Sogn District Court – Ruling: TSOGN-2015-152966

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Keywords:	Tort Law. Patient injury. Patient Injury Act, Section 2(1)a.
Summary	This case concerns a compensation claim on patient injury. The court has determined that the patient was misdiagnosed after contracting Lyme Borreliosis in 2007. The patient did not receive adequate health care because correct treatment was not initiated at an earlier time. The court finds it probable that the woman's health would have improved at a much earlier point in time if she had been offered antibiotic treatment by the specialised health services at her first appointment in December of 2007. Patient injury has been proven, and the woman is thus entitled to compensation. (Summary from Lovdata, the Norwegian judicial information foundation) **Ref.** Section 2 of the Norwegian Patient Injury Act (2001)
Court proceedings	Sogn District Court, Case number TSOGN-2015-152966 (15-152966TVI-SOFT). Appealed to the Gulating Court of Appeal as Case number LG-2017-111846.
Parties	A (represented by Attorney Gitta Balch Barth) versus Norwegian national administrative appeals body for health services (Nasjonalt Klageorgan for Helsetjenesten) represented by Attorney Christina Julsrud Thorstensen).
Author	District Court Judge Bjørn Gunnar Sælen.
References found in the text	Court Fees Act (1982) Section 2 | Patient Injury Act (2001) Section 4 | Dispute Act (2005) Section 20-2, Section 20-4, Section 20-5, Section 21-7, Section 21-8

This case concerns: determining whether the plaintiff received adequate medical care; ref. Section 2(1)a, of the Patient Injury Act. On 4 December 2014, the Norwegian System for Patient Injury Compensation (Norsk Pasientskadeerstatning, NPE) concluded that the plaintiff was not entitled to compensation in a decision confirmed by the Patient Injury Compensation Board (Pasientskadenemnda, PSN) on 24 March 2015.

1.1 Background information for the case

The plaintiff, designated as "A" in this document. Date of Birth 0.0.1968. She visited her doctor's office (henceforth medical center X in this document) on 4 October 2007. She was seen by Intern Doctor B.
The notes from that consultation are cited here in their entirety:

> Patient described a difficult period at work in May/June when the company was reorganizing. She developed neurological symptoms at that time including word-finding difficulties; sentences would contain a word which was completely meaningless in the context of the sentence. She returned home after accomplishing little at work and she felt uncertain about what she had done that

> day. Her children joked that she was acting a little *listless/dull*, but her co-workers did not make any comments of this kind.
>
> She developed a rash then, on lateral side of left leg, bilaterally in the axillae and on her the left groin. The rash did not itch, and it did not change in colour or size. The leg rash was 9x7 cm at its widest, I felt nothing on the outside, so the reaction must be subcutaneous.
>
> Medical examination: status of heart/lungs: nothing to note. Glandular status: nothing to note. Otherwise healthy. No palpitations.
>
> V: Viral encephalitis? Caused by stress? Borreliosis?
>
> Test for Borrelia, cholesterol, metabolism, B12, Hb and microsc, then refer patient to a dermatologist and have a CT-scan done of the head.
>
> New check-up in 4 weeks.

In the referral letter dated 5 October 2007 that was sent to the dermatology outpatient clinic at Y hospital, Intern Doctor B provides a different and more detailed description of the rash. We read the following:

> She developed a rash then, on lateral side of left leg, bilaterally in the axillae and on her the left groin. The rash did not itch, and it did not change in colour or size. The leg rash differs from the other three, which appears to have more of a ring shape. This rash has a sharp but looped delineation next to healthy skin, measuring 9x7 cm. It does not itch and is subcutaneous.

MRI caput done on 24 October 2007, with and without contrast. The test was inconclusive. The plaintiff consulted Chief Physician C at the dermatology outpatient clinic at district general hospital Z (Z Health Trust) On 12 December 2007 to have the rash looked at. The patient's records stated the following:

> Blood tests were done as part of the examination, including a Borrelia burgdorferi test done by the family doctor (GP). An MRI caput was performed 3-4 weeks ago. The results were considered normal. She is no longer experiencing word-finding difficulties, but the rash is still there. She remembers being bit by a tick.

A biopsy was taken of the rash on the left leg, which was sent to the histological lab for assessment. The request for an evaluation by the pathology Department at district general hospital Z stated the following in the box for "Problems and Clinical Diagnoses":

> Since May–June 2007, stationary rash on left leg, left axilla and right leg. Granuloma annulare? Eczema? Something else?

The response from the pathologist stated the following regarding the diagnostic assessment:

> Skin consistent with granuloma annulare, no malignancy.

A had a new consultation on 1 February 2007 with Dr D at the dermatology outpatient clinic at district general hospital Z. The court cites the following from the patient records:

> Evaluation:
>
> I would be careful with any diagnosis. A has an indisputable granuloma annulare. The acute rashes on both legs are most likely an urticaria vasculitis. An erythema nodosum would have remained much longer. It is difficult to say anything about the relationship between the rash and the headaches and general state of health. We know that low-grade infections, viral infections, and viral infections with meningeal irritation can trigger immunological phenomena in the skin, such as granuloma annulare and urticaria vasculitis, and we should not discard the possibility of a viral infection with a meningeal irritation in May of 2007.
>
> We checked the borrelia serology here again, which was clearly negative, so we can exclude borreliosis as the reason for this affliction. We will just wait now and see what happens. If she continues to get new, tender lesions on the skin, she can come back at any time for a new and certain diagnosis, and perhaps take a biopsy. I also want to see her if she experiences more inflammations in the oral cavity, and it would then be appropriate to have an oral surgeon take a biopsy.

