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Original
COVID-19: The wrong target for healthcare liability claims / Parisi, S. G.; Viel, G.; Cecchi, R.; Montisci, M.. - In: LEGAL MEDICINE. - ISSN 1344-6223. - 46:(2020), p. 101718. [10.1016/j.legalmed.2020.101718]

Availability:
This version is available at: 11381/2885826 since: 2022-01-21T20:31:46Z

Publisher:
Elsevier B.V.

Published
DOI:10.1016/j.legalmed.2020.101718

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(Article begins on next page)

12 October 2024

Legal Medicine

COVID-19: the wrong target for healthcare liability claims

--Manuscript Draft--

Manuscript Number:	LEGMED-D-20-00166
Article Type:	Editorial
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Dear Editor, hereby we send for publication in your journal a commentary on the current situation regarding COVID19 from a medico-legal point of view. We tried to start a debate on the possible criticalities that are expected to arise in the next future regarding issues of professional liability.

We hope our commentary will be of interest for your journal, and we propose it as an Editorial or Short communication.

Thank you very much and kind regards

COVID-19: the wrong target for healthcare liability claims

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We declare no competing interests.

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COVID-19: the wrong target for healthcare liability claims

Abstract: Regrettably, after a first moment of appreciation and praise of the citizens for healthcare personnel facing COVID 19 pandemia, numerous episodes of actions taken against them on the issue of their legal liability followed. Impelling is to start an argumentation on this problem that aims to establish a shared conduct in dealing with them. The authors propose a basis for discussion on which to begin a constructive debate.

Key words: pandemia, emergency, COVID19, professional liability, healthcare personnel

Regrettably, in the complex setting of the current coronavirus pandemic, an incoercible succession of events, revolving around the question of the professional liability of healthcare personnel, with the typical peculiarities of emergency situations, is emerging [1].

As a matter of fact, after an initial, choral and unquestioning appreciation and praise of the citizens for healthcare operators [2], numerous episodes of actions taken against them on the issue of their legal liability followed [3]. This has prompted the medical scientific societies and trade unions to take a defensive stance, and loudly call for the healthcare system as a whole to safeguard its interests. They have asked for targeted political actions to issue clear rules, and not only about the implementation of "quarantine" measures [4]. But the exceptional nature of the present emergency cannot hide the fact that individual health operators are responsible for their own work behavior, making it difficult to build a national normative "barrier" (criminal and civil) to protect them [1].

The scenario that has come true can undeniably be defined in insurance terms as "catastrophic", and, as such, necessitates organizational measures (at all health facilities) to identify appropriate standards of care, competencies, compliance with shift-scheduling rules, tracking of communications and activities, and the postponement of NON-Covid-19 services provisions, based on a proper definition of the guaranteed minimum levels of patient care.

Many stakeholders (i.e. some politicians, economists, citizens, etc.) do not appear to have fully understood what a global pandemic crisis means, and what efforts are being made to contain this new emergency situation. This is partly due to the paucity or absence of authoritative and shared scientific grounds (i.e. guidelines), also at an international level, for dealing with the disease caused by Covid-19 virus, which is still scarcely known [5].

Soon, it will be possible to predict that this situation will generate a marked increase in the insurance claims that the various health organizations and insurance companies will struggle to cope with. Demands for financial compensation will include not only the diseases caused by Covid-19, but also other health conditions, with important repercussions of the Covid-19 emergency on the management of all other patients and also on the availability of personal protective equipment (PPE), which have necessitated a fast supply to numerous urgent demands.

The present "catastrophic" situation undeniably imposes the need to take irreducible risks that cannot be assessed by local "technical" body delegated to act as a centralized hub. Otherwise, to bring forward the technical assessment, that is usually one of the fundamental parts of the criminal and civil trial, it would be not only complicated to organize and unavoidably self-referential for the sole decision-maker, but it would

also be unacceptable for cultural and legal reasons. There would be, indeed, no chance of a cross-examination, and the rightful role of the judge/court in arriving at an autonomous synthesis would be lacking. The most realistic option might be to establish an *ad hoc* fund for all claims for financial damages coronavirus-emergency related, that could award lump-sum payments for claims considered worthy of compensation, and thus contain the numbers of lawsuits. In such cases, it would be recommended to appeal for mediation. Trained mediators could be more effective in finding an agreement between the parties. Another workable solution could be to emphasize by law that the pandemic is characterized by *technical-scientific difficulty and/or novelty* inasmuch as it is an *emergency* – a condition that almost always renders even the easiest tasks difficult to accomplish. In these cases, similarly as in mass disasters, once the emergency has elapsed, responsibility can be recognized only for those who have clearly allowed an avoidable event to occur.

