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Navigating the Uncharted Territory: Exploring the Liability of NHS Health Professionals for COVID-related Damage¹

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At the time of writing, the UK has recorded a tragic toll of 231,026 individuals whose deaths were attributed to COVID-19 since the pandemic's onset.² Alongside this devastating loss of life, the crisis has given rise to additional adverse consequences. These include prolonged waiting periods for medical care, as well as profound psychological and health repercussions affecting the broader population.

Health professionals faced extraordinary and unparalleled challenges during the COVID-19 pandemic. They worked with limited resources and within an already burdened NHS, which experienced staff shortages.³ Retired and inexperienced staff were redeployed, Nightingale hospitals were constructed, and certain services were adapted to accommodate the increased patient load.⁴ Non-essential medical treatments had to be postponed.⁵

These conditions increased the possibility of human errors that could result in significant harm or even death to patients. The question arises as to whether these errors - which would not have occurred during 'normal' times - could fall within the ambit of negligence. With the heightened risk of errors, concerns about civil liability naturally emerged.⁶ The healthcare sector faced the daunting challenge of balancing the delivery of timely and effective care with the potential risks of malpractice claims. The initial concern expressed by health professionals⁷ regarding a potential increase in medical negligence cases appears to have been so far unfounded, as no reported cases have yet emerged in the UK media or law reports.⁸ Several contextual factors contribute to this, including the understanding shown by families of deceased patients towards healthcare challenges, court backlogs, and the three-year time limit for initiating personal injury claims in courts.

Following the pandemic, several jurisdictions implemented legal immunities to shield healthcare professionals from liability. However, this approach faced criticism in the UK.⁹ Here, the emphasis shifted toward NHS resolution indemnity schemes, which aim to minimize litigation and ensure swift compensation for patients, all while safeguarding the interests of

¹ I would like to express my sincere gratitude to Emma Cave, Craig Purshouse, Michael Da Silva, Haris Psarras, Robert Wheeler, Andrew Webb and Elisabeth Kombate who generously dedicated time and expertise to review and enhance this paper.

² <https://coronavirus.data.gov.uk/details/deaths>, accessed 25 October 2023.

³ R Barr-Keenan, T fay, A Radulovic, S Shetty, 'Identifying positive change within the NHS as a result of the COVID-19 pandemic', *Future Healthcare Journal* 2021 Vol 8, No 3: e671-5.

⁴ Ibid.

⁵ *The hidden impact of COVID-19 on patient care in the NHS in England*, British Medical Association, July 2020, 3.

⁶ J Ames, 'Senior doctors and insurers warn of big compensation claims emerging from the COVID-19 pandemic', *Times*, 24 February 2021, 12.

⁷ Medical Defence Union. MDU calls for national debate over protecting NHS from COVID-19 clinical negligence claims, 20 Apr 2020.

⁸ D Howarth, 'English tort law and the pandemic: the dog that has not barked', *The Geneva Papers on Risk and Insurance- Issues and Practice*, 8 April 2023.

⁹ K Duignan, C Bradbury, 'Covid-19 and medical negligence litigation: Immunity for healthcare professionals?', *Medico-Legal Journal*, Vol 88, Issue 1, Nov 2020; C Tomkins et al, 'Should doctors tackling Covid-19 be immune from negligence liability', *British Medical Journal* 2020; 370:m2487.

healthcare professionals. We are currently in a phase of recovery, and patients are seeking explanations and enhancements.¹⁰

This article explores the impact of COVID-19 on individual clinical negligence claims which could arise following the pandemic. Specifically, the paper enquires how well-established legal principles will be interpreted by courts in the context of a health crisis which has had lasting impact on health services and professionals. The article investigates how courts might assess what constitutes reasonable actions for clinicians in the face of conflicting knowledge, limited resources and staff shortage and redeployment. It also discusses the ramifications for causation, informed consent and the communication of medical risks to patients in light of the increasing use of phone and video consultations and the strain on healthcare staff. Finally, the article examines the role of NHS Resolution indemnity schemes in safeguarding health professionals from liability and evaluates their advantages and drawbacks in the ongoing healthcare crisis and the subsequent recovery phase concerning providing appropriate compensation to patients harmed during the pandemic.

Differing from the assertions made during the initial stages of the pandemic regarding a potential surge in clinical negligence claims¹¹, this article demonstrates that healthcare professionals are not at a heightened risk of facing clinical negligence litigation in the post-COVID-19 era. This perspective is grounded in the flexible nature of negligence rules and the effective protection offered to healthcare professionals through NHS Resolution indemnity schemes.¹² Overall, the paper contends that COVID itself is unlikely to bring about significant changes in the clinical negligence landscape. However, the existing NHS crisis, exacerbated by several factors, including the post-COVID impact and a growing staff shortage, has the potential and *should*, indeed, reshape the clinical negligence landscape. Drawing valuable lessons from this situation is crucial for driving improvements. The paper will illustrate that the solution does not solely hinge on litigation, even though establishing legal precedents in the aftermath of healthcare crises is essential. While the current NHS indemnity schemes offer certain advantages regarding reducing litigation, they are also inadequate due to their exorbitant costs. The situation is a cause for concern, and there is an urgent need for action to enhance the quality of care and ensure safety.

The findings of this article hold significance as they provide health and legal professionals with insights into the potential application of established negligence principles to situations arising from pandemic-related treatments and scenarios that may persist in a post-pandemic era marked by burnout, staff shortages, extended waiting lists, and delays. The thoroughness of the examination is also of great relevance to broader, continuous discussions¹³, such as the COVID-19 Inquiry, which underscores the importance of understanding and gaining insights

¹⁰ <https://covid19.public-inquiry.uk/documents/terms-of-reference/>, accessed 26 October 2023.

¹¹ K Duignan, C Bradbury (n9); C Tomkins et al (n9).

¹² While this article specifically addresses claims centred on alleged negligence by individual professionals, it is crucial to recognize that the majority of such claims would typically involve the employer (Eg the hospital Trust) as a defendant under vicarious liability, rather than the individual professional.

¹³ Above n9; D Howarth, 'English tort law and the pandemic: the dog that has not barked', *The Geneva Papers on Risk and Insurance- Issues and Practice*, 8 April 2023; Rob Heywood (2021) Systemic Negligence and NHS Hospitals: An Underutilised Argument, *King's Law Journal*, 32:3, 437-465, DOI: 10.1080/09615768.2021.1951496.

from the legal and healthcare aspects of the pandemic. This understanding is crucial for better preparation for future crises.

2. The Assessment of Health Professionals' Standard of Care Post-COVID

Questions about how claims based on alleged substandard care received during the COVID-19 pandemic, or as a result of decisions made during the pandemic will be handled by courts are not easy to answer. This section examines how legal standards may apply to specific instances of COVID-related incidents and discusses the challenges claimants may encounter in proving negligence during a global health emergency, where the actions of healthcare professionals are evaluated based on the unique circumstances of the situation.

The choices regarding prioritization of patients, such as prioritizing COVID-19 patients over those with cancer or cardiac conditions, have had both immediate and enduring effects on the latter groups. Delays in cancer treatment, for example, can significantly exacerbate the progression of the disease.¹⁴ Additionally, there have been instances where routine care has been shifted to virtual consultations or postponed. These alterations in healthcare practices give rise to novel legal factors that need to be taken into account.

