psychiatric care it needed only over one and a half years after the referral reached the hospital. However, the Treatment Guarantee has been in effect with respect to the arrangement of psychiatric care for children and adolescents since as long ago as 1.1.2001. Since then, there has been a requirement to arrange non-urgent psychiatric care not later than in the third month after it has been deemed necessary. The child's right to necessary psychiatric care had not been implemented when the child had to wait unduly long for it (2661/03).

Arising from three different complaints, the Ombudsman adopted a position on unlawfully long waiting times – in some cases even up to two years – for access to treatment at the eating disorders unit of the psychiatric segment of a university hospital (3822/06, 4008/07 and 163/08). In these decisions she emphasised that the Treatment Guarantee must be honoured also in the special field of psychiatry.

The Treatment Guarantee obligations in the Act on Specialised Medical Care were not met in one university hospital, because a patient had to wait over 10 months for a cervical spine operation. He had suffered severe pains and was hardly able to work. It had been estimated at the hospital that the target time for the patient to wait for the operation was two months. However, the hospital did not arrange treatment for the patient within this time nor even within the maximum period of six months as required under the Treatment Guarantee. It also failed to procure treatment for the patient from other service producers (2801/07).

A health centre acted contrary to the Treatment Guarantee obligations in the Primary Health Care Act, because a patient received the necessary treatment, in this case filling a split tooth and removing plaque, only a year and three months after the need for treatment had been assessed (3227/07).

The Treatment Guarantee legislation does not set a maximum period for assessing the need for treatment in specialist medical care (apart from the three weeks set for examining the

referral). Despite that, the waiting time of 10 months that the patient was told there would be until an initial examination was, in the Ombudsman's view, too long. The legislator's will as expressed by the Eduskunta Social Affairs and Health Committee in conjunction with passage of the Treatment Guarantee legislation is not being implemented if the patient has to wait so long for access to evaluation of the need for treatment (1363/06).

Explication of legislation is important

The view taken in the legal literature is that the dependence on complementary legislation of the obligations that municipalities have with respect to social fundamental rights is undisputed when the provision in the Constitution is formulated as a task for the legislator to perform. A regulation model of this kind has been embraced in Section 19.3 of the Constitution.

For the past decade, the direction of health care has been done by means of information guidance. Legislation on health care is framework legislation in which the obligations of municipalities are not set out precisely. The framework nature of the legislation has led in practice to a situation in which there are even major differences between municipalities with regard to the objectives for arranging services and the contents of these services. The framework legislation was enacted at a time when functions were steered by, in addition to legislation, planning systems. This system was abolished in 1993, when a new system of planning and state funding contributions for social welfare and health care was introduced. The 1995 revision of the fundamental rights provisions of the Constitution has meant the incorporation of a stronger individual-focused perspective into health care legislation. It appears that the old framework legislation is no longer compatible with a perspective that emphasises individual rights founded in the Constitution. It can be asked whether differences from one municipality to another in health services are any longer justifiable. Implementation on a basis of equality of the adequate health services that are safeguarded as a fundamental right presupposes a strengthening of guidance by means of statutory instruments.

How well information guidance by means of such instruments as guidelines and recommendations functions in social welfare and health care has been studied on a general level by the Eduskunta Audit Committee in one of its reports (TrVM 5/2008 vp). In the view of the Committee, the biggest weakness of information guidance is that, based as it is on recommendations, it is not binding and does not require municipalities to act in the way that the recommendations call for. Some municipalities have followed the recommendations; others have observed them in part, whilst a number have paid hardly any attention to them. This has led to an inability to provide, on a basis of equality, citizens living in different municipalities

with the social welfare and health services that are their fundamental rights. Reinforcing the degree to which guidelines and recommendations are binding presupposes the incorporation in sectoral legislation of statutory guidance. As a result of the Committee's report, the Eduskunta required on 16.10.2008 that the Government take measures to make guidance in the social affairs and health services sector more binding and effective as well as to strengthen equality in implementation of fundamental rights and access to social welfare and health services.

Since the revision of the fundamental rights provisions of the Constitution, a consistent effort has been made to develop and mould legislation in such a way that it better satisfies what is required of laws that limit the individual's rights to liberty, personal integrity, self-determination and privacy. Explication of the provisions of the Mental Health Act with respect to limiting a patient's right of self-determination was based on observations that the Ombudsman had made in the course of oversight of legality and her proposals in this regard (1893/97 and 2704/97). Although these provisions are now fairly precise, many problems associated with legislation and application of the provisions still continually crop up. On inspection visits to psychiatric hospitals, for example, attention must continually be drawn to the various preconditions for restraining (by means of limb restraints) and isolating patients. Changing the old care culture and tradition of hospitals is difficult. A question also often asked is whether a patient's right of self-determination can be limited by means of different treatment agreements and ward guidelines. In this respect, the Mental Health Act could be even more precise.

I shall now go on to outline four situations in which the Ombudsman has found explication of legislation to be necessary to safeguard adequate health services on a basis of equality.

Mental health services for young patients

The chief physicians responsible for youth psychiatry in a hospital district had unanimously recommended that a person aged under 23 who was in need of treatment should be admitted for specialist mental health care within three months irrespective of place of residence. They were likewise unanimous that the lack of a nationally uniform age limit has put young people in need of psychiatric care in different parts of Finland in an unequal position. This is due to the fact that the age limits for access to specialist psychiatric treatment by young people vary from one hospital district to another. At its worst, this means that especially 18–22-year-olds who are just becoming adults are easily included in the sphere of adult psychiatry, where access to treatment must be arranged within six months. The intention is that a uniform age limit for psychiatric care for children and young adults will be added to the Act on Specialised Medical Care or included in a Decree explicating it.