As stated in the patient records, it was concluded that A was suffering from a granuloma annulare. Borreliosis was excluded after referring her to a borrelia serology.

On 17 April 2008, A visited Dr D again at the dermatology outpatient clinic at district general hospital Z. The patient records state:

> She told us about multiple tick bites last spring and summer, but she never developed any clear signs of erythema cronicum migrans. She was feeling a little sore and stiff, but never had any real arthritis.
>
> Evaluation:
>
> These are generalised symptoms. Urtica vasculitis is considered a symptom. She has undergone an adequate immunological assessment to look for an underlying autoimmune cause of this, but these tests were all negative. A borrelia serology was done, which was negative. Yet again, I feel we should not forget that borreliosis can occasionally cause an early central nervous component, and it can *hop over* a peripheral affection. In such cases, the standard borrelia serology can be negative. I have therefore sent a referral today to the head of the department, E, to ask his opinion about an indication for a spinal tap.

A was then referred to the oral surgeon due to issues in her oral cavity. She went to see oral surgeon F on 26 March 2008. He found no pathology that needed treatment and he recommended a bite splint to see if this could alleviate her oral problem.

A new blood serology was done on 14 May 2008 to exclude borreliosis. A's cerebrospinal fluid was also examined at this time. Both the blood serology and the cerebrospinal fluid were negative for borreliosis.

The patient's medical records state that the patient contacted the health services after this due to some complications from the spinal tap. She was experiencing headaches. She also contacted a doctor after that due to pain in her knees etc.

The notes from the consultation on 8 June 2009 state the following:

> Inform about MRI. She had an episode 14 days ago with pain and a tension in the angle of the mandible. She also felt unwell and had difficulty finding words. It ended after a couple of days.

She contacted a doctor on 29 December 2009 after a skiing accident. She then started experiencing symptoms/pain in the neck.

A repeated her suspicion that she could have borreliosis at a new consultation at medical center X on 25 October 2010. A new blood serology was done and the sample was compared with the sample taken in 2007. The findings were not consistent with borreliosis.

A was referred to Sørlandet Hospital for a second opinion after voicing her persistent and strong suspicion of borreliosis. A was examined on 21 January 2011. She was informed on 28 February 2011 that there was no sign of an active borreliosis.

A was issued a prescription for antibiotics despite the negative lab tests etc. (14-day treatment with Doxycycline in tablet form). We refer you to the patient records prepared by Dr Åse Mygland on 7 March 2011.

A then started a lengthy period of antibiotic treatment under the auspices of the Norwegian Borreliosis Center (Norsk Borreliosis Senter) to combat the borreliosis. Her symptoms gradually decreased after that, and no one has disputed her apparent return to a normal state of health in 2011.

1.2 Decision by the Norwegian System for Patient Injury Compensation (NPE)

A submitted the Official Injury Report Form to NPE along with a letter dated 26 May 2013.

The Injury Report Form authorises NPE to obtain the patient's medical records from Z Health Trust (i.e. district general hospital Z) which provided its decision on 19 August 2013.

The case was then evaluated by a specialist in general medicine, Dr Tor Vattekar, who provided his expert opinion in an assessment dated 23 October 2013.

NPE made its decision on 4 December 2013. The decision reads as follows:

> A is not entitled to compensation on her patient injury claim.

A appealed the decision to the Patient Injury Compensation Board (PSN) in a letter dated 30 January 2014.

A second assessment was obtained from a specialist in neurology, Dr Rolf Nyberg-Hansen, who gave his expert opinion in an assessment dated 3 April 2014.

The appeal was rejected, and PSN's confirmed and maintained NPE's decision on 24 March 2015.

1.3 Court hearing

A then filed a writ of summons insisting on her compensation claim for patient injury on 27 September 2015 with the Sogn District Court against the State of Norway. The State is represented by the Patient Injury Compensation Board (PSN).

Attorney Ingrid Stokkeland submitted her formal Defence Reply on 3 December 2015 on behalf of the State/PSN, stating their objection to the summons and demanded that the claim be dismissed and that the State be awarded case costs.

At the planning meeting held on 11 January 2016, the court determined that it would decide on the question of liability, not the amount of any compensation that might be awarded.

Attorney Gitta Barth declared herself the legal representative for the plaintiff in the pleading she submitted on 28 January 2016.

The parties then used some time to address the question of expert witness who would evaluate the case and address the court before the parties formulated and submitted their formal written pleadings.

The court issued a statement on 22 April 2016 naming Chief Physician Per Harald Bjark as the court-appointed expert in this case.

He submitted his expert opinion to the court on 20 June 2016.

After receiving Dr Bjark's declaration, Attorney Stokkeland submitted her formal pleading on 5 August 2016 demanding that a specialist in dermatology also be appointed to address the court. Stokkeland also requested a postponement on the main hearing in that same pleading. The original hearing was scheduled for 6-8 September 2016. Attorney Barth opposed the appointment of any new experts on behalf of A, and contested the postponement of the case.

In a statement dated 23 August 2016, the court agreed to postpone the case until a dermatologist could be appointed. The court reasoned that this would form a better basis for coming to a correct decision in this case.

Following this, the parties exchanged many letters to agree on who would be appointed as court expert on dermatology.

In a statement dated 13 December 2016, Dermatologist Dr Alesya Knutsen from St Olavs Hospital was appointed as the new expert. She submitted her expert declaration on 22 January 2017.

Attorney Christina Thorstensen was appointed as the new legal representative for the State/PSN in February of 2017.

In the pleading dated 20 February 2017, the State/PSN withdrew the declaration of their party-appointed expert witness, Dr Nyberg-Hansen. In the same pleading, a neurologist from Haukeland University Hospital, Dr Christian Vedeler, was appointed as the new expert witness.