According to the latest data available, in July 2023, there were 7.68 million individuals on NHS waiting lists for consultant-led elective care, a significant increase from the 4.43 million reported in February 2020, before the pandemic. Among these patients, nearly 3.18 million have waited for more than 18 weeks, and the median waiting time for treatment is 14.1 weeks. This figure is nearly double the pre-COVID median waiting time of 7.3 weeks recorded in July 2019.¹⁵

In the upcoming sections, I illustrate how courts may analyse pertinent legal and contextual factors when determining healthcare professionals' liability for negligence during the COVID-19 pandemic in order to highlight their relevance for future healthcare crises.

a) The Reasonable Standard of Care

The section examines how the principles established by courts regarding the reasonable standard of care can be utilised to appraise the actions and decisions of healthcare professionals during pandemic situations.

In English law, the acceptable standard of care in the medical context is regulated by three landmark cases: *Bolam*, *Bolitho* and *Montgomery*. In *Bolam v Friern Hospital Management Committee*¹⁶, the House of Lords formulated the well-known *Bolam* test which establishes the standard of reasonable care for doctors and other professionals as follows:

A doctor who had acted in accordance with a practice accepted at the time as proper by a responsible body of medical opinion skilled in the particular form of treatment in question

¹⁴ A Sud et al, 'Collateral damage: the impact on outcomes from cancer surgery of the COVID-19 pandemic', *Annals of Oncology*, vol 31, Issue 8, 19 May 2020.

¹⁵ <https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/pressures/nhs-backlog-data-analysis#:~:text=around%207.68%20million%20people%20waiting,2019%2C%20before%20the%20pandemic%20began>, accessed 28 September 2023.

¹⁶ [1957] 1 WLR 582.

was not guilty of negligence merely because there was a body of competent professional opinion which might adopt a different technique.¹⁷

In other words, the defendant doctor's actions are being judged according to what is considered appropriate practice by a reasonable body of medical opinion.¹⁸

*Bolitho v City and Hackney Health Authority*¹⁹ further refined the *Bolam* principle, and the House of Lords decided that in applying the *Bolam* test where it is proven that other practitioners would have adopted the method employed by the defendant, it must also be demonstrated that the method was based on logic and was defensible. Following the *Bolitho* case, seven criteria have emerged to determine whether the medical practice in question is capable of withstanding logical analysis, or is 'unreasonable' or 'irresponsible'.²⁰

As articulated by Mulheron, the courts will assess whether the doctor's expert testimony

took account of a clear and simple precaution which was not followed but which, more probably than not, would have avoided the adverse outcome; considered conflicts of duties among patients, and resource limitations governing the medical practice; weighed the comparative risks/benefits of the medical practice, as opposed to other course(s) of conduct; took account of public/community expectations of acceptable medical practice; was correct in light of the factual context as a whole; was internally consistent; adhered to the correct legal test governing the requisite standard of care.²¹

A negative response to any of these questions could serve as a basis for courts to deem peer medical opinion as indefensible.

These criteria are relevant here to evaluate whether peer medical opinion presented for a case of alleged substandard care during the COVID-19 pandemic is logically defensible.

Applying the *Bolitho* test to cases of medical negligence during a pandemic acknowledges the unique challenges and circumstances faced by healthcare professionals. It takes into account the need for flexibility and adaptability while still ensuring that the actions and decisions made are logical and defensible given the context. This approach allows the courts to strike a balance between holding healthcare providers accountable for negligence and recognising the extraordinary challenges posed by a pandemic. As will be seen in the next sections, courts may consider various factors to establish or rule out a breach.²²

b) The Role of Professional Guidelines in the Assessment of Breach

This section seeks to elucidate how courts might incorporate pandemic-specific guidelines into their evaluation of alleged breaches committed by healthcare professionals while caring for patients during a healthcare crisis.

¹⁷ *Ibid.*

¹⁸ *Ibid* [588].

¹⁹ [1996] 4 All ER 771.

²⁰ R Mulheron, 'Trumping *Bolam*: A critical legal analysis of *Bolitho*'s gloss', *Cambridge Law Journal*, 69(3), November 2010, 637-638.

²¹ *Ibid.*

²² *Mulholland v Medway NHS Foundation Trust* [2015] EWHC 268 (QB).

In their assessment of reasonable practice, courts may take into account professional ethical guidelines, protocols and knowledge at the time of the alleged breach.²³ The courts may for instance consider whether the clinician's actions were a reasonable and logical application of national regulatory guidelines at the time.²⁴ Guidelines are seen as important in determining the viability of clinical negligence cases and can play a part in pre-trial resolution. In medical litigation, guidelines may be used by both claimants and defendants, although they may not always represent the perfect standard of care and can be subject to scrutiny.²⁵

Healthcare professionals 'have access to best practice guidance, issued by organisations like the General Medical Council (GMC), Royal Colleges, and treatment protocols from the National Institute for Health and Care Excellence'.²⁶ While adherence to guidelines does not automatically absolve a healthcare professional from negligence, it can serve as strong evidence that a defendant has satisfied the standard of care. In the case of *C v North Cumbria University Hospitals NHS Trust*²⁷, the court recognised the importance of guidelines and considered adherence to them as a factor mitigating against negligence. However the court also assessed the overall circumstances and surrounding facts in determining liability. Departing from guidelines is permissible,²⁸ but may require an explanation, as stated in *Price v Cwm Taf University Health Board*.²⁹

In response to the disruption caused by COVID-19, the National Institute for Health and Care Excellence (NICE) developed several 'Rapid Guidelines'³⁰ addressing various medical services, and offering guidance on managing COVID-19 in care settings. NICE has sought to give guidance on a range of issues including the required investigations and timing for effective COVID-19 management and complications assessment, the safety and clinical effectiveness of pharmacological and non-pharmacological interventions for acute COVID-19 symptoms and complications, approaches and protocols for the treatment of patients diagnosed with COVID-19, and palliative and end of life strategies for patients affected by COVID-19.³¹ The guidelines have emphasized key principles including communication and shared decision-making.

Other professional bodies produced guidelines from the start of the pandemic. For instance, in March 2020, a joint statement by the General Medical Council and the chief medical officers of the four nations of the UK stressed the importance of 'being a good doctor' during the pandemic. They acknowledged that the exceptional emergency situation required physicians to apply professional judgement and deviate from established procedures when necessary to provide care under time-bound and challenging circumstances.³²

²³ Joint statement from chief executives of statutory regulators of health and care professionals, 3 March 2020.

²⁴ *Sanderson v Guy's and St Thomas' NHS Foundation Trust* [2020] EWHC 20 (QB).

²⁵ A Samanta, M M Mello, C Foster, J Tingle, J Samanta, 'The role of clinical guidelines in medical negligence litigation: A shift from the *Bolam* standard?', *Medical Law Review*, 14, Autumn 2006, pp 321-366.

²⁶ E Jackson, *Medical law: Text, Cases, and Materials* (Oxford University Press, 6th edn, 2022), 144.

²⁷ *C v North Cumbria University Hospitals NHS Trust* [2014] EWHC 61 (QB).

²⁸ *Sanderson* (n24).

²⁹ *Price v Cwm Taf University Health Board* [2019] EWHC 938 (QB).

³⁰ For instance see NICE, COVID-19 rapid guideline: Critical care in adults. NICE guideline [NG159] (Last updated 12 February 2021) replaced by NICE, COVID-19 rapid guidelines: managing COVID-19, NICE guidelines [NG191], (Last updated 22 June 2023).

