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Shared Services Partnership

Legal and Risk Services
COVID-19 – Clinical Negligence Newsletter
April 2020

COVID-19 – End of Life Decision Making

It is anticipated that during the course of the COVID-19 pandemic there will be increased incidences of disputes with family members about the continuation or withdrawal of life sustaining treatment. This article provides a summary of the law that applies in situations where a patient lacks capacity to make the decision themselves. We provide recommendations as to what steps Health Boards need to take in order to ensure they are acting in the best interests of the patient. These principles apply irrespective of whether the patient has contracted COVID-19.

Defence under the Mental Capacity Act (MCA)

A doctor's defence under the Mental Capacity Act is separate to the normal test in clinical negligence claims. Reasonable steps must have been taken to establish that the patient lacks capacity and there must be a reasonable belief that the decision made is in the patient's best interests. There must be full compliance with the terms of the MCA. Anything less may not be considered reasonable.

Best Interests

In general, any best interests decision must take into account all the relevant circumstances. This includes permitting and encouraging the patient to participate. Their past and present wishes and feelings, beliefs and values must be taken into account. As too should the views of those interested in the patient's welfare.

There is a strong presumption in favour of the preservation of life, but this does not displace the patient's best interests as the paramount consideration.

When assessing best interests it is important to remember:

A. That the question is not whether it is in the best interests of the patient to die. The question is whether it is in the best interests of the patient to continue the treatment;
B. Decision-makers must look at welfare in the widest sense, not just medical but social and psychological;
C. Treatment does not have to cure or palliate the underlying condition or return the patient to full or reasonable health. Rather it should be capable of allowing the resumption of a quality of life which the patient would regard as worthwhile.

Common issues

Options – a Court can only choose from the options that would be available if the patient had capacity. Therefore it cannot order med-

This time of unprecedented uncertainty and change is giving rise to numerous and varied legal issues. I hope this special edition of our newsletter will provide some answers. It is aimed at considering the impact of COVID-19 in respect of clinical care and negligence claims. Unfortunately, many more difficult end of life decisions are likely to be necessary and our Complex Patient Team lead, Gavin Knox, has written an article setting out the legal issues, which you may wish to distribute to colleagues involved in these decisions.

Importantly, Mark Harris has been appointed the new Director of NWSSP Legal & Risk Services. Mark will be known to many of you already and has hit the ground running, taking over at such a crucial time. http://www.nwssp.wales.nhs.uk/page/100735

Finally, I want to finish by saying thank you on behalf of Legal & Risk Services to all our frontline colleagues and assure you we are fully operational and here to support you.

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ical treatment to be provided if it would not otherwise be available. If a treatment is not being offered (e.g. admission to ITU, CPR) then clinicians need to be clear as to their reasons and whether these are truly based on a professional objection to offering the treatment, or as a reflection of their opinion on best interests. A good test is to consider if the clinician would still refuse to offer the treatment if a Court was to find that it was in the patient's best interests. The challenge during the COVID-19 pandemic is the danger of the perception that treatment options are being withheld in order to prioritise other patients. If such rationing of resources is contemplated then policies and clinical criteria need to be very carefully defined to ensure they are not unlawfully discriminatory.

Communication – often the source of dispute with families has at its origins, communication of key information. During the COVID-19 pandemic this will be a particularly challenging problem as visitors are restricted and there may be a perception that treatment options are being rationed unfairly. The MCA requires that those interested in a person's welfare must be consulted where practicable and appropriate. Health Boards need to make every effort to establish the most effective way of communicating in such situations, making use of technology where possible, or considering exceptions to visitor restrictions.

Insufficient assessment evidence - the level of awareness and ability to experience pleasure and pain is often one of the main disputes between health professionals and family. The Courts recognise that family members are with the patient more often than health professionals and that family members are often more able to elicit a response from patients than the people treating them. However, the courts also recognise that the views of any families may, very understandably, be coloured by their own emotion or sentiment. There is a risk of lack of trust in clinician judgement in situations where families are restricted from visiting. The Health Board will therefore need to provide clear evidence of the patient's level of awareness and ability to experience pain and pleasure. This should be done in an objective way in accordance with best clinical practice.