In the pleading dated 24 February 2017, Attorney Barth demanded that the court exclude any evidence submitted by Dr Vedeler in his testimony. The plaintiff argued that two expert declarations were already submitted in this case, and that any testimony from Dr Vedeler would not strengthen the factual basis for coming to a decision to any significant degree; ref. Section 21-7(2)b of the Dispute Act. The plaintiff also argued that the evidence should be excluded because it was not proportionate in pursuance of Section 21-8 of the Dispute Act.

Attorney Thorstensen refuted Barth's arguments in a pleading dated 6 March 2017, after which new pleadings were submitted by both parties.

**In the pleading dated 8 March 2017, Dr Vedeler's expert testimony submitted.

The Sogn District Court came to a decision in the case on 15 March 2017 with this conclusion:

> The request to exclude evidence in Case no. 15-152966TVI-SOFT is denied

The main hearing was conducted at the Sogn District Court on 5-7 April 2017. A appeared in court with her legal representative to provide her statement to the court. The legal representative for the State/PSN also attended the main hearing. Furthermore, Dr Vedeler and Dr Vattekar participated in the hearing as expert witnesses for the State. Both provided their statements to the court.

The court-appointed experts appeared in court to provide their expert opinions. One more witness was brought before the court.

The parties provided documentation and submitted their formal assertions as stated in the court records for these proceedings.

The court delivered its ruling *after* the statutory deadline had passed. The ruling came late for various reasons: scheduling problems around Easter vacation and a seminar the court administrator was obligated to participate in, and the administrator's increased workload regarding other cases. However, the ruling was delivered within the time specified by the court administrator (no later than the end of May 2017) at the end of the main hearing, which the parties had no objections to.

2. The parties' assertions and reasoning of claims

2.1 Attorney Barth submitted these assertions on behalf of A:

1. A is entitled to compensation from the State via the Patient Injury Compensation Board.
2. A be awarded case costs.

2.2 Attorney Barth submitted a summary of her reasoning, on behalf of A:

A is entitled to compensation pursuant to Section 2a of the Patient Injury Act after being misdiagnosed and a failure to begin antibiotic treatment. The failure to begin antibiotic therapy resulted in extensive afflictions for the plaintiff from 2007 to 2011. Both the

primary care service and the specialist health service failed to provide adequate health care.

She summarised how inadequate symptom descriptions and poor record-keeping affected the diagnosis. She also pointed out how these errors influenced the incorrect assessments of the State's experts.

Barth argued that the General Practitioner at medical center X failed to follow the then-current guidelines for treatment when the doctor – without requisitioning blood tests – failed to treat A's symptoms with antibiotics after her first medical consultation in October 2007. She should have understood that the neurological symptoms and rashes were symptoms of borreliosis. As an alternative, she should have referred A to a neurologist at once.

As another alternative, the General Practitioner should have referred A to a specialist to carry out a cerebrospinal fluid examination shortly after confirming her suspicion of borreliosis. A cerebrospinal fluid test at that time (October 2007) could have provided a better response in determining whether A had borreliosis or not. The cerebrospinal fluid test was done in May of 2008, which was far too late. We refer you to Dr Bjark's statement that changes in cerebrospinal fluid may disappear in a matter of 3-4 months after the onset of an infection.

The plaintiff added that Dermatologist C failed in assessing A's multiple erythema migrans rashes. The dermatologist also failed to comply with good medical practice by not recording the significant changes in the rashes that occurred after the referral on 5 October 2007. The doctor also mistakenly described the rashes as *stationary*. She failed to comply with good practice when she forgot to ask the pathologist about a possible diagnosis of erythema migrans, even though she knew that A had been bitten by ticks, and when she could clearly read the question about borreliosis in the referral from the General Practitioner.

Furthermore, the plaintiff argues that Dermatologist D failed to comply with the guidelines in the Norwegian Medicines Manual for Health Personnel (Legemiddelhåndboka) when he excluded borreliosis based on results from lab tests that came back negative. He failed to comply with good medical practice when he did not take a new biopsy and send it to PCR to secure a more accurate diagnosis.

Finally, the plaintiff argued that there were a number of weaknesses in the follow-up A received at medical center X (General Practitioner) in the period 2008 to 2010. The plaintiff pointed out that this was not in line with good practice, that A's ailments were not noted in her records despite various telephone calls A had with her General Practitioner. The fact that she was not referred to a dermatologist after a new type of rash appeared in 2010 is also a sign of failure to comply with good medical practice.

The plaintiff's reasoning is based on these assertions: a sequence of errors was made in A's assessment and diagnosis that individually and/or as a whole make the State liable for compensation.

In conclusion, the plaintiff argues that *patient injury* was the result of all the failures in A's treatment. We refer you to the extensive health problems A suffered because she did not receive antibiotic treatment at an earlier point in time. It is obvious that this triggered a

financial loss for her that exceeds 5000 kroner. All the statutory conditions for compensation are thus fulfilled.

2.3 Attorney Thorstensen provided these assertions on behalf of the State/PSN:

1. The State/PSN be found not liable.
2. The State/PSN be awarded case costs in this case.

2.4 Attorney Thorstensen provided a summary of her reasoning, on behalf of the State/PSN:

She argued that the Patient Injury Compensation Board's decision is correct regarding the assessment of evidence and the application of law. None of the statutory conditions for compensation are fulfilled.

According to Section 2 of the Patient Injury Act, patients who suffered a loss due to patient injury are entitled to compensation in certain cases, including when injury results or is caused by a *failure in connection with the providing of health services, even if no single person can be blamed*.