³¹ *Ibid.*

³² GMC Joint Statement: Supporting doctors in the event of a COVID-19 epidemic in the UK, 11 March 2020. <https://www.gmc-uk.org/news/news-archive/supporting-doctors-in-the-event-of-a-covid19-epidemic-in-the-uk#:~:text=in%20the%20UK-,Joint%20statement%3A%20Supporting%20doctors%20in%20the%20event%20of%20a%20COVID,19%20epi>

The evolving knowledge on COVID-19 and rapidly changing situations demanded flexibility in ethical guidance. Various pieces of professional ethical guidance emphasized the importance of adapting regulatory standards to diverse scenarios and maintaining essential principles such as evidence-based practices, collaboration and understanding and operating within respective skill boundaries.³³

The British Medical Association (BMA)'s note on COVID-19 from March 2020 highlighted the ethical challenges health professionals faced during the pandemic, such as prioritising overall reduction of mortality and morbidity, which sometimes necessitated decisions based on utilitarianism and maximization over patient autonomy.³⁴ The pandemic brought to light the difficulties involved in determining the allocation of ventilators and identifying individuals with the highest chances of positive outcomes. There was a heightened need for specific and clear guidance, especially from the Government, about allocation of scarce resources and triage decision-making. A BMA report on the pandemic response found that 'the guidance was often unclear, contradictory, poorly communicated and difficult to implement at a local level'.³⁵ The report also finds that 'processes for training and ensuring safe fit [of Personal Protective Equipment kits] were inadequate'.³⁶ Smaller hospitals were particularly affected by the lack of adequate and clear guidance from the Government. For instance, a Nuffield Trust report finds that challenges in managing the operational response to the pandemic were attributed to the inability of management teams to make timely decisions, clinicians being confronted with unfamiliar and complex issues, insufficient handling of dissenting opinions, perceived interference from centralized or external organizations, and the lack of reassurance, confidence, and unified messaging, particularly regarding Personal Protective Equipment (PPE).³⁷

The GMC's approach to fitness-to-practice complaints could shed light on evaluating clinicians' standards during COVID-related incidents. The GMC assesses doctors' actions and behaviour in response to such events considering factors like evidence-based care, communication, collaboration, and reporting. Similar considerations might apply in courts' assessment of doctors' standards. The GMC also lists scenarios indicating impaired fitness to practice during the pandemic, focusing on knowledge and moral responsibility. These include cases of recklessness, refusal to use PPE, unjustified treatment decisions, violation of patient autonomy, and mismanagement of changes in patient capacity.³⁸

In essence, the incorporation of pandemic-specific guidelines is vital in assessing the reasonableness of healthcare professionals' actions during extraordinary circumstances like a

demic%20in%20the%20UK&text=If%20COVID%2D19%20becomes%20an,be%20put%20under%20extreme%20pressure. Accessed 17 May 2023.

³³ H Smith et al, 'Principles for pandemics: COVID-19 and professional ethical guidance in England and Wales', *BMC Med Ethics* (2021) 22:78; Joint statement from chief executives of statutory regulators of health and care professionals, 3 March 2020.

³⁴ BMA, COVID-19 ethical issues. A guidance note, 6 March 2020, 3.

³⁵ BMA, 'COVID-19: How well-protected was the medical profession?', updated 13 June 2023, <https://www.bma.org.uk/advice-and-support/covid-19/what-the-bma-is-doing/covid-19-how-well-protected-was-the-medical-profession>, accessed 14 June 2023.

³⁶ *Ibid.*

³⁷ L Vaughan, C Leone, 'Overlooked, but not overcome: Smaller hospitals and the staff response to the Covid-19 pandemic', Briefing December 2022, Nuffield Trust, 13.

³⁸ GMC, COVID-19: assessing the risk to public protection posed by a doctor as a result of concerns about their practice during the pandemic, 14 September 2020, 8-9.

pandemic, where adaptability and ethical considerations play a significant role. Adherence to guidelines can be strong evidence that a healthcare professional has met the standard of care, although it does not automatically absolve them from negligence.

c) Distinctive Contextual Factors

This section aims to investigate the contextual factors courts may assess in cases of alleged medical negligence during the pandemic, such as resource availability, and delays, to provide a comprehensive understanding of the challenges healthcare professionals faced.

In the initial stages of the pandemic, there was a heightened need for oxygen supply in hospital wards due to the severe lung inflammation caused by the virus, which impaired patients' breathing. Consequently, a greater number of patients necessitated oxygen therapy. In some hospitals, inadequate oxygen supply to critically ill individuals led to grave outcomes.³⁹ The decision-making process regarding patient care was primarily carried out by respiratory physicians in conjunction with intensive care specialists. While not every hospital had a shortage of intensive care beds, most hospitals suffered a lack of adequate oxygen supply due to the pipe work being unable to carry enough oxygen for the increasing number of patients.⁴⁰ Critical care demand surged while bed availability remained constrained, leading to instances of accommodating two patients within a single bed space. To contextualise, the UK possesses notably fewer hospital beds per capita compared to many other nations. While the average among OECD EU countries stands at 5 beds per 1,000 people, the UK lags with 2.4 beds. In stark contrast, Germany boasts 7.8 beds.⁴¹

In the early phases of the pandemic, a scarcity of PPE posed a significant challenge, especially for frontline healthcare professionals such as nurses.⁴² During the subsequent wave, although capacity improved, oxygen supply remained a concern. Hospitals nationwide, including surgical units, were repurposed.⁴³ Many hospitals bolstered their critical care capabilities, shifting resources towards intensive care units (ICUs), thereby postponing non-essential services and treatments, consequently impacting the provision of specific medical interventions.⁴⁴

³⁹ S Lintern, 'Investigation into hospital's Covid oxygen shortages finds staff missed key safety meetings', *The Independent*, 25 March 2021.

⁴⁰ D Campbell, 'Coronavirus: London hospital almost runs out of oxygen for COVID-19 patients', *The Guardian*, 2 April 2020.

⁴¹ BMA, 'NHS hospital beds data analysis' <https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/pressures/nhs-hospital-beds-data-analysis#:~:text=The%20UK%20entered%20the%20pandemic,having%20risen%20over%20the%20years>, accessed 14 June 2023.

⁴² K Hoernke, N Djellouli, L Andrews, et al. 'Frontline healthcare workers' experiences with personal protective equipment during the COVID-19 pandemic in the UK: a rapid qualitative appraisal', *BMJ Open* 2021;11:e046199. doi:10.1136/bmjopen-2020-046199.

⁴³ S Anandaciva, 'Critical care services in the English NHS', 25 November 2020, King's Fund, <https://www.kingsfund.org.uk/publications/critical-care-services-nhs>, accessed 14 June 2023.

⁴⁴ S Kumar, D Warwick, 'Surgical rationing in times of COVID-19 pandemic – how does it affect the Montgomery ruling and GMC guidance on consent?', *Journal of Trauma and Orthopedics*, Vol 9, Issue 01, March 2021; M Anderson et al, 'LSE-Lancet Commission on the future of the NHS: re-laying the foundations for an equitable and efficient health and care service after COVID-19', *The Lancet* 2021; 397: 1915-78.

In these circumstances, claims may arise based on triage decisions, including ventilator allocation decisions⁴⁵, failure to diagnose and treat COVID-19 accordingly⁴⁶, delayed diagnosis and/or treatment for patients with long term conditions, or needing surgery, exposing patients to hospital acquired infection including COVID-19 for patients with long-term or serious illness, contributing to the worsening of their condition⁴⁷, health complications resulting from remote consultation misdiagnosis.

