COVID-19: second round legal issues

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We are now into the second wave of COVID-19 and it may be timely to have a look at the legal principles that may come into play. This article looks at three discrete challenges: COVID-19 wards, non-COVID-19 medical practice and health and safety of those working within hospital settings.

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COVID-19 ward

Let's start with a nightmare. Assume the case of a consultant orthopaedic surgeon in an NHS hospital who has to be deployed to a COVID-19 ward because otherwise there would be no medical cover; however, the orthopaedic surgeon has not worked in A&E or respiratory medicine for 30 years. A patient is treated in a manner that no responsible body of A&E/respiratory physician opinion would logically support (i.e. Bolam/Bolitho negligent) and suffers a worse outcome than s/he would otherwise have done. Where does the orthopaedic surgeon (or rather NHSR, who will indemnify him) stand?

The starting point is that any patient in a hospital is owed a duty of care. The issue is the standard of care required. The issue of the experience of the clinician in relation to the standard of care to be expected in his or her given role has occupied the Courts for many years. In *Wilsher v Essex Health Authority* [1987] Q.B. 730, it was held that the length of experience of the clinician was not relevant, and the duty of care related not to the individual but to the post they occupied. A houseman had failed to reach this standard by failing to notice a patient's spitting and pooling of saliva, in simply accepting what the patient's representative said and failing to obtain a proper case history, thereby failing to elicit details of a difficulty in swallowing which would reasonably have required him to detain the patient pending examination by an ENT specialist. It was probable that such further investigation would have revealed the condition and that treatment at that stage would have avoided brain damage.

In *FB v Princess Alexandra Hospital NHS Trust* [2017] EWCA Civ 334, the Court of Appeal overturned a decision that only a senior doctor would have had the expertise to apprehend the claimant's developing problem. Jackson LJ noted:

"59. In Wilsher v Essex AHA [1987] 1 QB 730 the Court of Appeal for the first time gave detailed consideration to the standard of care required of a junior doctor. (This issue did not arise in the subsequent appeal to the House of Lords). The majority of the court held that a hospital doctor should be judged by the standard of skill and care appropriate to the post which he or she was fulfilling, for example the post of junior houseman in a specialised unit. That involves leaving out of account the particular experience of the doctor or their length of service. This analysis works in the context of a hospital, where there is a clear hierarchy with consultants at the top, then registrars and below them various levels of junior doctors. Whether doctors are performing their normal role or 'acting up', they are judged by reference to the post which they are fulfilling at the material time. The health authority or health trust is liable if the doctor whom it puts into a particular position does not possess (and therefore does not exercise) the requisite degree of skill for the task in hand.
60. Thus in professional negligence, as in the general law of negligence, the standard of care which the law requires is an imperfect compromise. It achieves a balance between the interests of society and fairness to the individual practitioner."

That view was reiterated in the context of the facts of the case:

"The conduct of Dr R---- in the present case must be judged by the standard of a reasonably competent SHO in an accident and emergency department. The fact that Dr R---- was aged 25 and 'relatively inexperienced' (witness statement paragraph 5) does not diminish the required standard of skill and care. On the other hand, the fact that she had spent six months in a paediatric department does not elevate the required standard. Other SHOs in A&E departments will have different backgrounds and experience, but they are all judged by the same standard."

The law thus requires a standard no higher, and no lower, than a reasonably competent healthcare professional of the role which is being fulfilled.

So our orthopod is in trouble. Unless ...

The law has a principle – the 'rescuer principle' which in essence allows for a relaxation of the standard of care where individuals are working in an unprecedented emergency; its purpose being to prevent a fear of liability acting as brake on such activity.

This is now in statutory form via the Social Action, Responsibility and Heroism Act 2015. Section 1 of the Act states that it applies "when a court, in considering a claim that a person was negligent or in breach of statutory duty, is determining the steps that the person was required to take to meet a standard of care". Sections 2-4 detail matters which the court must have regard to, relating to the circumstances of the alleged breach of duty: whether it occurred when the person was acting for the benefit of society or any of its members, whether the person demonstrated a predominantly responsible approach towards protecting the safety or other interests of others, and whether that person was acting heroically by intervening in an emergency to assist an individual in danger. That might help our orthopaedic surgeon and his or her hospital avoid a finding of negligence.

