


PERSPECTIVE

COVID-19 and medical litigation: More than just the obvious

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Abstract

COVID-19 has massively changed the health landscape around the world. Wide-ranging changes to healthcare delivery have occurred, especially in hospitals and EDs. Health services have made local decisions about care pathways, in some cases deviating from what would, until recently, have been considered widely accepted care. These changes bring with them new medicolegal risk for clinicians. In Australia, civil liability Acts provide protection for professionals when the criterion of having undertaken ‘competent’ practice that would be ‘widely accepted’ ‘in the circumstances’ is met. There is doubt how courts, and the medical experts who advise them, will evaluate clinical care provided during the pandemic when health services have developed local care pathways and there is no nationally accepted standard.

Key words: COVID, medicolegal, negligence.

COVID-19 has massively changed the health and economic landscape around the world. At the time of writing (4 May 2020), there have been 3.5 million confirmed cases of COVID-19 worldwide and 247 000 deaths.¹ Due to variation in testing and how deaths are counted, this is likely to be a significant under-estimation. Fortunately, so far, Australia and New Zealand

have been relatively spared, with 6797 and 1487 confirmed cases and 95 and 20 deaths, respectively.¹

Early in the pandemic, clinicians were rightly worried about potential medicolegal implications of treatment decisions (particularly allocation of ventilators and ICU care) in confirmed or suspected COVID-19 patients in a potentially resource-poor, over-stretched health system. Fortunately, so far, we have been spared this in Australasia.

However, changes to the health system because of COVID-19 have been wide ranging and not limited to suspected or confirmed cases. Some treatments recognised as the standard of care have been curtailed. Patients in hospitals are being cohorted based on COVID-19 risk rather than clinical need. In Australia, these changes may leave clinicians open to allegations of negligence. While this commentary will focus on medical litigation, the same legal principles apply to other clinicians.

Standard of care in professional negligence

To understand how claims in negligence can arise, some explanation of the legal basis of claims is needed. Australian civil liabilities Acts define negligence as failure to exercise reasonable care and skill.² They also contain what is known as the professional practice defence. Although worded

slightly differently in different states, this provides that a person practicing a profession does not incur liability in negligence if the professional acted in a manner that (at the time the service was provided) was widely accepted in Australia by peer professional opinion as competent practice in the circumstances. If there are differing peer professional opinions widely accepted in Australia concerning a practice, one or more can be relied on for the defence. Professional practice does not have to be universally accepted to be considered widely accepted.²

Whether professional practice was ‘competent’ is decided by the court. Clinical experts provide evidence to inform the court. In the case of ED care, these experts are usually, but not exclusively, emergency physicians.

The key words of relevance during the current pandemic are ‘widely accepted’ and ‘in the circumstances’.

The obvious

The ‘circumstances’ that were most ethically and legally concerning were the prospect of having to decide who would be ventilated and/or receive ICU care if demand exceeded resources. This is the position faced by colleagues in UK, Europe and United States.

This led to the development of a large number of ethical guidelines at the health service, discipline and national levels.³ While helpful, many were short on practical details about how to make decisions. They effectively put the onus on hospitals, health services and clinical teams to make decisions at the local level. Whether decisions made in this context could ever be considered ‘widely accepted’ is open to question. In practical terms, how would an

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independent expert or court reliably assess whether clinical practice in these circumstances was ‘competent’?

Another thorny question, especially if ventilators are scarce, is withdrawal of ventilation – more specifically withdrawal of ventilation from one patient so that another can be ventilated. If a patient being ventilated is deriving benefit from ventilation, even if their prognosis is poor, withdrawal of ventilation could raise the question of unlawful killing.

Some jurisdictions have recognised these medicolegal risks and moved to protect health workers who act in good faith. For example, New York State Executive Order no. 202.10 provides immunity from liability to healthcare workers who provide care ‘in support of the state’s response to COVID-19.’ Other US states have made similar provisions. This immunity does not protect against gross negligence or from being sued, but does provide a defence against a claim of negligence. In the UK, a different approach has been adopted with the National Health Service being indemnified for claims of negligence, limited to care provided to known or suspected COVID-19 patients, under the *Corona Virus Act 2020*. Healthcare regulators such as the General Medical Council (UK) has recognised the challenges of the pandemic and undertaken to assess any complaints against a clinician based

on the specific facts of the case, the environment in which the professional was working and any relevant information about resources, guidelines or protocols in place at the time.⁴ No such provisions have, as yet, been made in Australia.

The not so obvious

Patients with respiratory symptoms, in particular shortness of breath, provide the biggest challenge. Some patients may have COVID-19 as the cause of their shortness of breath, but most will not, especially when COVID-19 cases numbers are small, as is the case currently in Australasia.