To assess the reasonableness of a doctor's behaviour amid these circumstances, courts may consider the pressure of the environment, and the overall reality in which the health professional acted and made decisions. Precedents indicate that emergency doctors working in a busy A & E department 'do not have the luxury of long and mature consideration. They take decisions at short notice in a pressurised environment ... the standard of care ... must be calibrated in a manner reflecting reality'.⁴⁸ This analogy can be aptly extended to professionals working under extreme stress during COVID spikes.

In a clinical negligence claim involving COVID-related damage, triage decisions made during the pandemic, including cases where doctors had to deny life-saving treatment, may play a significant role. Triage decisions have long been employed in medical practice, but during the pandemic, health professionals faced the challenge of making swift and frequent prioritisation choices due to limited resources, such as determining ventilator allocation. Evaluating the reasonableness of a doctor's decision-making in triage and prioritization will involve the courts assessing whether a responsible body of medical experts would find the professional's actions acceptable.

Although guidelines produced at the start of the pandemic did not give specific instructions on patient prioritization and emphasized the importance of key principles, such as minimizing harm, the capacity to benefit quickly, reasonableness, and proportionality, the BMA's note from March 2020 did provide that:

it is both lawful and ethical for a doctor, following appropriate prioritisation policies, to refuse someone potentially life-saving treatment where someone else has a higher priority for the available treatment. These are grave decisions, but the legal principles were established in relation to the allocation of organs for transplantation and have been recently upheld by the Court of Appeal.⁴⁹

Furthermore, context will be crucial in determining whether a breach exists. As explained in *Mulholland*, 'the assessment of breach of duty is not an abstract exercise but one formed within a context'.⁵⁰

⁴⁵ I G Cohen, A M Crespo, D B White, 'Potential Legal liability for Withdrawing or Withholding Ventilators During COVID-19, Assessing the Risks and Identifying Needed Reforms', *Journal of the American Medical Association*, May 19, 2020, Vol 323, Number 19.

⁴⁶ I Alexe et al, 'Legal provisions tendencies of malpractice and medical liability regarding the COVID-19 pandemic', *Rom J Leg Med* [29] 299-304 [2021].

⁴⁷ R Barranco et al, 'Medical Liability in Cancer Care During COVID-19 Pandemic: Heroes or Guilty?', *Frontiers in Public Health*, 18 December 2020.

⁴⁸ *Mulholland* (n22) [101].

⁴⁹ BMA, COVID-19 ethical issues. A guidance note, 6 march 2020, 3; *R (BA) v The Secretary of State for Health and Social Care* [2018] EWCA Civ 2696.

⁵⁰ *Mulholland* (n22) [90].

Negligence claims might also emerge from decisions to defer or reschedule treatment for patients with chronic conditions. A case in point is cardiac patients, where delays have played a role in the worsening of their health.⁵¹ Similarly, postponing cancer treatment has notably influenced survival rates, resulting in higher mortality among cancer patients with multiple health issues. These delays have compelled more invasive interventions and detrimentally affected patient well-being and overall quality of life.⁵²

An example that illustrates this situation is seen in the case of *Pope v NHS Commissioning Board*.⁵³ During the swine flu pandemic of 2009, a patient with flu-like symptoms visited a walk-in centre seeking medical attention. The guidance at that time stipulated that all cases of flu-like illness must be treated as swine flu, necessitating the compulsory measurement of peripheral oxygen saturation.⁵⁴ However, an experienced nurse did not measure the patient's blood oxygen saturation levels due to the unavailability of the required equipment. The nurse's failure to conduct essential tests on the patient, including blood pressure, respiratory rate, oxygen saturation, and pulse/heart rate, amounted in a breach of duty. This breach led to the patient not being admitted to the hospital, which subsequently caused her to miss appropriate treatment for swine flu and pneumonia. As a consequence, the patient experienced a collapse, resulting in profound disability and cognitive impairment that could have been avoided if she had received timely and appropriate care. This case also illustrates the role of guidance in the evaluation of the defendant's breach of duty in the context of an epidemic. The nurse's failure to adhere to the relevant guidance led to the determination a breach of duty.

This would be particularly relevant in cases where specific protocols were established for the management of COVID-19 patients. For example, if guidance stipulated that COVID-19 patients should be isolated from the rest of the patient population, a failure to adhere to this could potentially be deemed a breach of duty, as seen in the *Pope* case. However, in situations involving decisions guided by reasonableness rather than explicit protocols, such as triage decisions with vague guidance, it is unlikely that a health professional who creatively utilized available resources to prioritize patient well-being during the pandemic would be deemed to have breached their duty of care.

As demonstrated in *Morrison v Liverpool Women's NHS Foundation Trust*⁵⁵, depending on the situation, prompt action might be essential in critical and urgent cases, whereas there could be instances when patient concerns must be set aside to address other priorities. If the patient's risk is minimal, treatment might be delayed, but if the risk is substantial and escalating, a thorough assessment of conflicting factors becomes imperative. As stated by Mr Justice Turner in *Morrison*, 'a balance has to be struck between the needs of any given patient and any other competing professional demands placed upon the clinicians involved'.⁵⁶ As we have seen, the COVID-19 pandemic presented numerous situations where healthcare professionals had to make difficult decisions about patient care. For example, during the peak of the pandemic, there was a shortage of ventilators and Intensive Care Unit (ICU) beds. In such cases, doctors

⁵¹ British Heart Foundation, 'The Untold Heartbreak', 2021, 21.

⁵² A Sud et al, (n14); A G Lai et al, 'Estimated impact of the COVID-19 pandemic on cancer services and excess 1-year mortality in people with cancer and multimorbidity: near real-time data on cancer care, cancer deaths and a population-based cohort study, *BMJ Open* 2020; 10: e043828; J Davies, 'What impact has Covid-19 had on cancer services?', Nuffield Trust, 27/05/2021, <https://www.nuffieldtrust.org.uk/news-item/what-impact-has-covid-19-had-on-cancer-services#treatment>, accessed 18/05/2023.

⁵³ [2015] 9 WLUK 380 (unreported).

⁵⁴ [2015] 9 WLUK 380 para 55, 59.

⁵⁵ [2020] EWHC 91 (QB).

⁵⁶ *Morrison v Liverpool Women's NHS Foundation Trust* [2020] EWHC 91 (QB) [24].

had to prioritize which patients would receive these critical resources. They had to consider factors like the severity of a patient's condition, their chances of recovery, and the available resources. This necessitated balancing the immediate needs of individual patients with the broader demand for these life-saving treatments. These situations that arose during the pandemic highlight the intricate and demanding process of prioritizing patient care in the context of a worldwide health crisis. In such scenarios, it appears that only severe misconduct would warrant an evaluation of a breach of the expected standard of care.

d) Staff Shortage and Redeployment

This section analyses the implications of staff shortage and redeployment in new circumstances during the pandemic, and in doing so, it explores the applicability of relevant cases to healthcare professionals facing allegations of medical negligence during healthcare crises.