Predicting prospect of recovery – families often have a different view on prospect of recovery to the clinicians and, in some high-profile cases families have been right and the patient has recovered when they were not expected to do so. Therefore, the court will want to have sufficient evidence over a period of time to be able to conclude whether or not the patient is improving, deteriorating or stable. Remember, the Court is not concerned with the prospect of making a return to good health but rather whether the patient can resume a quality of life which they would regard as worthwhile. A second opinion from a clinician not directly involved in treatment is usually the best first step.

Establishing the wishes, feelings, values and beliefs of the patient

The quality of life should be judged not by the values of others but from the particular perspective of the patient. It is an important part of the process to have full and frank discussions with the family about the patient's beliefs and values at the earliest opportunity, as this will help distinguish between what the patient would have wanted and what the family member wants, which may be different. The restrictions due to COVID-19 will pose significant challenges to this process.

Obtaining Legal Advice

These are often complex dynamic situations, which if unresolved necessitate an application to the Court of Protection. Our Complex Patient Team has significant experience in helping resolve disputes with families and where necessary making applications to court to determine what is in the patient's best interests.

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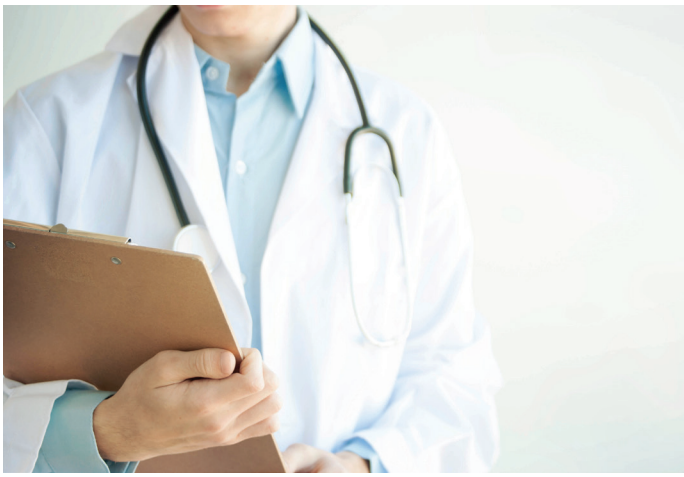
The Impact of COVID-19 on Clinical Negligence Claims

This crisis is requiring huge changes in the way healthcare is being provided in terms of location, personnel and availability of treatment.

As a member of the legal profession I am ashamed to say that clinical negligence lawyers are already considering how to bring claims arising out of the pandemic. We assure you that these will be robustly defended. However, we need your help to be able to do this as the ability to defend a clinical negligence claim hinges on the evidence available.



From my limited knowledge of the virus, I do not envisage there being a significant number of claims in respect of patients suffering from COVID-19 alone. Where patients have died from the virus, claims may be brought in respect of decision making around admission to ITU, ventilation and any other treatment options. There could also be claims in respect of allegedly negligent infection control from patients who claim to have contracted COVID-19 whilst an in-patient with an unrelated issue. These will be very difficult for Claimants to prove.

However, there may be an increase in the number of "usual" clinical negligence claims which arise from acute events during this crisis period. It is unlikely, for example, that there will be less people suffering from cauda equina syndrome, acute appendicitis and many other acute presentations which lead to claims. However, the ability of the NHS to respond to patients who present with these conditions, may be significantly compromised, which could lead to less favourable outcomes for patients. It is also inevitable that the procedures and policies in respect of ante-natal care, labour and cancer treatment, will have changed to protect staff and patients from infection. These changes may have increased risks to patients, for example because routine assessments have been cancelled. Injuries which would not have occurred, but for the changes made to combat the virus, are not due to negligence, and will be defended.

It is important to remember the legal test for whether there was a breach of duty of care -

A clinician has been negligent if they have not followed a practice which was deemed to be acceptable by a responsible body of medical opinion. That responsible body need not be a majority body. The clinician must then act in accordance with the practice to a standard to be expected of a reasonably competent clinician. If the doctor holds himself out to be especially qualified in any particular field then the standard is that of a reasonably competent specialist.