The main problems in this setting will ineluctably gradually shift the focus of liability evaluations from the physician's conduct to the handling of the various levels of management (primarily technical and organizational), that have to suggest appropriate risk parameters to the political decision-makers.

Perhaps, the world of politics has lost the ability to choose the right experts based on the grounds of their merits, those able to guide government strategies at their best [6]. The real problem is to ascertain the liability of top managers in the health administration, those appointed to handle public health emergencies, though with unclear margins of autonomy. The lack, or late adoption, of clear and cogent directives applicable everywhere also does not exempt all the intermediate-level institutions from their obligation to take independent actions, if necessary, dictated by common sense and/or trustworthy experts [7].

Different countries have a *specific technical support framework* (STSF) for political and administrative decision-makers on a local level, which, for instance, advises health facilities and hospitals on matters of infectious diseases. Leveraging on the emergency as an excuse for failing to activate and consult the STSF, either urgently or according to the established protocols, and even after its involvement had been specifically requested by other parties, certainly has all the features of a culpable omission and, therefore, of a liability. In the same way, the disregard for bottom-up recommendations made by the STSF's experts, made it necessary to deal with problems that their suggestions would have enabled to be managed differently.

These seem to be the issues most likely to be the focus of discussion in the future.

Below are a few examples of clinical and care activity management areas susceptible to the recommendations and coordination of a STSF.

Inside hospitals:

1) the opening of spaces SARS-CoV-2 patients dedicated outside infectious diseases departments, with the related problems of: a) structural adequacy (who assessed them and based on what expertise?); b) the use of dedicated medical and paramedical personnel (whole teams established *ex abrupto*; who was responsible for the infection's propagation to personnel and patients?); c) the distribution of personnel expert on matters of infectious diseases who could serve as tutors for other workgroups;
2) responsibility for exposure to the risk of infection, with the need for constant monitoring of the rates of detection of new positive cases, in-hospital exposure for patients previously tested negative for Covid-19, the timely identification of clusters, the management of personnel testing positive for the virus and their contacts, and the corresponding quarantine measures, which often take on a different meaning when applied to the general population or to public health personnel;
3) workflows of follow-up tests for personnel in all areas based on the risk of transmission within teams and to the patients;
4) responsibility for managing tests (turn-around-time to get results, materials procurement, prioritizing different requests, suspected cases, tests on patients, personnel, and other potentially

exposed individuals), and the demand for other diagnostic services (who is in charge and whose responsibility is it?).

Outside hospitals:

1) long-term care facilities: in a setting where specialist expertise is not widespread, the role of bodies responsible for controlling the spread of infections, with the aid of specialized individuals, becomes essential in disseminating appropriate organization and control measures. In this setting, any responsibility for delays and omissions certainly cannot be attributed to the managers of these territorial facilities. Responsibilities have therefore to be ascribed to the competent public health bodies and control authorities from the moment they are informed;
2) general practitioners: specific training and support for the management and control of their professional exposure should be carefully coordinated at top management level, and translated into timely action.

All these problems will demand an "economically sustainable" response, that will affect the budgeting of health organizations and insurance companies alike.

At the time of writing, the situation may still not be entirely clear. It will take a while to find solutions for all the problems in the longer term. It will be essential to strike the correct balance between the rights of damaged individuals and the proper safeguarding of health-care professionals in a frame that considers the responsibilities of the whole health system. This system should be submitted to a necessary, and not self-referential auditing process.

All authors provided critical feedback, contributed to the writing of the letter and approved the final version.

We declare no competing interests.

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