The State contests any genuine failure by any part of the health care system that A received. Not from medical center X, district general hospital Z nor Sørlandet Hospital; ref. Section 2a of the Patient Injury Act. The law requires a *failure in connection with the providing of health services* to be the cause of A's alleged ailments to justify compensation. For the basis of liability to apply, the law requires a departure from standard medical practice.

A argues that liability for damages does apply in her case, because her borreliosis symptoms were incorrectly diagnosed.

We argue that her medical assessment, diagnoses and treatment from October 2007 to 2011 at medical center X, at the dermatology and neurological department at district general hospital Z, as well as the neurology department at Sørlandet Hospital were in line with good medical practice with regard to her symptoms and the suspicion of borreliosis.

We refer you to the fact that A was examined by dermatologists and neurologists, various blood tests were taken, cerebrospinal fluid tests done, skin biopsies taken and MRIs taken of the head to determine the cause of her neurological symptoms. All possible tests and examinations were done, also with a suspected borreliosis in mind. We argue that there was no basis for examining the plaintiff, or treating her with antibiotics.

As alternative, even in the event the court concludes that the diagnosis was not in line with general medical practice or guidelines, we argue that the plaintiff did not suffer any real injury. The State refers the court to the extensive examinations and diagnostics the plaintiff underwent in the period 2007-2011 (which includes blood tests, histological skin tests, medical image diagnostics, cerebrospinal fluid tests, dermatologist and neurologist consultations and several second opinions).

All these examinations produced negative results without any evidence of active borreliosis. There is no evidence – neither clinical, immunological nor dermatological/biopsies – that prove the plaintiff acquired borreliosis. We refer you to the fact that borrelia antibodies were never identified in the cerebrospinal fluid nor in the blood tests.

We also refer you to the examination done at the Neurology department at district general hospital Z on 14 May 2008, which found no neurological affliction. The notes from the examination stressed the fact that no symptoms or signs suggestive of Lyme borreliosis were found. The department concluded that her problems in 2007 were related to stress.

The plaintiff has the burden of proving that all conditions for compensation are fulfilled, which includes proving a *failure in connection with providing health services* and proving that this failure was the cause of the alleged injury. The law also requires proof of a *causal connection*, which is neither probable nor fulfilled in this case.

3. The court's remarks

3.1 Introduction – Some key issues

To start with, the parties disagree as to whether A was misdiagnosed or not at any stage of her contact with the health care services. NPE argues that A never developed borreliosis – contrary to assessments and conclusions stated by the court-appointed experts. NPE also argues that there were never sufficient medical grounds for starting antibiotic treatment at any stage of A's contact with the health care system from 2007 to 2011.

If the court has understood NPE's assertions correctly – regardless of A's diagnosis – NPE argues that there was never any failure by any part of the health care system that offered health care to the plaintiff during the time period in question. As evidence of this, NPE argues in particular that none of the laboratory tests or test results gave any indication of Lyme borreliosis. The clinical symptomology that might have indicated borreliosis was never clear enough to initiate antibiotic treatment, despite the fact that it was obvious – fairly early in the course of treatment – that A had been exposed to multiple tick bites in May/June 2007 followed by extensive rashes and some neurological symptoms.

3.2 Was A misdiagnosed?

It is clear from the documentation presented to the court that the specialised health services concluded that A's ailments were consistent with a diagnosis of granuloma annulare fairly early in the treatment phase. It also seems clear that neither the General Practitioner at medical center X nor the dermatologist at the hospital perceived A's rashes (in October 2007 and later) as characteristic of a skin rash that could be caused by a tick bite (erythema migrans).

The first time granuloma annulare shows up in the patient's medical records as a possible diagnosis is when dermatologist C sent a requisition letter to the pathologist to request a biopsy, which was done in December of 2007. The requisition letter expressly asked for feedback as to whether the findings could be consistent with this illness. The requisition did not, however, explicitly ask for a borreliosis test, although the terms "exem, annat" (see above: Eczema, Something else) were used. The response from the pathologist stated the following, in the item labelled "Diagnosis":

> Skin consistent with granuloma annulare, no malignancy

The diagnosis mentioned above was manifested further when Chief Physician D concluded that A had "an indisputable granuloma annulare"; see the patient's medical records dated 1 February 2008.

A diagnosis of granuloma annulare seems essentially to have been maintained as the most probable diagnosis from that point in time, generally excluding borreliosis as a possibility. I refer you to Chief Physician D's statement in the aforementioned patient records, which states that:

> "We checked the borrelia serology here again, which was clearly negative, so we can exclude borreliosis as the reason for this affliction."

The patient records dated 18 February 2008 maintained the diagnosis of granuloma annulare, but Chief Physician D emphasised that his diagnosis was uncertain ("for a more certain diagnosis..."). The same patient records suggest that A could have contracted mononucleosis and had contracted the Epstein-Barr virus, and that this could be the cause of A's ailments. She was then referred to an oral surgeon to look at the rash in her mouth/oral cavity. The patient records also state that "it is extremely rare for granuloma annulare to affect the mucous membrane in the mouth".

The records from 26 March 2008 state the following about the oral surgeon's notes:

> 39-year-old woman referred from head of dept/chief physician D at dermatology outpatient clinic here for second opinion on changes in oral cavity. He diagnosed granuloma annulare of the skin. (Court's underlining)

The image became more nuanced however on 17 April 2008, after Chief Physician D said the possibility of borreliosis should not be excluded, despite the fact that none of the lab results supported this possibility. The court cites the following from the patient records:

> Yet again, I feel we should not forget that borreliosis can occasionally cause an early central nervous component, and it can *skip* the peripheral affection. In such cases, the standard borrelia serology can be negative. I have therefore sent a referral today to the head of the department, Doctor E, to ask his opinion about ordering a spinal tap.