The pandemic exposed the well-known issue of staff shortage and insufficiently trained staff to manage the treatment of severely ill patients, resulting from long-standing policy failures in investing in training initiatives.⁵⁷ In some hospitals, consultants from other specialities were present in critical care units at all times, yet they sometimes lacked the necessary training to effectively handle such cases.⁵⁸ The lack of protocolized work and operating at 80% of capacity, along with a heavy reliance on agency staff rather than fully recruited personnel, is also an ongoing problem in UK hospitals.⁵⁹ The existing shortage of healthcare workers was worsened by increased staff absences caused by infection and self-isolation, as well as a significant decrease in international recruitment. As a result, staff had to be redeployed to high-demand services in order to maintain a basic level of care in critical and emergency settings.⁶⁰

Furthermore, the COVID-19 pandemic presented an immediate danger to the physical well-being of healthcare workers, particularly those on the frontline who were highly susceptible to infection. Numerous medical professionals contracted COVID-19, and a considerable portion of them suffered from long COVID, enduring severe and persistent symptoms over an extended period.⁶¹ NHS staff members are experiencing extreme stress, burnout and feeling undervalued.⁶² The absence of explicit government support for clinicians has negatively impacted the reputation of healthcare personnel in the UK, leading to unrealistic patient expectations and, in certain instances, cases of mistreatment and abuse towards medical professionals.⁶³

⁵⁷ A Charlesworth, 'Staff shortages left the NHS vulnerable to the COVID-19 storm', 12 January 2021, The Health Foundation.

⁵⁸ NHS England, 'Redeploying your secondary care medical workforce safely', 14 July 2020, 001559, 10.

⁵⁹ BMA, 'COVID-19: Impact of the pandemic on healthcare delivery', updated 13 June 2023, <https://www.bma.org.uk/advice-and-support/covid-19/what-the-bma-is-doing/covid-19-impact-of-the-pandemic-on-healthcare-delivery> accessed 14 June 2023; A Waters, 'High spending on agency staff by NHS is a 'completely false economy', warns BMA', *BMJ* 2022;379:o2749.

⁶⁰ C M Montgomery et al, 'Critical care work during COVID-19: a qualitative study of staff experiences in the UK', *BMJ Open* 2021; 11: e048124.

⁶¹ BMA, 'COVID-19: The impact of the pandemic on the medical profession', Updated 13 June 2023, <https://www.bma.org.uk/advice-and-support/covid-19/what-the-bma-is-doing/covid-19-the-impact-of-the-pandemic-on-the-medical-profession>, accessed 14 June 2023.

⁶² C M Montgomery et al (n60).

⁶³ BMA, (n61).

During the pandemic, the NHS faced overwhelming patient numbers, leading to a potential ‘dilution in the standard of care that could feasibly be provided’.⁶⁴ For instance, in intensive care units, nurses were responsible for multiple patients due to the shortage of staff. In these circumstances, staff who have been redeployed might face a higher susceptibility to clinical negligence claims. As demonstrated by the examples mentioned earlier, like the inadequate diagnosis or treatment of COVID-19 or the failure to identify long-term conditions requiring surgery, the situations may have been worsened when healthcare professionals practiced beyond their specialty or when junior doctors assumed greater responsibilities.

Although courts may take into account the specific context in which the defendant was working, experience or lack thereof, will not determine the level of care required. In law, the relevant standard of care is judged by reference to the post held by the person who is said to have been negligent.⁶⁵ When considering a position and the tasks performed, the courts focus on the usual occupant of that position rather than taking into account factors like the nurse or doctor's experience, seniority, or length of service. The standard of care expected from a professionally qualified defendant is determined by assessing the nature of their "post" and the associated tasks it entails.⁶⁶ This means that if a doctor in a specific position fails to demonstrate the necessary level of skill for the assigned task, they will breach the standard of care. For instance, it is well established case law that a junior doctor will be held to the same professional standard as a fully qualified doctor.⁶⁷ This has been reiterated the recent case of *Dowson v Lane*⁶⁸. The principle here is that the expected standard aligns with the task's nature. The status as a junior doctor does not matter when performing tasks within the scope of senior colleagues. If a task exceeds the capabilities of a junior doctor, they should refrain from performing it. Engaging in such tasks does not lead to a lenient assessment due to inexperience. Though it might appear unjust to hold junior doctors to the same standard as their experienced counterparts, varying standards tied to experience could hinder the learning curve for junior doctors and erode patient trust in their care.⁶⁹

However, this does not imply that a breach of duty will be automatically established in the case of professionals working in unfamiliar clinical services or junior doctors. As elaborated earlier, the assessment of breach will heavily rely on contextual factors. These well-established principles that govern the standard of care in cases of professional negligence should not be altered, even in light of circumstances stemming from healthcare emergencies. These principles reflect a delicate balance between societal interests and fairness to individual practitioners. Despite the challenges junior doctors face, such as long hours and high-pressure situations, the expectation of a consistent standard remains. Under such conditions, measures can be taken to minimize the occurrence of errors. For instance, inexperienced staff may have their work reviewed by more experienced colleagues to ensure it meets the required standard, as was the case in *Wilsher*⁷⁰.

⁶⁴ E Jackson (n26) 146.

⁶⁵ *Darnley v Croydon Health Services NHS Trust* [2018] UKSC 50; J Tingle, ‘Clinical negligence claims following the COVID-19 pandemic, 25 June 2020, BJN, <https://www.britishjournalofnursing.com/content/patient-safety/clinical-negligence-claims-following-the-covid-19-pandemic/>, accessed 19 May 2023.

⁶⁶ *FB v Princess Alexandra Hospital NHS Trust* ([2017] EWCA Civ 334).

⁶⁷ *Wilsher v Essex AHA* [1988] 1 AC 1074; *FB v Princess Alexandra Hospital NHS Trust* ([2017] EWCA Civ 334).

⁶⁸ [2020] EWHC 642 (QB).

⁶⁹ E Jackson, (n26) 146.

⁷⁰ *Wilsher* (n67).

e) Disclosure of Risks to Patients During a Health Crisis

The COVID-19 pandemic and its associated effects on healthcare services have also raised new questions about informed consent and disclosure of medical risks to patients.⁷¹ Situations like limited resources, the reassignment of staff to unfamiliar clinical areas, understaffing, and the rise in remote consultations may ‘have important implications for the professional capacity and knowledge available to discuss the risks and benefits of and alternatives to proposed treatment with patients’.⁷²

In the famous *Montgomery*⁷³ decision which has been the subject of much debate among legal commentators and medical professionals⁷⁴, the UK Supreme Court unanimously decided that the *Bolam* test was inapplicable to disputes arising from a breach of the obligation to disclose medical risks to the patient. The *Montgomery* judgment established the ‘material risks’ test which provides that

The doctor is [...] under a duty to take *reasonable* care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any *reasonable* alternative or variant treatments. The test of materiality is whether, in the circumstances of the particular case, 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 (emphasis added).⁷⁵

The only exception to this principle is the ‘therapeutic exception’, which provides that the doctor is not required to disclose the risks inherent in the treatment to his patient if, in the exercise of reasonable medical judgment, it would be detrimental to the patient’s health to do so; and there is no obligation to disclose the risks when a patient chooses not to receive this information, but the physician must make a reasonable judgment of the patient’s reluctance.

Courts will take into account the context to assess the doctor’s ability to follow the principles of shared decision-making.⁷⁶ This is also mentioned in various regulatory guidance documents and statements. For instance the BMA’s COVID-19 guidance note from March 2020 affirms that doctors should be reassured that, from an ethical, professional, and legal standpoint, they are unlikely to face criticism for their care during the pandemic if their decisions meet the criteria of reasonableness, evidence-based practice, adherence to guidance, collaborative decision-making, and prioritizing safe and effective patient care given the circumstances.⁷⁷

⁷¹ S Kumar, D Warwick, ‘Surgical rationing in times of COVID-19 pandemic – how does it affect the Montgomery ruling and GMC guidance on consent?’, *Journal of Trauma and Orthopedics*, Vol 9, Issue 01, March 2021.

⁷² S Devaney et al, ‘Healthcare Professional Standards in Pandemic Conditions: The Duty to Obtain Consent to Treatment’, *Bioethical Inquiry*, 10 September 2020.

