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Analysis and recommendations regarding surgeons’ liabilities during an acute health crisis

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ABSTRACT

The SARS-CoV-2 pandemic has highlighted discrepancies between surgeons’ professional duties and legal protections when acting outside their specialities during the pandemic. These discrepancies between legal and professional standards leave surgeons and the NHS vulnerable to litigation. In the following article, we explore the liabilities that have arisen for surgeons during this period in the United Kingdom and Canada. We recommend, upon review of the literature, that a two-pronged approach be taken to address these discrepancies; (a) a change in policy at the national level to accurately reflect the constraints and demands placed upon the profession in this acute health crisis and (b) the provision of clearer, more stringent legal protection. In the interim, we suggest that individual surgeons utilise a decision-making framework where they consider their personal and professional obligations in regard to resource stewardship, innovation in practice, patient-specific contexts, and patient advocacy while acting outside of their speciality.

1. Introduction

During the SARS-CoV-2 pandemic, ethical and professional duties have compelled surgeons to act outside their specialities. In the following article, we explore the liabilities that have arisen for surgeons during this period in the United Kingdom and Canada. Following our analysis of cases and outcomes within these jurisdictions, we propose a framework that facilitates decision making for surgeons acting outside their surgical speciality but within a general medical capacity whilst providing care during the ongoing acute health crisis.

2. Methods

A scoping review of articles pertaining to physicians’ legal rights and liabilities during the SARS-CoV-2 pandemic was conducted of medical and legal databases; PubMed, Ovid MEDLINE, WestLaw, and LexisNexis. Statutes and case law across two jurisdictions; the United Kingdom and Canada were retrieved and analysed.

3. Results & discussion

3.1. Professional body guidance

The medical regulatory bodies in both countries – the Canadian Medical Association (Canada) and the General Medical Council (GMC) (UK) – hold a similar position; imposing ethical and professional duties to act in an emergency [1,2]. This directly conflicts with the legal position of both countries. The Social Action, Responsibility & Heroism Act 2015 (UK) and the Good Samaritan Act 2001, (Ontario, Canada) both state that individuals (regardless of their level of medical training) have no legal duty to act in a medical emergency, and if they do offer assistance they will not be held liable and are protected from negligence claims [3,4]. Most provinces in Canada have a similar Act in place as Ontario, with only the province of Quebec ruling that individuals have a legal obligation to assist others in an emergency [5]. Professional guidance urges surgeons to assist during medical emergencies (including the SARS-CoV-2 pandemic), however, the law imposes no obligation to act. This conflict makes it unclear what level of negligence protection surgeons would receive if they chose to work outside their surgical speciality. For example, The Social Action, Responsibility & Heroism Act 2015 (UK) and the Good Samaritan Act 2001 (Ontario, Canada), only offer protection from negligence claims if the medical assistance offered...
is ‘voluntary and without reasonable expectation of compensation or reward’ [4]. However, if the medical regulatory bodies claim that assisting during the pandemic is merely an extension of a physician’s professional duties (and therefore, not voluntary), then physicians may not be legally protected under the Good Samaritan laws. This becomes problematic when surgeons are re-deployed into acute medical wards and intensive care centres without proper training whilst still being liable to provide the same standard of care as a fully qualified intensive care physician.

3.2. Case law

This legal precedent was set in the UK by the Wilsher case (1988) which ruled that a junior doctor owes the same standard of care as a fully qualified doctor [6]. Applied in the context of the SARS-CoV-2 pandemic, a surgeon acting as a physician in a general medical capacity may be liable to provide the same standard of care as a medical specialty consultant, despite having received vastly different training. Whilst it is understandable that this legal precedent was set to ensure that all physicians deliver the same standard of care, it is unrealistic to assume that surgeons, who have been abruptly re-deployed to acute medical wards, would possess the same skills and knowledge of their medical specialty counterparts. Therefore, there is a need for protective legislature to protect the surgeons who chose to step out of the comfort of their specialty and assist during this acute health crisis.

Bonvini et al. discussed the worrisome potential litigation arising from physicians ‘unintentionally causing an epidemic’ due to negligence, inexperience, or failure to comply with regulations [7]. While it may be exceptionally difficult to prove causality of a physician’s actions in causing an epidemic, it nonetheless adds an additional stress to an already confusing and novel environment, especially to redeployed surgeons working in a new capacity. In efforts to prevent a wave of litigation post-pandemic, a BMJ article argues that governments should address the current extraordinary and uncertain climate by introducing legislation to exempt physicians from COVID-19 related clinical negligence claims [8]. Whilst physicians would still be held accountable for their actions, they would not need to fear litigation for practicing medicine in unprecedented times where guidance and resources are limited.