The results from the spinal tap gave no indication of borreliosis.

In their statements to the court, the party-appointed experts, Dr Vedeler and Dr Vattekar, stressed their opinion that none of the laboratory tests gave sufficient evidence of

borreliosis. This, in conjunction with the clinical observations and findings, was decisive for their conclusion that at no time was there any basis for a diagnosis of borreliosis.

The court agrees that the findings from the lab tests, blood tests, biopsy and cerebrospinal fluid test were inconclusive and thus repudiate borreliosis as the party-appointed experts insist. However, lab results are never conclusive. The court refers you first to that stated in the Norwegian Medicines Manual for Health Personnel from 2007. We read in the chapter on "Diagnostics" that:

> Skin manifestations are primarily a clinical diagnosis.

This implies that a diagnosis of erythema migrans is primarily made on the appearance of a skin rash, its development over time and any subjective ailments such as itching, burning etc. The neurological symptoms come in addition to that. The court-appointed expert, Dr Bjark, also made it very clear in his legal declaration to the court that negative laboratory results alone do not rule out borreliosis. According to Dr Bjark, this was a general medical doctrine in 2007.

The court agrees with Dr Bjark in that the party-appointed experts failed to adequately take into account and stress the neurological symptoms A described at her first consultation on 4 October 2007. As stated above, A gave a fairly detailed account of various neurological symptoms. Those are common symptoms of Lyme borreliosis.

The court also wishes to point out the importance of A's statement that she contacted the specialised health services and medical center X on several occasions and pointed out her neurological symptoms which significantly reduced her functioning in daily life and at times greatly reduced her ability to work. These symptoms showed up at various stages and in different degrees during the period in question (2007-2011).

The notes from the consultation on 8 June 2009 state the following:

> Inform about MRI. She had an episode 14 days ago with pain and tension in the angle of the mandible. She also felt unwell and had difficulty finding words during this time. It ended after a couple of days. (Court's underlining)

The court also refers you to the patient's medical records dated 6 December 2010 which i.a. state the following:

> Has been suffering from symptoms a long time now, which she suspects have to do with Borrelia.

We also refer you to the records dated 21 January 2011 in which A told about her symptoms from the summer of 2007. We read the following:

> She had other symptoms at that time:
> - Speech problems, often saying the wrong words.
> - Flu feeling in the body
> - Memory problems. She had to look up the names of co-workers before phoning them at work because she forgot their names, even though she only had 10-15 co-workers.
> - Body pain, bumps in the skin (felt like inflammation, thumping feeling and tenderness). Pain in the joints.

- Significantly reduced capacity for work, only managed a fraction of what she used to do. Her children and spouse noted that she seemed forgetful and wondered if she had Alzheimer's.
- Fatigue. Problems falling asleep, not feeling rested.
- Nausea. Abdominal pain and dizziness.
- Problems with reading. Vision problems.
- Shivers.
- Paresthesia and feeling cold in the arms.
- Feeling as if her body was at war with itself.

Symptoms have varied a bit with bad periods and occasional better periods. She is completely passive and hardly dares to talk with people in her worst periods. Her General Practitioner suggested chronic fatigue, but she says that does not describe her ailments. She had various blood tests done, suspecting borreliosis. She was also evaluated at the neurology department at Z (cerebrospinal fluid and MRI), but all the results came back normal. Various periods absent from work (with doctor's note). She has taken a leave of absence from work, without pay.

We refer you to other patient records during the period in question, which pointed out that A was struggling with fatigue, muscle pain et cetera. Based on A's statements, the court finds it highly likely that she discussed various neurological symptoms several times with professionals who could provide treatment during the period in question – without this being specifically stated in her medical records. We refer you to one example, in which A told us that she called her GP at medical center X on several occasions to discuss these issues, which she brought up repeatedly. According to A, the information from these phone calls was not always registered in the medical records at the doctor's office. She also told us about consultations at her doctor's office for which the patient records were absent/missing.

The court has also noted that the court-appointed expert, Dr Alesya Knutsen, explained how she rarely or never came across a case of granuloma annulare that had not triggered fairly extensive itching. She pointed out that itching is a fairly frequent symptom of this disorder. Based on A's statements and the patient records submitted to the court, there is no evidence that she was afflicted by itching.

A told her doctor at the first consultation that she had multiple lesions. Based on Dr Knutsen's statement to the court as well as her expert declaration, we must conclude that it would be very unusual for granuloma annulare to involve numerous lesions. The conditions described above also led Dr Knutsen to conclude that these lesions, A's neurological ailments and being informed about tick bites from earlier that year should have led the doctor to suspect ticks as the cause of the rashes (erythema migrans). It should also be said that none of the evidence submitted to the court to suggest granuloma annulare as a diagnosis would trigger the neurological symptoms A described on repeated occasions.

After an overall assessment, the court therefore agrees with court-appointed expert Dr Bjark that the evidence proves A was misdiagnosed and that she incurred borreliosis after suffering multiple tick bites in May/June 2007. The court also refers you to Dr Bjark's declaration, where the following was stated:

> In my assessment, a diagnosis of Lyme borreliosis is reasonably assured and far beyond the legal limit of 50% probability.

His explanation and conclusions were substantially supported by the other court-appointed expert, Dr Knutsen, in her declaration to the court.

Agreeing with Dr Bjark, the court stresses the significance of the rash's appearance as it appeared during the first consultation at medical center X on 4 October 2007, as well as the neurological symptoms presented by A during that consultation. Those symptoms involved a difficulty finding words and memory loss. The court also considers A's statement about having a variety of neurological symptoms, memory problems etc., even after that time, which is consistent with Lyme borreliosis. As mentioned above, the range of circumstances/symptoms are not consistent with a diagnosis of granuloma annulare where A's rashes are concerned.