⁷³ *Montgomery v Lanarkshire Health Board* [2015] UKSC 11.

⁷⁴ SW Chan et al., ‘Montgomery and informed consent: where are we now?’ (2017) 357:j2224 *British Medical Journal*; J Montgomery, E Montgomery, ‘Montgomery on informed consent: an inexpert decision?’, *J Med Ethics* 2016;42:89-94 ; AM Farrell, M Brazier, ‘Not so new directions in the law of consent? Examining Montgomery v Lanarkshire Health Board’, *J Med Ethics* 2016;42:85-8.

⁷⁵ [2015] UKSC [87].

⁷⁶ S Devaney et al (n72).

⁷⁷ BMA, COVID-19 ethical issues. A guidance note, 6 march 2020, 1.

The *Montgomery* judgment's application post-COVID will likely to continue to prioritize patient-centered care and informed decision-making. The emphasis on 'material risks' where doctors are obligated to disclose significant risks, reasonable alternatives and variants will persist.⁷⁸ However, the exceptional context of the pandemic and its aftermath, with its challenges like resource scarcity and staff redeployment, may influence how courts evaluate the doctor's ability to fulfil these obligations. Given the circumstances, the 'therapeutic exception' could become particularly relevant in cases where full risk disclosure might be detrimental to a patient's health due to heightened vulnerability or stressors related to the pandemic. The patient's consent to receiving information will surely remain a crucial factor. In essence, while the core principles of the *Montgomery* judgment are expected to endure post-COVID, their application might be influenced by the unique challenges and circumstances introduced by the pandemic, ensuring a balance between patient autonomy and the reality of healthcare constraints. In the aftermath of the pandemic, it will be crucial for healthcare services to adhere to the principles established in the *Montgomery* case, which safeguard patients' rights to receive comprehensive information, a practice that has not been consistently integrated into NHS practice.⁷⁹ This presents a notable challenge, especially with the growing use of video and phone consultations, as these mediums can hinder the effective transmission and comprehension of information.

In conclusion, this section has illustrated how the standards governing the reasonable standard of care can be applied in assessing the actions of healthcare professionals during a healthcare crisis, exemplified by the COVID-19 pandemic. It was argued that pandemic-specific guidelines may be considered by the courts when evaluating a healthcare professional's standard of care, with adherence to guidelines serving as compelling evidence but not an absolute defence against negligence claims. The courts will assess what was reasonable in the given circumstances, applying the criteria established in *Bolam* and *Bolitho*, with reasonableness as the central principle in determining whether a healthcare professional met the expected standard. While the pandemic's unique conditions, including the initial lack of clear guidance and effective treatments, staff shortages, and limited resources, may have increased the likelihood of errors, they are unlikely to heighten the potential for liability, as the guiding principle for court decisions remains reasonableness within the specific context. Finally, the core principles concerning informed consent and medical risk disclosure are expected to remain unchanged during healthcare crises, as these principles, when reasonably applied by the courts, inherently allow for a balance between patient autonomy and healthcare constraints. Ensuring the consistent application of the *Montgomery* standard in NHS practice however continues to be a concerning hurdle.

3) The Assessment of Causation During a Health Crisis

The proof of a causal link is usually a determining factor in medical negligence claims, as it represents a huge obstacle for claimants in obtaining compensation. This section aims to illustrate the challenges in establishing causation in medical negligence cases, especially within the context of the COVID-19 pandemic, while highlighting tools and precedents that provide potential solutions for claimants.

⁷⁸ *McCulloch v Forth Valley Health Board* [2023] UKSC 26.

⁷⁹ N Ainsworth et al, 'Informed consent failures: National Health Service Resolution data', *British Journal of Surgery*, 2023, 110, 12 May 2023, 993-995.

In the medical context, multiple causes can contribute to the same harm, and the principle of 'but for' usually does not allow for mere contributions to constitute a causal link. The claimant needs to prove on the balance of probabilities (over 50%) that the breach caused the harm suffered. But, as will be seen below, there have been some exceptions to this rule in the medical context. The circumstances of the COVID-19 pandemic will further complicate the issue of causation. As an example, claimants may need to demonstrate how and where they have contracted COVID-19 and whether it directly caused their deaths or long-term illness. Claimants may also need to demonstrate that delayed treatment contributed to the worsening of their condition.

In relation to a weak causal link or where multiple causes are responsible for the damage, the courts have used legal tools to allow the claimants to receive compensation, where a strict application of the 'but for' test would otherwise lead to an unsuccessful outcome for the claimant. In the medical context, multiple causes are frequent, and we could anticipate that claims arising out of the COVID-19 pandemic will feature complex causation issues, and will constitute a huge barrier in obtaining compensation for claimants.

While courts have occasionally displayed some flexibility in applying the "but for" test⁸⁰, such flexibility has been restricted to specific instances. In situations where treatment was administered during the pandemic and multiple causes of harm are probable, claimants may find support in arguments based on "material contribution" or "material increase" in risk, previously established in cases regarding industrial diseases.⁸¹ These arguments offer assistance to claimants who cannot establish the "but for" test due to the involvement of multiple causes.

As provided in *Heneghan*⁸²

There are three ways of establishing causation in disease cases. The first is by showing that but for the defendant's negligence, the claimant would not have suffered the disease. Secondly, where the disease is caused by the cumulative effect of an agency part of which is attributable to breach of duty on the part of the defendant and part which involves no breach of duty, the defendant will be liable on the ground that his breach of duty made a material contribution to the disease : *Bonnington v Castings Ltd v Wardlaw* [1956] AC 613. The disease in that case was pneumoconiosis which is a divisible disease (i.e. one whose severity increases with increased exposure to the agency). Thirdly, where causation cannot be proved in either of these ways, for example because the disease is indivisible, causation may be established if it is proved that the defendant materially increased the risk of the victim contracting the disease : the *Fairchild* exception.

It is important to note however that the principle of material increase relies on a strong inference drawn from the facts presented and does not always lead to the finding of a causal link. For instance, the case of *Wilsher*⁸³ involved a prematurely born baby who developed retrolental fibroplasia (RLF) and subsequently became blind. The claimant alleged that the inexperienced junior doctor who was responsible for the postnatal care of the child, had been negligent in administering oxygen therapy. The central issue was whether the doctor's negligence was the

⁸⁰ *Chester v Afshar* [2004] UKHL 41; *Wilsher* (n67); *Bailey v Ministry of Defence* [2009] 1 WLR 1052.

⁸¹ *McGhee v National Coal Board* [1972] UKHL 7; *Fairchild v Glenhaven Funeral Services Ltd* [2002] UKHL 22.

⁸² *Heneghan v Manchester Dry Docks Ltd* [2016] EWCA Civ 86 at [23].

⁸³ [1988] AC 1074.

cause of the claimant's RLF. The House of Lords held that the 'but for' test should be modified in cases involving multiple causes of harm. Since the harm could have been caused by several factors, including negligent and non-negligent ones, it was not possible to ascertain which specific factor was the sole cause. The House of Lords concluded that it was impracticable to determine that the defendant's negligence directly caused or significantly contributed to the injury, leading to the dismissal of the claim. The court made it clear that the previously established principle of material increase held in the *McGhee*⁸⁴ case relied on a strong inference drawn from the facts presented and could not always lead to the finding of a causal link.