3.3. Current professional body guidance

On March 11th 2020, the GMC and Chief Medical Officers released a joint statement of support for surgeons acting outside of their training during the SARS-CoV-2 pandemic and restated the GMC position that there is an ethical and professional duty to act [9]. Although current pandemic specific guidance still places an onus on surgeons to act and provide care for patients, it fails to address the following:

- Consider the specific training required to address an essentially medical presentation.
- Provide an appropriate medium for address or redress of liabilities as they arise.
- Formally recognise the pandemic as an exceptional situation in which increased context-specific subjective provision of care would be required.
- Advise surgeons of the potential penalties of using alternative less preferred therapies in order to accommodate the global need of the community.
- Identify the limitations and liabilities from innovation that are arising with the use of novel drugs, devices, and procedures in the treatment of SARS-CoV-2.
- Address the liabilities that may arise from the higher risk of occupational exposure and concomitant second-order risk that an infected surgeon may pose to patients or colleagues.

3.4. Decision-making framework

Whilst our research has identified some of the more pressing issues that have arisen as a result of the pandemic, it is by no means a comprehensive list. Further liabilities may arise due to the constantly evolving clinical environment created by the SARS-CoV-2 pandemic. It is acknowledged that to enact policy changes at a national level requires stakeholder input, consensus, and regulatory body impetus. It is our recommendation, upon review of the literature, that a two-pronged approach be taken to address the aforementioned points; (a) a change in policy at the national level to accurately reflect the constraints and demands placed upon the profession in this acute health crisis and (b) the provision of clearer, more stringent legal protection. In the interim, until formalisation of such policy, and in light of our research findings, we recommend that individual surgeons utilise a decision-making framework where they consider their personal and professional obligations in regards to: resource stewardship, innovation in practice, patient-specific contexts, and patient advocacy whilst acting outside of their specialty (see Fig. 1). Resource stewardship refers to balancing the needs of the patient population with the realities of supply availability to ensure that resources are allocated and distributed fairly. This will involve active collaboration throughout the multidisciplinary team and hospital administration along with a willingness to communicate regularly to ensure resources are continually optimised. To consider innovations in practice physicians will need to remain up to date on the current evidence-based practices and be able to critically review and consider the benefits and harms of implementing new medical interventions. This is especially important for surgeons who have not practiced acute medicine recently and will require a concerted effort to review current best practice guidelines, as well as remaining aware of the latest COVID-19 innovations. During the SARS-CoV-2 pandemic, it will be more important than ever to consider patient-specific contexts to ensure that patient quality of life is optimised and that their care is governed by a holistic medical approach. This includes active review and consideration of patients’ comorbidities and social circumstances whilst treating their SARS-CoV-2 infection. Finally, medical professionals will need to become advocates for their patients during this health crisis to ensure equitable access to healthcare is provided and that barriers to access are challenged. This may be particularly relevant for patients who are shielding and as a result, have greatly reduced access to medical care. It is vital that extra effort is made to ensure these patients have safe access to care throughout the pandemic.

Overarching these four pillars, are physicians’ personal and professional obligations during an acute health crisis. Physicians’ personal obligations are similar to those of the public during an acute health crisis in the fact that all persons are governed by the Good Samaritan Laws if they choose to offer voluntary assistance to those in need. Physicians’ professional obligations are governed by the GMC Good Medical Practice which states that physicians should ‘make the care of [their] patient [their] first concern’ [2]. This includes seeking expert advice if unsure about any aspect of a patient’s management. However, this may be problematic during an acute health crisis where departments are short staffed and senior medical physicians may be unavailable. In these scenarios, it will be important for surgeons working in an acute medical capacity to assess the urgency of patient’s medical need and allow this to guide whether it is appropriate to act immediately, or to wait for senior input. This decision-making framework is flexible and can be applied during the ongoing SARS-CoV-2 pandemic and any future acute health crises until formal policies are implemented.

3.5. Limitation Act 1980

Currently, professional regulatory bodies impose a duty to act in healthcare emergencies. Yet, formal legal protection has not been codified by either professional regulatory bodies or governments. These discrepancies between legal and professional standards leave surgeons
and the NHS vulnerable to litigation. It is important to note that under the Limitation Act 1980, claimants retain their ability to file a claim of negligence for three years after they become aware of their injury (the three years do not begin until the claimant has reached the age of 18) [10]. This means that negligence claims can continue to be filed for many years after the pandemic has subsided and therefore, there will be a long-lasting need for protective legislature.

In addition to protective legislature, Parisi et al. suggest the creation of ad hoc emergency funds to provide compensation to patients who suffer financial damages due to the COVID-19 pandemic [11]. Trained mediators could be used in lieu of legal courts for determining which patients deserve compensation which could help further reduce costs and streamline the process.

4. Conclusion

Ultimately, the SARS-CoV-2 pandemic has highlighted discrepancies between physicians’ professional duties and legal protections. It has forced surgeons to work outside their specialities, increasing their liability and risk of negligence claims. This situation is echoed in other countries, with Canada examined as an example above. This risk will continue for years following the pandemic, so it is imperative that the legal and professional discrepancies are remedied, and formal legal protections are put in place. In the meantime, our framework is designed to similarly evolve and adapt to these changing circumstances and provide a robust decision-making framework to protect and support surgeons working outside of their scope of training.

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Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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