Surgical rationing in times of COVID-19 pandemic - how does it affect the Montgomery ruling and GMC guidance on consent?

Shyam Kumar and David Warwick

Shyam Kumar is a Consultant Orthopaedic Surgeon based at the Royal Lancaster Infirmary. He has completed an LLM in Medical Law and Ethics with Merit. His other roles include: Member of the BOA Medico-legal Committee, Clinical Assessor-PPA (Formerly NCAS) and Member of Appointments Advisory Committee, Royal College of Surgeons of England. His name has been nominated recently to the Lord Chancellor to be a member on the Cumbria & Lancashire Magistrates' Recruitment Advisory Committee.

David Warwick is Chair of the BOA Medico-legal Committee and a Consultant Hand Surgeon at University Hospital Southampton.

The Oxford dictionary defines a ration as *"a fixed amount of a commodity officially allowed to each person during a time of shortage, as in wartime."*[1] This allocation of scarce resources in healthcare inevitably leads to withholding of potentially beneficial treatment from some individuals or groups. Some commentators have accepted the fact that rationing care is a fact of life in the NHS[2]. Rationing happens on day-to-day basis as resources are always short in healthcare and this situation is not unique to the UK. On an administrative level, rationing happens in the macro-allocation of resources. Triaging at a scene of mass casualty (natural disasters, terrorist attacks etc.), deciding the appropriateness of a patient to be admitted to the intensive care unit (ICU) etc. are examples of frontline rationing which are typical and frequent.

With the advent of the COVID-19 pandemic, these issues are coming very close to us in Trauma & Orthopaedic also. In many hospitals, theatres are taken over by ICUs leading to loss of surgical output. This is compounded by the staff sickness absence[3] and the increased anaesthetic time due the extra precautions that need to be taken[4]. As such, theatre time has become premium and the duration which patients spend on a surgical waiting list is increasing[5]. In order to cater to the neediest patients, at the request of NHS England, the Federation of Surgical Specialty Associations (FSSA) have come up with a new method to prioritise patients who are already on the waiting list for surgery[6]. This guidance, with which most surgeons would be familiar by now, grades patients according to clinical need from P1 to P4 based on the diagnosis and recommends the maximum waiting times for surgery. P1a comprises of procedure which must be done within 24 hours and P1b to be performed within 72 hours; P4 comprises procedures which can wait for more than three months.

From a medico-legal point of view these are not without implications. This approach would certainly have an impact on patients who have been waiting longer on the waiting list. Some conditions are likely to progress such that an inordinate wait can cause irreversible changes with poor outcomes (e.g.: progression of arthritis resulting in a straightforward joint replacement becoming a complex primary with added morbidity and mortality, or prolonged nerve compression causing irreversible limb function due to entrapment neuropathies).

The allocation of resources in rationing of care also means that *"beneficial interventions are withheld from some individuals"*.[7] Withholding of any form of care as a result of rationing is likely to engage Article 2 and 3 of the Human Rights Act 1998[8]. Article 2 of the Human Rights Act deals with the right to life and Article 3 confers freedom from torture and inhuman or degrading treatment.

The NHS Constitution[9] establishes the principles and values of the NHS in England. Principle 1 mentions that, *"It (NHS) has a duty to each and every individual that it serves and must respect their human rights..."*. Although rationing happens on the bedside for clinical reasons (e.g.: Intensive Care Units), the last decade has seen rationing for economic reasons driven by various state apparatus (NHS England, Clinical Commissioning Groups etc.). Concerns were expressed by the Royal College of Surgeons previously where the government decided to restrict elective operations[10].

The above debates give an indication of the resource crunch the system was under even during normal times. COVID-19 has pulled the world into a war like situation and we are involved in day to day rationing while making treatment decisions. At the time of writing this article, the UK had reported more than 87,000 deaths while the vaccine is being rolled out. As this is unprecedented, rules

which might have been deemed unacceptable may have to be introduced. This is recognised by all stakeholders. The BOA acknowledges through its BOAST guidelines that, *"during the coronavirus pandemic, surgeons and patients will have difficult choices to make about management options for a wide variety of injuries and urgent conditions. They will need to balance optimum treatment of a patient's injury or condition against clinical safety and resources."* The BOA recognises that non-operative management of many injuries and reduced face-to-face follow up will be increasingly the norm[11]. The BOAST guidelines also recognises that changes to standard management plans may be required to minimise patient exposure to disease and overall impact on resources.

In this context, it is obvious that some patients undergoing elective surgery after a prolonged wait or those provided with non-operative treatment of some fractures are likely to end up with poor outcomes. Some of these cases might end with a legal challenges. From a practitioner's perspective although there is communal support at present from professional bodies and NHS institutions for deviating from standard management plans, it is important that each surgeon takes the responsibility for their actions and document the reasons for any deviation from the generally accepted standard of care. It is reasonable to expect that claims are likely to be processed in the same manner in the future also. As advised by the BOA, it is important that documentation is clear about the decision making, and treatment which has occurred during the COVID-19 pandemic.

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Although the above measures would make us feel comfortable, the effect of the Montgomery[12] ruling and the GMC consent guidance cannot be ignored even in the current circumstances. By law, patients are entitled to make irrational choices. The judges observed that patients should be seen as individuals holding rights and not as "passive recipients of care". Not surprisingly, the medical fraternity has suddenly woken up to the new reality and is calling for changes in the law[13]. In line with case law and the GMC guidance on consent, we are required to explain the options for treatment. There are a number of patients who would risk COVID-19 infection (with its associated mortality) to receive operative treatment for their fractures. This puts surgeons in a very difficult situation. As per the GMC's new consent guidance, there is only one situation where the patient's wishes can be refused: *"If after discussion you still consider that the treatment or care would not serve the patient's needs, then you should not provide it."*[14]

In the current pandemic, the surgeon is not holding back operative treatment as "it would not serve the patient's needs". The choice of treatment is decided by a combination of factors including decreasing risk to the patient and others by minimising hospital contact and by preserving theatre resources. Unfortunately, the GMC guidance does not cover this eventuality and surgeons may feel that their backs are uncovered in this unusual and unforeseen situation. It is the authors' opinion that the GMC should update the guidance to include the current scenario which could repeat itself (where it is obvious that the patient is likely to get a better outcome with early operative treatment e.g. fractures), but it could cause potential harm to others directly or indirectly due to COVID-19 risk and consumption of theatre time from which more needy patients would have benefitted. The case law which is aligned with the GMC guidance[15] mentions that confidentiality can be breached in exceptional circumstances where there is a danger to the individual or the public. Using the same principle, the surgeon should be enabled so that refusal of operative treatment requested by patient does not land the surgeon in deep waters and conflict with the current GMC guidance on consent. It is likely that there would be COVID-19 driven interpretations of Montgomery from the Courts to follow. ■

References

References can be found online at www.boa.ac.uk/publications/JTO.