The court further puts to reason another element in this case: A was offered antibiotics (Doxycycline) in 2011 after a long period of time without experiencing any recovery or improvement to her health. (Doxycycline is often used to treat borreliosis). The plaintiff's health improved after antibiotic treatment, and by 2011 she was perceived as being symptom-free. There seems to be a correlation over time between A's improved health (that she was feeling much better) and the antibiotic treatment she received. Thus, the court does not agree with the party-appointed experts when they say A's recovery or improved state of health after starting the antibiotic cure is totally *irrelevant* where the diagnosis is concerned. This last consideration is strengthened because everyone agrees that antibiotic treatment (e.g. Doxycycline) would have had no effect on a possible granuloma annulare or any of the other differential diagnoses that were considered and mentioned by the health service in those years.

3.1 Was there a failure in the health services that A received?

The next question which the court must decide on, is whether the health services failed to provide A with adequate health care during any part of the health care process. The parties chose to address this element of the case in terms of two questions. The first question is whether the misdiagnosis was the result of a failure by any part of the health care system/health care providers, and the second question is whether the health services failed in providing adequate health care by not offering antibiotic treatment for borreliosis at an earlier point in time.

Section 2(1)a of the Patient Injury Act states that a person who has suffered a loss due to patient injury is entitled to compensation if the injury is the result of *a failure to provide adequate health services*, even if no one is to blame.

In Official Norwegian Report NOU 1992:6 Compensation for Patient Injuries, the special motives to section 2 (section 3 of the draft bill) state that liability extends further than traditional liability for negligent harm/injury. The document sets no condition for finding someone to blame for the injury. On the other hand, not every injury is eligible for compensation. Something irregular has to have occurred. An objectivised assessment of these factors should be based on a standard for professionalism that the patient should reasonably expect to receive.

We read on page 64 of the Proposition to the Odelsting No. 31 (1998-1999) that the concept *feil* or *svikt* (i.e. failure) – which was the wording used in the draft legislation – should be interpreted in terms of the concept of 'adequate' in the temporary legislation, and that a lower standard exists than what one could consider 'optimal' treatment. The basis for comparison is normal good practice for the relevant occupational group. In connection with the second sentence of Section 2 – that one must take into account whether the claims the injured party may reasonably make regarding the activity or service having been disregarded or not – we read on page 90 of the Proposition that the starting point shall be the injured party's expectations rather than the actions of the medical practitioner.

In the Recommendation to the Odelsting No. 68 (2000-2001), emphasis was placed on an objectivised assessment, making it clear that the word *feil* (i.e. mistake) was removed from the Act itself, and Section 2a was changed to state that it was not a condition that someone can be blamed ("kan lastes").

Based on the Supreme Court's ruling delivered on 30 April 2017 (Ref. HR-2017-687-A), the court took its point of departure in the term failure (*svikt*) seeming to express an objective norm based on what the injured party should have expected from treatment.

The term failure (*svikt)* as suggested above does not imply that any injury caused by a failure by the health care services would entitle the injured party to compensation. How we understand failure (svikt) in the legal sense must be based on common good practice for the occupational group in question – in this case, the doctors employed at medical center X (primary health service) and the specialists in dermatology and neurology (specialised health service). The starting point must be the professional group that was available at the time (October 2007 to February 2011).

Where the assessment of evidence is concerned, the court must base its decision on the facts that seem most likely and probable after an overall assessment is made. It is true that the injured party has the burden of proof when we assess whether the conditions for compensation are fulfilled or not. That means the benefit of the doubt goes to the defending party. This is what is usually referred to as "bearing the risk of doubt".

In several decisions regarding compensation for patient injury, the Norwegian Supreme Court has set a requirement entailing "reasonable preponderance of probability" when it comes to the basis of liability requirement (ref. Rt-1980-1299 and Rt-1989-674) and the causal connection requirement (ref. Rt-1974-1160, birth control pill ruling). In Supreme Court ruling Rt-1980-1299 (ulnar nerve injury) we read the following on page 1305:

> The Supreme Court's decision in the so-called birth control pill case, Rt-1974-1160, states that one must find a reasonable preponderance of probability that the failure (*svikt*) etc. caused the injury on which the compensation claim is based. I also refer you to the ruling in Rt-1979-1224, which states that there must be a reasonable preponderance of probability that the alleged tortious condition led to the injury.

The court took its point of departure in those rulings when it assessed whether there was a failure in the A's health care. The same evidentiary principles also apply when determining whether A was injured, and when deciding the question of causal connection; see more below in Item 3.3.

After an overall assessment, the court has not found sufficient evidence to conclude that there was an element of failure in health care when A was not given antibiotic treatment immediately after her first consultation at medical center X. This first consultation was undertaken by an intern doctor who chose to refer A to the specialised health services based on the circumstances of the examination. She probably did this because she was unsure how to interpret the symptoms A told her about, and what the rashes looked like at the consultation. The court assumes that none of the rashes that A showed at the consultation were indisputable examples and typical for an erythema migrans rash. The patient's medical records do not contain enough details for the court to come to a decision with a reasonable degree of certainty on this matter.

When assessing failure (*svikt)*, the court had to consider the fact that there is no evidence that the doctor at the first consultation was informed that A had been exposed to multiple tick bites a few months earlier. Why the intern doctor did not ask A – during or after the consultation – if she had been bitten by a tick when the doctor suspected borreliosis is, however, unclear. The court is of the opinion that an affirmative answer to such a question would have given sufficient indication to initiate antibiotic treatment at this time. The court also thinks the intern doctor should have asked about tick bites, but it is not necessary to evaluate this further because it does not change the result of determining whether this, in itself, constitutes a failure in the legal sense.