In contrast, in the case of *Bailey*⁸⁵, the claimant had travelled to Kenya and returned with suspected gallstones. In January 2001, she was admitted to hospital run by the Ministry of Defence, where complications arose during an Endoscopic retrograde cholangiopancreatography (ERCP) procedure to remove the stones. After excessive bleeding and inadequate supervision, she became very unwell. At the same time, she developed pancreatitis, a possible consequence of the ERCP. She was later transferred to another hospital, where her condition improved but tragically worsened when she choked while drinking lemonade. Due to her weakness from previous complications, she could not clear her air passages, leading to cardiac arrest and hypoxic brain damage.

The court stated that

In a case where medical science cannot establish the probability that 'but for' an act of negligence, the injury would not have happened but can establish that the contribution of the negligent cause was more than negligible, the 'but for' test is modified and the claimant will succeed.⁸⁶

This emphasizes the notion that a contribution to an injury, even if not the primary cause, can still be considered material. As long as there is evidence, based on the balance of probabilities, that a negligent act or omission played a role, no matter how minor, in causing the injury, causation will be deemed established.⁸⁷

As shown in a more recent case⁸⁸, courts will continue to use common sense in their approach to causation, and may not always need to use the material contribution test if they find that 'but for' causation is made out on the balance of probabilities, for instance where the indivisible outcome of death, was the result of a disease which involved a process that took its course over a period of time.⁸⁹

Another case which may help claimants establish causation in the medical sphere is *Chester*⁹⁰, where the claimant consented to surgery for a spinal cord problem without being informed of the minor risk involved. The House of Lords ruled that the defendant doctor had failed in his professional duty by not adequately informing the claimant of the risks, and therefore, the claimant deserved a remedy, even though it could not be shown that the failure to inform had

⁸⁴ [1972] UKHL 7.

⁸⁵ [2009] 1 WLR 1052.

⁸⁶ *Bailey v Ministry of Defence* [2009] 1 WLR 1052 at [46]–[47].

⁸⁷ *Williams v The Bermuda Hospitals Board* [2016] UKPC 4.

⁸⁸ *Davies v Frimley Health NHS Foundation Trust* [2021] EWHC 169 (QB).

⁸⁹ *Ibid.*

⁹⁰ *Chester* (n80).

in fact caused the harm. It is interesting to note that in *Correia*⁹¹, the Court of Appeal decided to confine the ‘*Chester* exception’ to cases with similar facts. Importantly, Simon LJ emphasised the necessity for a party to plead the *Chester* principle and substantiate it with evidence. In particular, this entails assessing (1) whether the risk was inherent to the surgery, making the injury 'intimately linked' to the duty to provide a warning, and (2) whether the claimant would have proceeded with the same procedure at the same time if a warning had been given. Claimants should be aware that any claim relying on the ‘*Chester* exception’ must be explicitly pleaded to preempt potential counterarguments. In *Diamond*⁹², the Court of Appeal ruled that no independent claim for damages could be made due to a failure to provide a warning about the risks associated with a procedure that, based on the facts, the claimant would have still undergone regardless.

In addition, with regard to delayed diagnosis, if it is established that the delay was negligent and if the claimant can demonstrate that the likelihood of survival, but for the negligent delay in diagnosis and treatment, exceeded 50%, causation will be established.⁹³ Consider the scenario of a patient who had been waiting for cancer treatment on NHS waiting lists for months due to pandemic-related backlogs. The patient is eventually admitted to the hospital for treatment, but there is a subsequent delay in providing treatment, resulting in the patient's death. If the delay in referring the patient for hospital treatment is determined to be negligent, the claimant would need to prove, on the balance of probabilities, that this delay directly caused the patient's death. A delayed referral for hospital treatment can be deemed negligent and sufficiently causative, even if there is a subsequent delay in diagnosis and treatment within the hospital.⁹⁴

In summary, the circumstances surrounding COVID-19, although complex, are unlikely to result in substantial changes to the overall approach to causation in legal cases. While courts may deviate from the strict ‘but for’ test when multiple causes are involved, such departures will only be made when the courts consider it fair and just, on a case-by-case basis. The outcome of each case will heavily rely on the specific facts presented, but it should not be anticipated that a more lenient, and claimant-friendly approach to causation will become the norm post-COVID.

3) Protecting Health Professionals from Litigation: The Role of Indemnity Schemes

In addition to the challenging obstacles that claimants must overcome in clinical negligence cases, the establishment of indemnity schemes has provided an additional layer of safeguard against litigation for professionals. This protection has become even more pronounced in the aftermath of the pandemic.

NHS Resolution, formerly the NHS Litigation Authority until 2017, is a distinct entity under the Department of Health and Social Care (DHSC). The primary objective of NHS Resolution is to offer its specialised knowledge to the NHS for the equitable resolution of disputes, to disseminate knowledge to promote enhancement, and to safeguard resources dedicated to

⁹¹ *Correia v University Hospital of North Staffordshire NHS Trust* [2017] EWCA Civ 356 at [28].

⁹² *Lucy Diamond v Royal Devon & Exeter NHS Foundation Trust* [2019] EWCA Civ 585.

⁹³ *Gregg v Scott* [2005] UKHL 2.

⁹⁴ *Wright v Cambridge Medical Group* [2011] EWCA Civ 669.

patient care.⁹⁵ The funding for NHS Resolution is derived from both direct contributions from the DHSC and the income generated from its members, which is determined based on annual calculations of expected claims.⁹⁶

In the discharge of their responsibilities, NHS Resolution possesses the authority to establish schemes that offer state-backed legal protection against medical negligence claims for healthcare professionals employed by member trusts. This legal protection ensures that in cases of medical negligence claims against an NHS worker, any legal fees or compensation payable to a successful claimant are managed by NHS Resolution, rather than being the individual healthcare professional's responsibility.

Presently, NHS Resolution administers eight clinical negligence indemnity schemes and four non-clinical negligence schemes. One notable example is the Clinical Negligence Scheme for Trusts (CNST), the largest among them. CNST handles all clinical negligence claims brought against any NHS member trust for incidents occurring after April 1, 1995. While the relevant trust remains the legal defendant in such cases, CNST assumes the financial burden of litigation.

In 2020, NHS Resolution launched a special scheme to deal with liabilities arising from special healthcare arrangements put in place in response to the coronavirus pandemic: the NHS Resolution Clinical Negligence Scheme For Coronavirus (CNSC). This scheme had been established under the new powers of the Coronavirus Act 2020. It provides additional indemnification cover for medical negligence liabilities which may arise when healthcare professionals and others working as part of the response to coronavirus or other NHS staff, where existing arrangements (e.g. CNST or individual arrangements) do not cover a particular activity.⁹⁷

In contrast to other jurisdictions that have opted to grant healthcare professionals legal immunity from civil claims related to COVID incidents⁹⁸, NHS Resolution decided to maintain its existing strategy of employing indemnity schemes for COVID-related occurrences. While discussions surrounding legal immunity did take place in the UK⁹⁹, this approach was seen as unsuitable because it would have provided blanket protection from litigation to healthcare professionals and the NHS, even in cases of severe misconduct.¹⁰⁰ The establishment of the CNSC was, therefore, deemed an essential substitute for legal immunity following the pandemic.

⁹⁵<https://resolution.nhs.uk/about/#:~:text=NHS%20Resolution%20is%20an%20arm%27s,strategy%20for%202022%20to%202025>, accessed 23 October 2023.

⁹⁶ NHS Resolution Annual Report and Accounts 2022-23, Published 13 July 2023, HC 1560, ISBN 978-1-5286-4153-1, 19.

⁹⁷ <https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-coronavirus/>, accessed 5 May 2023.