In pre-COVID times, treatment pathways for acute pulmonary oedema (APO) and exacerbations of chronic obstructive pulmonary disease (COPD) were similar across health services. These included the use of non-invasive ventilation (NIV) for more severe cases, as it has been shown to reduce mortality and the need for intubation.^{5,6} NIV is, however, regarded as an aerosol-generating procedure and thus poses a risk of transmission of COVID-19 (if present) to staff and other patients. Many hospitals have developed new, local treatment pathways. Specifically, a proportion now preclude the use of NIV, except in very exceptional circumstances. It is likely that as a result of this treatment

change some patients with APO and COPD who may have survived will die, leaving clinicians open to an action in negligence. While the rationale for minimising NIV was sound when large numbers of COVID-19 cases were anticipated, it will be hard to argue when numbers are small and when risk mitigation strategies such as personal protective equipment (PPE) and negative pressure rooms are not in high demand. Argument will hinge on how likely the presentation was to be COVID-related (including how to define and quantify ‘suspected’), the availability of risk mitigation strategies and what was ‘reasonable’ in the circumstances. This will be hard to judge in hindsight.

Health system changes also impacted residential aged care facilities (RACF). Although there has been no formal directive to avoid transfers from RACF, a fall in transfers has been observed (anecdotal). This is likely to be multi-factorial. Staff at RACF are having to weigh up the clinical risk to patients if cared for in place, the risk to a resident that they might contract COVID-19 in an ED, the risk that a patient might bring back COVID-19 from a hospital to a facility and use of ambulance and ED resources. This is a significant change from pre-COVID decision-making processes.

At the time of writing, there is reportedly at least one case before the Victorian coroner of a RACF patient who died from an intracranial haemorrhage following a fall in whom ED transfer was deferred. It is unclear how coroners and courts will take the circumstances of the pandemic into consideration in cases such as this.

There are other medicolegal implications. Space does not allow discussion of clinicians working outside their area of expertise or of the potential negative impact on outcome of patient cohorting in hospitals by perceived COVID risk rather than clinical care streams.

A question of timing

When pandemic planning in Australasia began in February, large

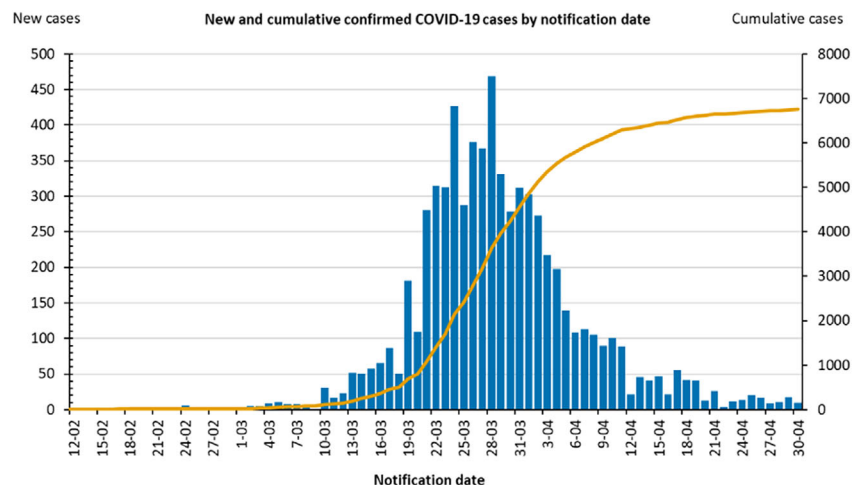


Figure 1. Case notification profile in Australia (reproduced from the Department of Health, www.health.gov.au, with permission). (■), New cases; (—), cumulative cases.

case numbers and an overstretched health system were anticipated, and clinical pathway decisions were made on that basis. As case number rose quickly in early March (Fig. 1), these decisions seemed justifiable. But as control measures worked and case numbers fell to low levels (Fig. 1), the justification for some of the changes is tenuous. For example, the justification for withholding NIV for patients with APO and COPD when risk mitigation strategies are available, could be challenged. Put another way it would be possible to argue that a death related to withholding of NIV for APO or COPD patients between mid and late March was justifiable based on the case-rate trajectory and risk that the presentation was COVID-related. By mid-late April, that argument is weak, especially in communities with very low (or no) cases.

Accurate and dynamic record keeping by health services and/or clinicians about the circumstances of the ED or health service at the time care was delivered will be influential in justifying chosen courses of action. But will it be available?

Summary

Changes in Australasian healthcare systems due to COVID-19 have increased clinicians' risk of medical litigation. The risks directly associated with decision-making for patients with known or suspected COVID-19 are obvious. There are also less obvious risks related to interfacility transfers and decision-making for patients with respiratory symptoms who have otherwise low COVID risk. For this latter group, the risk is dynamic. While actions may have been justifiable when case numbers were rising, they may not be when case numbers are very low. How courts, and the experts who advise them, will balance the facts and the issues if cases arise will be interesting to observe.

Competing interests

AMK is a member of the editorial board of *Emergency Medicine Australasia*.

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