The court is however certain that not offering antibiotic treatment in December 2007 was a *failure in the performance of the health care* following the consultation with Dermatologist C at hospital Z. It is clear that Dr C received specific information that A had been exposed to multiple tick bites a few months earlier (see the patient records from that time as submitted to the court). In the court's opinion, it is obvious that Dr C – as a specialist in skin diseases – failed to provide adequate health care by not initiating antibiotic treatment based on the pattern of symptoms A presented and the information available in the patient's medical records at that time. The court also wishes to point out that Dr C failed to provide adequate care by not noticing the changes to the rashes following the first consultation on 4 October 2007. It is the court's opinion that the assessment made by Dr C was inadequate when he described the rashes as *stationary*.

As suggested above, one should not have based a diagnosis on the negative lab results alone, at this time. The court is basing its conclusion here on the description of the rash from the medical records and the referral note which shows that A had a rash that might be consistent with erythema migrans. Moreover, the court puts to reason that A described a wide range of additional neurological symptoms at this time which were also consistent with borreliosis. The court refers here to Dr Bjark's expert declaration, in which he concludes as follows in relation to the pattern of symptoms such as they were described in the medical records:

> Without any reasonable doubt, I find that the correct diagnosis at this stage would have been early disseminated borreliosis with a typical stage 2 manifestation of multiple erythema migrans. Any other likely diagnosis would not have been plausible, and multiple erythema migrans is also a pathognomonic manifestation (ref. question 1 above). With the mental/cognitive symptoms pointing to neurological issue as part of the same condition, in my opinion the patient should have been hospitalised with full-scale mapping and a cerebrospinal fluid examination without unnecessary delay. (The reason that memory problems arise in neuroborreliosis is regarded by modern science as almost certainly associated

with an increase in the amount of so-called cytokine (CXCL13) in the nervous system/ cerebrospinal fluid (27). These symptoms have however been described many year ago (28).)

The court finds it sufficiently probable that the failure to assess these conditions properly at this stage of treatment meant the specialised health services put too great an emphasis on a *locked* diagnosis of granuloma annulare while excluding the possibility of erythema migrans and borreliosis as a differential diagnosis.

After assessing the evidence in this case, these incorrect decisions seem to have been a key element in NOT offering A antibiotic treatment after this (during the period up to 2011). The aforementioned conditions were also a contributing factor in the incorrect diagnosis following the patient through a course of treatment when Dr D took over responsibility for treatment in February 2008.

In light of the patient's symptoms at the time and the information about A's tick bites, it is also incomprehensible that Dr C failed to test for borreliosis (erythema migrans) when the doctor ordered the biopsies that were sent to the pathologist in December 2007.

The court also finds it hard to understand why a sufficient and verifiable explanation was not given as to why antibiotic treatment was not started on the basis of the pattern of symptoms A described to the intern doctor and Dr C. This is supported further by the information that A had been exposed to multiple tick bites a few months earlier, in May/June of that year. The court would point out that, at the time in question, it was common knowledge among medical practitioners that borreliosis cannot always be discovered using laboratory tests. Too much time had passed since A had been exposed to the tick bites for a cerebrospinal fluid test to provide a definite answer as to whether A had borreliosis or not. We refer you to Dr Bjark's explanation that changes in cerebrospinal fluid can disappear in a matter of 3-4 months after a patient is infected.

After reviewing the health care that A received, the court finds some support in the Patient Injury Compensation Board's decision of 10 June 2015 (PSN-2015-5163). In that case, the Board reasoned that the patient did not receive treatment in accordance with good medical practice when she visited her General Practitioner with a characteristic skin rash after a tick bite (erythema migrans) and the General Practitioner failed to initiate antibiotic treatment right away. The Board's decision specifically states that, after erythema migrans is detected, one should *not wait for lab results before initiating treatment, because as many as 60% of all lab tests can come back as a false negative*.

In A's case, as mentioned above, there were multiple clinical indications/symptoms (annular rash, neurological symptoms etc.) for borreliosis which, seen in conjunction with the information about multiple tick bites in May/June 2007, should have led Dr C to initiate antibiotic treatment in December 2007. In the court's opinion, this would be true (and as indicated above) regardless of whether all the lab results came back negative.

With help from the party-appointed experts, the State argued that it would have been incorrect and almost medically indefensible, based on her symptoms at the time, to treat A with antibiotics based on negative lab results and the pattern of symptoms that otherwise existed at the time. The State maintained this argument despite the existence of information that A had been exposed to multiple tick bites a few months earlier, in May/June of 2007.

In this context, the State referred to a ruling by the Oslo District Court on 4 October 2016 where a doctor lost his authorisation because i.a. he indiscriminately initiated long-term antibiotic treatments for patients partly based on vague and unspecified symptoms, and partly based on inadequate patient examination.

The State also pointed out that the indiscriminate use of antibiotics can eventually result in antibiotic resistance that, in addition to being a generalised societal problem, could also be harmful to a patient who was subjected to the treatment.

This court does not consider the conditions for which that doctor was criticised which led to the loss of his authorisation to be comparable with the facts we face in our case. The court refers you to the remarks above regarding A's incorrect diagnosis, as well as the clinical and neurological symptoms in this case, which lead to the conclusion that she should have been offered antibiotic treatment when she went to see the specialist in December 2007. The court also refers you on this point to the explanation by court-appointed expert, Dr Bjark. He was very clear and unambiguous in his explanation, stating that A should have been offered antibiotic treatment based on the pattern of her symptoms at that time.