In the view of the Ombudsman, regulations explicating access to mental health services for young people are essential to ensure that these services are provided on a basis of equality, and she believes that amendments to the legislative provisions must be made as a matter of urgency. She informed the Ministry of Social Affairs and Health of her opinion on 14.5.2009 (4008/07).

Decisions to limit treatment

The Ombudsman has had to deal with complaints concerning the making of Do not Resuscitate (DNR) decisions in health care operational units. Interpretation of DNR orders and the practices involved have been seen as contradictory, unclear and difficult to form a perception of. The view has been that the situation especially jeopardises the legal security of patients in a weak situation and their relatives. In the opinion of the Ombudsman, Section 6 of the Patient Act needs to be explicated with regard to how it, and especially its sub-section 3, is to be applied to making DNR decisions when an adult is no longer capable of making decisions on his or her treatment. The present situation with respect to legislation cannot be deemed appropriate from the perspective of the legal security of patients and their representatives or indeed professional medical staff (1794/07). The Ombudsman has taken the view that also the legislation regulating decisions to limit the treatment of a minor patient needs explicating (818/09).

Limiting the right of self-determination in somatic health care

Situations in which a restless, confused or violent patient causes a disturbance in a somatic health care operational unit are common. To protect the health or safety of either the patient or the health and safety of another person, staff have then had to resort to coercive measures which restrict the patient's right of self-determination and for the use of which by medical staff there is no basis in law. These measures are isolating patients, taking possession of their property, placing them in restraints or medicating them against their will or in a situation where the patient's will has not been ascertained. The provisions of the Penal Code with regard to, for example, a situation of necessity or self-defence are cited as justification for restrictive measures.

It is very problematic that the provisions of the Penal Code with regard to self-defence and necessity have to be applied, in the absence of appropriate legislation, to restriction of the patient's right of self-determination in the situations described above. This is inadequate from the perspective of both the patient's and the staff's legal security. Measures taken to restrain a restless, confused or violent patient mean forceful intervention in his or her right

of self-determination. The regulations in the Patient Act do not in this respect fulfil the demands with respect to precision and precise delimitation that are set in the Constitution for legislation restricting personal liberty and integrity. The Ombudsman recommended to the Ministry of Social Affairs and Health on 14.4.2009 that this shortcoming in legislation be remedied (1073/07).

Distribution of health care supplies

There is no legislation regulating the distribution of health care supplies by health centres. The intention of the Ministry of Social Affairs and Health when it drafted a recommendation was to ensure implementation of distribution and bring uniformity to the practice that municipalities follow when dispensing these supplies. The recommendation is not binding on municipalities.

Because distribution practice is based on the voluntariness of municipalities, patients who need care supplies find themselves in a position of inequality on the basis of their municipality of residence. According to a report supplied by the State Provincial Offices, the following differences, for example, are found in the practices adopted by health centres: in some municipalities, supplies that are not generally included in the range distributed are provided; patients must themselves obtain the supplies, although they are generally included in the range distributed; patients have to pay for delivery of supplies to their homes; in some municipalities, a demand for rectification of a decision can be made to the chief medical officer or a board.

The Ministry's recommendation and municipalities' own guidelines do not, however, adequately safeguard citizens' equality in this matter. In the view of the Ombudsman, legislation would help ensure that care supplies are provided on a basis of equality. She informed the Ministry of this opinion on 20.5.2009 (1860/07).

Temporary locums

I shall mention one further problematic situation that would need to be remedied through legislation. The problem relates to the legal status of agency-supplied temporary locums and outsourcing of health services.

The Ombudsman decided on her own initiative to examine the circumstances of the death of an intoxicated person in a police custody facility. In this case, she evaluated the actions of a medical student who was working as a health centre doctor. The student had been employed

under contract by a company that rented out medical personnel and had been assigned to the health centre. Thus he was not in an official post or a comparable employment relationship with a public body, for which reason he could not be regarded as a public servant and his official accountability could not be founded on the nature of his service relationship.

It was essential in the case to assess whether the medical student had exercised the public power of a health centre doctor in his task when he decided whether a person was in need of treatment and should be admitted for it. Based on an expert statement and recent case law, the Ombudsman concluded that the student had not exercised public power when deciding whether an intoxicated person needed treatment or not. Therefore the misconduct-in-office provisions of the Penal Code could not be applied in this respect to the student's actions (1147/04).

The present situation is unsatisfactory. When a municipality discharges its health care tasks by procuring services from a private producer, the accountability for performance of the task is different from what obtains when the person performing it is in a direct employment relationship under public law with the municipality. Looked at from the patient's perspective, patients are likewise in a different position depending on whether they are treated by a temporary locum or a doctor who has been officially appointed. Unlike a temporary locum, a doctor in a permanent post acts with official accountability, which is independent of the factual nature of the tasks.

Likewise unsatisfactory is the fact that it is not clear on the basis of the current legislation what are the tasks in which a health care doctor or a hospital doctor exercises public power or possibly significant public power. The Ombudsman considers this very problematic from the perspective of legal remedies.

To clarify the matter, the Ombudsman requested on 14.5.2009 that the Ministry of Social Affairs and Health obtain a report from the National Supervisory Authority for Welfare and Health and arising from this provide a statement of its own. She has asked that the following questions be answered in the statement and report: What, in the Ministry's perception, are the tasks of a doctor working in public health care that include exercise of public power? What kinds of tasks do temporary locums perform in public health care and what guidelines have they been given for doing them? Is it acceptable, and if so on what grounds, that doctors performing the same tasks in public health care have a different kind of accountability for their tasks? The Ombudsman has requested that the matter be evaluated also from the patient perspective (711/09).