The appropriate standard of care during the current crisis may well be different to the previous standard. This will be a matter of fact in each case. If the actions of a clinician during the current crisis would be supported by a responsible body of medical opinion, which can be a minority body, a legal claim will not succeed.

However, evidence will be needed to demonstrate the working environment in which the clinician found themselves at that point in time. Setting out the context will be key. This will include reference to national, professional and local guidance/policies; information regarding staffing levels; and of course, patient records. Resource allocation decisions will also need to be scrutinised as will minutes of meetings discussing changes to procedures, which demonstrate the balancing of risks and resources. Review of these decisions as the crisis progresses, will be essential.

There will also be an impact on clinical negligence claims where the allegedly negligent event occurred prior to this crisis. There will be some instances where there was already a negligent delay in treatment, which previously would have been unlikely to have caused any, or only minimal, damage as treatment would have been provided in time to avoid this. However, if such treatment is further delayed as a result of the impact of COVID-19, the breach of duty may now result in significant damage and a more substantial legal claim. Therefore, with many treatments and surgeries cancelled for the foreseeable future, the possibility of limiting the damage caused by already negligent delays has significantly decreased and, in some instances, will have been lost. The higher the value of a potential claim, the more likely it is that it will be pursued. Therefore, it is likely we will see more of these claims once this crisis is over.

In the short term it is likely there will eventually be a fall in the number of new legal claims being brought as claimant solicitors' firms have closed their offices and potential clients will find it more difficult to access legal advice. However, there is no doubt there will be an influx of claims when the current crisis is over.

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Informed Consent during COVID-19

The legal position as to what constitutes informed consent has not changed in light of COVID-19. The issue is how best to approach, and indeed evidence, informed consent. This is a practical, rather than legal, issue.

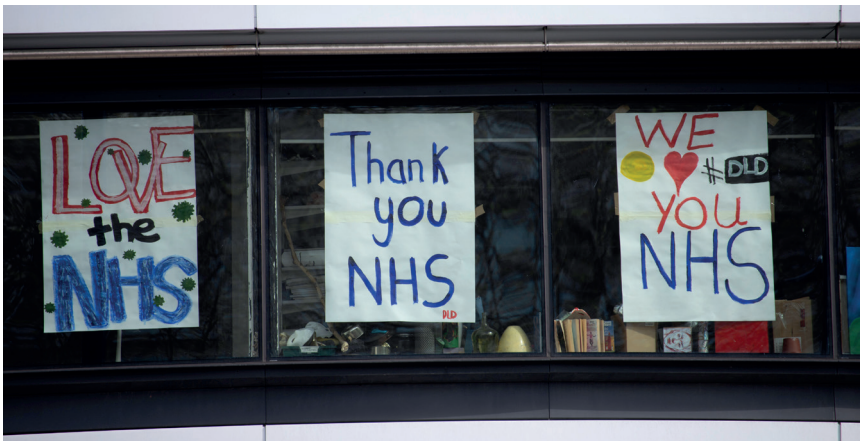
Following the Supreme Court judgement in ***Montgomery v Lanarkshire Health Board (2015)*** a doctor is under a duty to take reasonable care to ensure that the patient is aware of any material risks involved in a recommended treatment and of any reasonable alternative or variant treatments.

The test of materiality is subjective in that it should be considered whether, in the particular circumstances, a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it. The legal position is in line with the patient centred approach to informed consent that is contained within the GMC Guidelines.

The following observations concerning consent may be of assistance to organisations who are re-visiting their processes for obtaining informed consent in light of COVID-19.

Firstly, there is no strict legal rule on who can obtain consent. The person who is consenting the patient should, however:

- Be competent to provide the information
- Be trained to advise
- Have knowledge and understanding of the potential complications and risks
- Be able to conduct the relevant treatment/procedure



Secondly, validity of consent does not depend on the form that it is given. That is to say, in general, there is no legal requirement for consent to treatment to be in writing. Valid informed consent can be implied or oral. Nevertheless, it remains good and standard practice for consent to be provided in writing, so it is evidenced.