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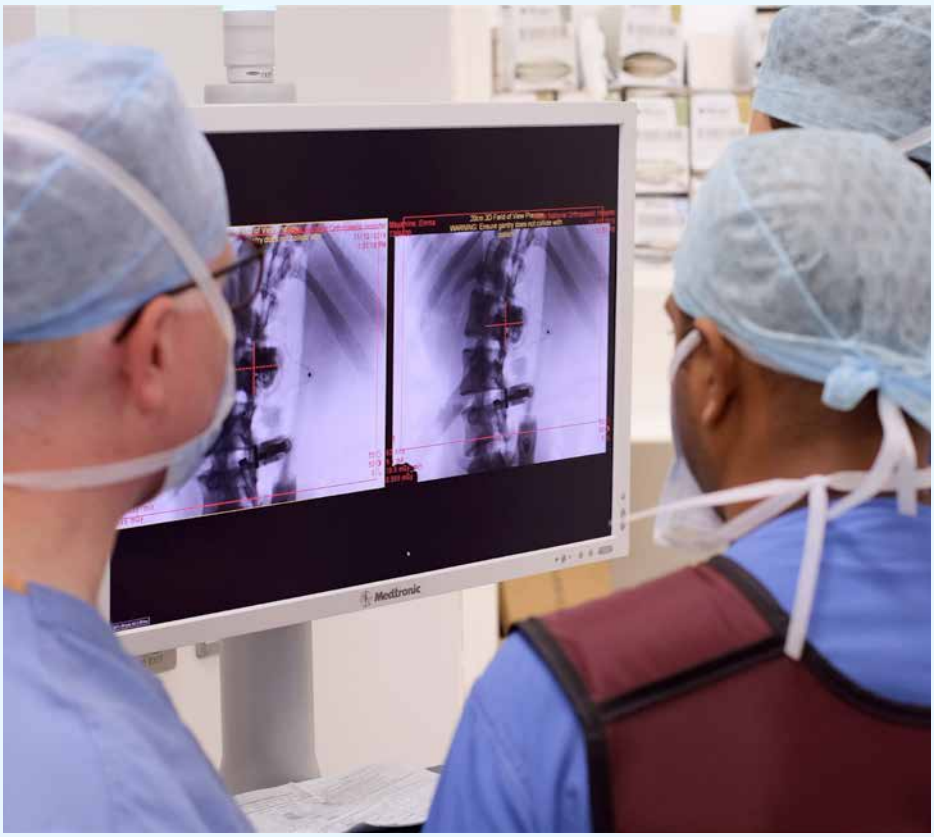
Assistance might also be drawn from Section 1 of the Compensation Act 2006, which provides that, when considering breach of duty, the court may have regard to whether the steps that should have been taken by the defendant to meet a standard of care might either prevent a desirable activity from being undertaken at all, to a particular extent or in a particular way, or discourage persons from undertaking functions in connection with a desirable activity. Whilst this does not strictly apply to our orthopaedic surgeon, in that healthcare professionals clearly do not fail to carry out desirable activities in respect of treating patients, it does give a clear indication that the standard of care has limits. It suggests that in certain cases, the rights of individuals to be compensated for their loss is trumped by the necessity of defendants not being deterred from carrying out important activities. So it may be a helping hand.

This principle has also appeared in case law, for example in *Marshall v Osmond* [1982] Q.B. 857, which involved a police officer whose driving caused injury to a passenger of a vehicle he was pursuing. In the first instance decision in this case, it was held that the defendant's *'actions must not be judged by standards which would be applicable if the situation were such that the officer had time to consider all possible alternative* >>



courses of action that he could have taken to discharge his duty successfully'. The Court of Appeal ([1983] Q.B. 1034) upheld the first instance decision, finding that there had been an error of judgment, but considering that there was not negligence. Sir John Donaldson M.R. referred to the circumstances of the collision, including that the officer was working in stressful circumstances. So it may be the case that the error of our orthopod incorrectly triaging a patient, this is more likely to be seen as a mere error of judgment.

But there is a problem here. We now know about COVID-19. The second wave has been predicted. The Courts are going to expect hospital management to have some planning in place. The Courts would also be asking our orthopod what if any steps s/he took to ascertain that it was a case of treatment from the orthopod or nobody better qualified.

Now let's notch down the example and assume that a respiratory physician decides not to treat a patient according to a particular protocol or with a particular drug. We are back with Bolam/Bolitho and judging clinicians by the standards of reasonably competent practitioners in the particular role acting logically. If the treatment ticks that box then there has not been a breach of duty: the law allows for different approaches to problems, different views.

Non-COVID-19 practice

There are three problems here.

Firstly, the five P's – Proper Preparation Prevents Poor Planning. The problem is receding but in respect of high end and indeed even some basic procedures there is a re-learning curve. Absent dire emergency the Courts are going to take a dim view if injury occurs because a consultant has missed something basic.

Next, consent. There may be a subliminal temptation to get up to speed with operations on patients who really don't fit the criteria. The urge would be entirely natural. I wonder if particular care with the consent process may provide the natural corrective.

Then there is the issue of post-operative support. Is it going to be there for the patient? Is an isolating eighty year old patient going to be in a position to undertake post-operative physiotherapy themselves following basic instruction? Would Zoom instruction be adequate? Has the patient access to Zoom? Even taking all that into account might it be better to operate? Essentially we are back with the informed consent process. If difficult decisions are involved – possibly unusual decisions based on available treatment and follow-up modalities then best to ensure that the problems are discussed carefully and recorded. I recollect doing some training for local government health and safety officers many years ago on then recent health and safety legislation which involved the need for risk assessments. At the end one of the delegates stood up and said: "This is all splendid stuff but me and my boss know what we're doing: and if you don't write it down they can't get you!" Hopefully their insurers had deep pockets ...

Safety for those working in the hospital

The government watered down protections for workers when it introduced legislation in the form of the Enterprise and Regulatory Reform Act 2013 that removed any civil liability from a breach of the Health and Safety at Work Act/regulations made under it. So a claimant alleging, for example, defective or inadequate personal protective equipment now has to show negligence – it is not possible to rely on what sometimes amounted to strict liability, or where the employer had to effectively disprove negligence. In practice there has not been much difference: if relevant regulations have not been complied with the judiciary is very content to take that as evidence of negligence but the burden is full square on the claimant.

In terms of exposure to COVID-19 the greater problem may be that of causation. How does the infected clinician show that it was defective or inadequate or non-existent personal protective equipment that resulted in the clinician contracting COVID-19 and falling very ill? That will be a matter of evidence gathering: if it is a one-off occasion that may be harder than a systematic failure. Of course the same issues pertain if a patient has become infected at hospital and believes that a clinician was not using PPE, for example.

Finally, fatigue. This is pernicious – deep tiredness most certainly plunders the ability to appreciate and deal with the tiredness by taking a break/time off. That may in any event be difficult with waiting lists, but in terms of personal health and the health of patients it is a pretty critical issue. Hospital planning may not always have been perfect.

These may all be issues requiring action at consultant, clinical director and deanery level.

For all of the above it is worth remembering that the Courts are largely and rightly sympathetic to clinicians, and pragmatic.

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