After an overall assessment, the court therefore finds that A was not offered adequate health care. Therefore, the court concludes that a basis of liability exists in this case.

3.3 Was there patient injury as a result of the failure to provide adequate health care?

As mentioned above, the court has determined that the patient was misdiagnosed and thus did not receive adequate health care. The court also puts to reason that A should have been offered antibiotic treatment for her borreliosis as early as December 2007.

It is clear that A suffered a range of ailments related to borreliosis which she would have suffered during the first phase of her treatment regardless of the health care she was offered.

We are tasked with deciding whether the failure to treat her adequately – i.e. she was not offered antibiotics at an earlier stage – means her loss of functional abilities and failing state of health could have been avoided or reduced at any time during the period in question (2007-2011). In other words, the question is whether there is sufficient probability that A's health would have improved if she had received adequate treatment at an earlier stage.

The court refers you to Rt-1992-64, where the causal requirement is formulated in the following way:

> The causal connection requirement between an act or omission and an injury is usually fulfilled if the injury would not have happened if the act or omission had not occurred. The act or omission is thus a necessary condition for proving injury.

Otherwise, the court takes its point of departure in assessing the causal basis in the rules for burden of proof, which are described above in the court's treatment of basis of liability.

When it comes to A's state of health during the period in question, it is obvious to the court that her health was greatly reduced as a result of borreliosis. The court refers you to the patient records dated 4 October 2007, as well as subsequent patient records.

The court also refers you to the declaration from witness G, who is a friend of A. In her statement to the court, G described A's general functioning in detail before the period of illness, and how she saw a dramatic decay in A's functional abilities in the spring/summer of 2007. She described A as a very active and social contributor to the community before here functional loss. This changed radically in the spring/summer of 2007 and her failing state of health persisted at different degrees during the subsequent period. It should also be mentioned that the documentation/patient records and other information indicate that A had not had similar complaints and loss of functional abilities before she was bitten by the ticks in May/June of 2007.

The court is also of the opinion that it has been sufficiently demonstrated that A's health problems and symptoms continued until the time she was offered antibiotic treatment in 2011. Even if the symptoms varied in character and strength, the patient's medical records leave us with an unambiguous image of A having extensive health problems that can be directly related to the fact that she did not receive adequate treatment in December 2007.

After a thorough assessment, the court finds it probable that the woman's health would have improved at a much earlier point in time if she had been offered antibiotic treatment in December of 2007. The court's opinions are based on the presentation of evidence in this case, and Dr Bjark's statements and explanations to the court. The court finds it probable that A's health would have improved dramatically in the course of 2008 if she had received such treatment. There is thus a patient injury as a result of the failing health care. We also refer you to A's rapid improvement after she started adequate antibiotic treatment in 2011.

For these reasons – and after an overall assessment – the court considers it more probable than not that a substantial part of A's health ailments and loss of functionality in that period would have been avoided if the failure in health care had not occurred; ref. Rt-1992-64. The condition that a causal connection must exist between the failure of health care and patient injury is thus fulfilled.

The court is not authorised to calculate A's overall economic loss that resulted from the patient injury where this case is concerned. The parties have not presented any tax documents etc. that would allow the court to calculate A's overall economic loss for that period.

Under any circumstances, A has demonstrated that the lack of antibiotic treatment reduced her work and income capacity to an extent that triggered a financial loss on her earning that exceeds 5000 kroner; ref. Patient Injury Act (then-in-force) Section 4(1).

4. Case costs

A has thus won this case for all intents and purposes; ref. Section 20-2(1) and 20-2(2) of the Dispute Act. Following statutory rules, the State is sentenced to pay full restitution of case costs to the plaintiff; ref. Section 20-2(1) of the Dispute Act.

After an overall assessment, the court finds no grounds for an exemption to Section 20-2(3) or Section 20-4 of the Dispute Act.

A's legal representative has submitted a Statement of Costs in which his salary amounts to 305 500 kroner, excluding value added tax. In addition to this come the court fees for three days of the main hearing amounting to 11 539 kroner. Finally, there are travel, accommodation and subsistence costs for the legal representative, who declared a remuneration of 10 203 kroner. A also claims fees worth 2535 kroner.

Attorney Thorstensen voiced an objection when the procedures ended about Attorney Barth's Statement of Costs – without being specific beyond feeling the case costs were too high. She did not want to elaborate on her arguments in the subsequent pleading; ref. court records for the proceedings.

The court finds that the asserted salary claim from Attorney Barth is somewhat high, and that is not balanced in relation to what these proceedings would demand for the scope of the case and the time needed to prepare, exchange pleadings and conclude the main hearing which took place over three days in court; ref. Section 20-5(1) of the Dispute Act.

The court has taken into account the fact that this case raised some difficult medical questions which required consulting multiple experts. The quantity of documentation in this case was rather significant. The case was also deferred as a result of the State's need to consult other experts, which added time and costs to the plaintiff's work, but the plaintiff cannot be blamed for this. Still, the court believes a total of 130 hours of work leading up to the main proceedings is somewhat high considering the nature of the case and its complexity and scope.

The court has thus determined a discretionary cost for this case of 360 000 kroner, including value added tax.
The expenses for the court-appointed experts shall be paid by the State in accordance with Section 2 of the Court Fees Act.

The court came to this

Conclusion

1. A is entitled to compensation from the State via the Patient Injury Compensation Board.

2. The State/PSN is sentenced to pay A's case costs amounting to 360 000 kroner, with the addition of the statutory interest rate from the due date until payment is made, within 2 – two – weeks after the declaration of the ruling.