⁹⁸ C Tomkins et al. (n9). For example, in several U.S. states, laws have been passed to grant doctors immunity from negligence claims stemming from the COVID-19 pandemic. Likewise, in France, medical professionals are protected from negligence claims that could arise due to medical mishaps when they are operating under the conditions of a severe health crisis, like the COVID-19 pandemic: see L3131-3 Code de la Santé Publique.

⁹⁹ A R Mehta, T Szakmany, A Sorbie, 'The medicolegal landscape through the lens of COVID-19: time for reform', *Journal of the Royal Society of Medicine*, 2021, Vol. 114(2) 55-59; C Tomkins et al. (n9).

¹⁰⁰ C Tomkins et al. (n9).

The scheme also seemed to be a suitable response to concerns¹⁰¹ about a potential surge in civil negligence claims following the pandemic, even though such an increase did not actually materialise. In fact the total number of claims related to COVID-19 (under all schemes) is extremely low, with 364 out of a total of 15,078 claims in 2021/22, and 346 out of 13,511 total claims in 2022/23.¹⁰² According to NHS Resolution, the majority of these claims pertain to repercussions indirectly linked to the pandemic, such as treatment or diagnosis lapses and delays. In 2022/23, there were only 15 CNSC claims, a decrease from the 22 claims in 2021/22. What significantly overshadows the quantity of claims within NHS Resolution schemes are maternity-related claims, constituting a substantial £44.965 million (or 65%) of the clinical negligence provision for the 2022/23 period.¹⁰³

The reason for the low numbers of COVID-related claims remains uncertain at this point. NHS Resolution claims that ‘due to the fact that claims are time-lagged, we only have an early picture of the claims profile for COVID-19, and we can’t draw any conclusions at this stage as to future trends and patterns this may lead to’.¹⁰⁴ However, NHS Resolution has commended the scheme's efficiency, asserting that CNSC provides a simplified approach for managing responsibilities associated with unique healthcare situations during the pandemic.

NHS Resolution asserts that another commendable aspect of their strategy is their decision to adopt a collaborative approach to the handling of negligence claims related to COVID-19. They have implemented the COVID-19 Clinical Negligence Claims Protocol in collaboration with Action against Medical Accidents (AvMA) and the Society of Clinical Injury Lawyers (SCIL) ‘in designing and operating the Covid 19 Clinical Negligence Claims Protocol’, which is believed to have ‘significantly reduced the volume of clinical negligence claims that have become litigated and created savings benefiting the NHS and patients’.¹⁰⁵

NHS Resolution reports that in 2022/23, ‘80% of clinical claims were settled without litigation’, emphasizing the importance of ‘resolving matters without the need for court proceedings’, which is claimed to reduce costs and pressure on courts, and ‘can provide an improved experience on claimants and healthcare staff’.¹⁰⁶ This system of indemnification has however been criticised for its high cost, and negative impact on healthcare staff.¹⁰⁷ Payments for settling claims in 2022/23 across all indemnity schemes increased by £232.4 million, to nearly £2.7 billion from the previous year.¹⁰⁸ A system that purports to efficiently tackle the expenses of clinical negligence claims is, in fact, incurring costs amounting to billions annually, funds that could otherwise be directed towards enhancing NHS care.

Furthermore, the decision-making process for claims presented to NHS Resolution lacks transparency, and this deficiency has adverse consequences for both claimants and the broader patient community. Although NHS Resolution applies tort principles to assess whether medical

¹⁰¹ J Ames, ‘Senior doctors and insurers warn of big compensation claims emerging from the COVID-19 pandemic’, *Times*, 24 February 2021, 12.

¹⁰² NHS Resolution Annual Report and Accounts 2022-23, Published 13 July 2023, HC 1560, ISBN 978-1-5286-4153-1, 16.

¹⁰³ *Ibid* 18.

¹⁰⁴ *Ibid* 39.

¹⁰⁵ <https://resolution.nhs.uk/2023/01/25/collaboration-on-covid-clinical-negligence-claims-reaps-rewards/> accessed 5 May 2023.

¹⁰⁶ NHS Resolution (n96) 42.

¹⁰⁷ ‘Urgent need for legal reform as costs of NHS claims rise again, MDU says’, 19 July 2023.

¹⁰⁸ NHS Resolution (n96) 17.

care has fallen short of acceptable standards, there is limited available information pertaining to resolved claims.¹⁰⁹

While NHS resolution's primary aim is to minimize litigation where possible, it recognizes the importance of creating legal precedents. This entails entering 'litigation when there is a requirement to take claims to trial or to the higher courts in areas of law which need to be challenged in the broader interests of the NHS or which require certainty'.¹¹⁰ Yet, the heavy reliance on NHS resolution schemes is causing a lack of certainty and hindering access to justice for claimants. Recent cases have underscored the need for enhancements in safety, transparency, adherence to the duty of candour, and an overall improvement in the quality of patient care within NHS services.¹¹¹ It is yet to be demonstrated whether organizations responsible for enhancing safety, such as NHS Resolution and the Care Quality Commission, are effectively achieving their goal of ensuring patient safety within the NHS.

4) Conclusion

This paper has examined the impact of the COVID-19 pandemic on clinical negligence litigation. The paper has brought attention to the emergence of new legal inquiries posed by COVID-19, particularly concerning the assessment of the standard of care and the evaluation of medical professionals' actions or inactions that took place amidst the pandemic which have led to avoidable harm to patients. The paper has first demonstrated that establishing a breach of duty on the part of a health professional for conduct which occurred during the pandemic will be difficult. Courts may consider guidelines and contextual factors such as shortages, pressures, and lack of support when evaluating a professional's conduct. It is anticipated that the proof of a breach under these circumstances would necessitate a substantial degree of moral culpability. An area that will increasingly pose challenges in medical negligence cases pertains to informed consent and the disclosure of material risks. Despite being a legal obligation, its consistent implementation into medical practice appears to be inadequate, and this issue is further compounded by the growing prevalence of video and phone consultations.

The paper further showed that the pandemic may introduce complex causation issues, often involving multiple factors. Previous legal cases altering the "but for" test and employing the concept of 'material contribution' could have pertinence in the context of COVID-19 and future healthcare crises. Yet, while courts have occasionally been more lenient toward causation, favouring claimants, this leniency has been confined to specific instances. The study has concluded that the fundamental approach to causation is unlikely to undergo substantial changes due to the influence of COVID-19.

Lastly, the predominant handling of claims through the NHS Resolution indemnity schemes has led to a reduced number of negligence cases reaching the courts to date. This approach, characterized by NHS Resolution's proactive and collaborative stance, aims to expedite resolutions, reduce costs, and provide necessary indemnification cover. Continued assessment will refine the approach's effectiveness. For now it seems that some major drawbacks of the system are its high costs and lack of transparency. The UK's reliance on NHS Resolution

¹⁰⁹ NHS Resolution (n96) 34.

¹¹⁰ Ibid 47.

¹¹¹ R Thomas, J Kirby, 'Damning verdict on maternity care in England as two thirds of units found to be unsafe', *The Independent*, 20 October 2023.

schemes may hinder access to justice for patients, and may delay the establishment of crucial legal precedents pertinent to future health crises. This has implications for legal transparency and consistency, as individualistic case resolutions may not foster the advancement of clinical negligence law. In conclusion, this paper has demonstrated that the COVID-19 pandemic has provided a glimpse into what constitutes the 'new normal' in NHS medical practice. Addressing current safety concerns promptly is imperative to prevent potential future crises.