Consent should continue to be documented and consent forms should continue to be used. If obtaining a physical signature is proving to be difficult then consideration should be given to using electronic signatures, if possible. Alternatively, the patient could provide his/her written consent in clear unequivocal terms electronically, but without a signature, as long as the person taking that consent is confident that the consent being provided is voluntary. Good practice, and an additional safeguard would be to ensure that when the person attends for treatment, the consent process is revisited so that the patient is asked to confirm that they have previously undergone a thorough consent process and given their informed consent. At this stage a signature can be obtained if possible.

Key elements of discussions with patients and the details of decisions made, should continue to be recorded in writing. More specifically, the nature/purpose of the procedure (and aftercare) should be documented, the benefits and material risks should be noted, and alternative treatments should also be discussed and recorded. Any information that is provided by way of leaflet for example, should also be noted.

It is important to continue to ensure the consent process is documented, patient specific, clear and understandable. With this in mind, any alterations to the consent process as a result of COVID-19 must suit the particular patient in question and not hinder their ability to give effective informed consent. Furthermore, if, as a result of COVID-19, there is a change to the way consent is being given then it should be clearly noted that the reason for this is because of COVID-19.

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Legal Liability for Clinical Negligence Claims – Vicarious Liability

Vicarious liability means simply that one person will be held liable for the actions of another. In law an employer is legally liable for the actions of its employees. Therefore, any legal claim brought by a patient for negligence is brought against the employing NHS body and not the individual/s who provided the treatment.

This legal principle is not limited just to traditional employees. It can apply outside the traditional employer/employee relationship, to relationships similar to employment. The key issues are the extent to which the individual carries out work for the benefit of the employer and the extent to which the employer has some element of control over the individual in question ("the relationship test").

In addition, for the employer to be found to be vicariously liable, the employee must have committed the negligent act during the course of their employment ("the connection test).

The application of the two tests has given rise to much litigation and the law has recently been clarified by the judgement given by the Supreme Court on the 1st of April 2020 in the cases of ***WM Morrisons Supermarkets plc v Various Claimants*** [2020] UKSC 12 and ***Barclays Bank plc v Various Claimants*** [2020] UKSC 13 ("*Barclays*"). Barclays had engaged a private medical practitioner to carry out the examinations on its behalf. The Supreme Court found that Barclays was not vicariously liable for sexual assaults carried out by the private medical practitioner, as he was carrying on business on his own account. In the Morrisons case, the Supreme Court found that Morrisons was not vicariously liable for the actions of an employee who leaked the personal information of 126,000 of Morrisons' employees. Crucially, he did so for the specific purpose of harming his employer and it was therefore found he was not engaged in furthering his employer's business.

The new ways of working necessitated by this crisis raise many indemnity issues. Guidance on the most common queries can be found at http://www.nwssp.wales.nhs.uk/page/100775.

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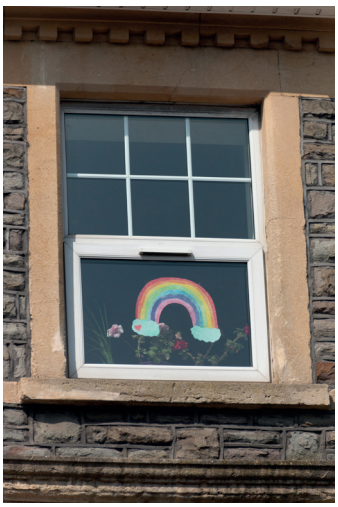

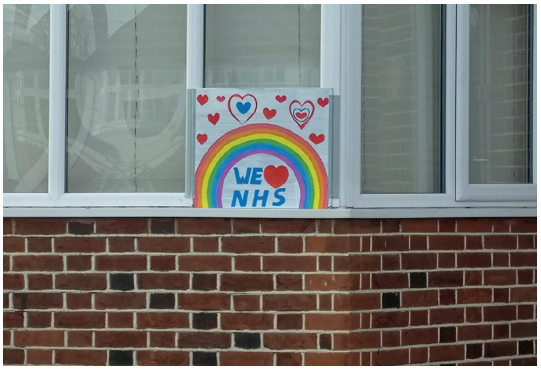

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