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LEGAL CHALLENGES OF MEDICAL PRACTICE DURING THE COVID-19 PANDEMIC

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Abstract: This article attempts to illustrate the challenges of medical practice during the COVID-19 pandemic. We address and discuss patient and medical worker's safety, access to healthcare, standard of care and the emerging role of telemedicine, from both, medical and legal perspectives.
We conclude that attention should be paid to problems related to allocation of scarce resources, the moral dilemma on who to treat, and pressing legal considerations regarding the medical practice during the pandemic and to burden and stress of the medical workers.

Keywords: legal challenges, covid 19, healthcare coverage, ethics.

INTRODUCTION

Since a cluster of pneumonia cases was reported in Wuhan, Hubei Province, China in December 2019, the number of identified cases quickly rose around the world, until the World Health Organization declared a global pandemic [1,2]. The subsequent evolution of the infectious disease triggered a global crisis with long-term impact on people's habits, disrupted education and imposed major changes in healthcare systems and resources[3]. Some of them required rapid response and decision-making in an environment of uncertainty. Healthcare providers were forced to implement drastic workflow changes in a very short amount of time. The legal framework did not cover many of the circumstances which arose, while new laws and updates lagged.

The health crisis has emphasized the best of the healthcare workforce, some sacrificing their safety and family life to help treat the waves of infected patients. This effort was initially acknowledged by the populations around the world [4]. To slow down the pandemic and prevent the overcrowding of hospitals, governments imposed mitigation measures that limited individual rights granted by the constitution. The confinement decisions have substantially impacted people's travel patterns, lifestyle, and drinking habits [5]. The economy was negatively impacted and unemployment rose. All these factors changed public perception and as a result, the government's healthcare-driven decisions were met with adversity: the cheering for the medical workers had stopped.

This article attempts to illustrate the challenges of medical practice during the COVID-19 pandemic, from both a medical and legal perspective.

Patient and medical worker's safety

The COVID-19 pandemic has highlighted the risks that healthcare workers are confronted with; many doctors and nurses experienced fear and anxiety at work like never before. Unfortunately, these professionals had every reason to be concerned both for their own and their patient's safety.

No healthcare system was prepared for a

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pandemic and the insufficient supply of personal protective equipment [PPE] was a well-known problem. In such situations, the shortage of PPE for healthcare workers highlights serious ethical and legal concerns: what are the obligations of employers to ensure adequate equipment is available and would healthcare workers be constrained to treat patients? What criteria should be used in the distribution of limited PPE among healthcare services? [6–8].

Medical staff must wear adequate PPE according to the code of labor and not following the adequate standards constitutes a legal liability as it endangers both the patients and the healthcare worker. Who is legally responsible for not being able to assure these appropriate safety measures?

It is within any employer's duty and responsibility to offer a safe workspace and work system as well as supply proper work equipment and resources, all in line with industry standards [9,10].

When establishing whether employers fail to solve the lack of PPE issue, the laws and work codes should be consulted, and factors such as the nature of the work, associated risks, the possibility of taking preventive measures to prevent or limit the predictable risks , the laws that govern public acquisition workflow [9].

Medical establishments drafted consents informing patients about the risk of infection with COVID-19 during hospital admission. However, that was not a relief for doctors, who feared that the complications and potential death caused by COVID-19 together with the underlying comorbidities would attract malpractice accusations.

Access to healthcare and standard of care

Healthcare access implies the ability of individuals to receive medical care based on their personal healthcare needs. According to Goddard, the concept translates into the "ability to secure a specified range of services, at a specified level of quality" [11, 12].

In Romania, public healthcare is offered by the state and financed from the state budget, local budgets, the budget of the Single National Health Insurance Fund, or from other sources, based on the specific case and according to the national law. The protection of public health is an obligation of the central and local public administration authorities, as well as that of all natural and legal persons [13].

The COVID-19 pandemic has severely affected the ability of healthcare systems to carry on with essential healthcare services[14]. This worldwide health crisis caused a very high increase in admissions to the emergency rooms and intensive care units, which have a limited number of highly trained personnel, complex equipment, and beds. Efforts to increase the necessary resources such as beds, equipment, and ventilators have been made. All these resources can be acquired relatively quickly, however, training qualified staff takes years. Doctors and nurses from other departments, with different qualifications, volunteered and were temporarily transferred to the overcrowded departments to compensate for the deficit of healthcare workers. This commendable and altruistic effort has created a legal vulnerability of exceeding the medical competence recognized by the medical college and in relation to the insurers of malpractice policies.

Under pressure, some states reacted quickly and adopted protective legislation. The state of New York, for example, passed article 30-d Emergency or disaster treatment protection act, broadly protecting the healthcare facilities and healthcare professionals in this state from potential liability resulting from treating individuals under conditions from circumstances associated with the public health emergency [15]. In most countries, however, the legal framework has lagged, and this remains a legal vulnerability for medical staff.

With patient safety being an essential element of universal healthcare coverage, patients should not be challenged with having to choose between unsafe care or no care at all [16]. Adequate access to healthcare during pandemics such as COVID-19 requires keeping guidelines constantly up to date. Moreover, the research and guidelines must always complement each other. Treating a new illness always brings complexities [11].

As new studies were completed, new recommendations were published with remarkable speed, but physicians feared implementing new treatments that could deviate from good practice guidelines, worrying that there will be an increase in complaints against them. When analyzing the statistics of patient mortality, it is essential to consider the severity of the patient's illness at the time when they are admitted and the associated comorbidities. If in clinical practice definitive diagnostic criteria had been established, after death sepsis is often difficult to diagnose, especially if a site of origin is not found or if no clinical data is available [17].

The overload of the pandemic on the healthcare systems caused severe challenges for people in receiving care for health conditions unrelated to COVID-19. Based on the equity principle, patients who require

healthcare should be able to receive it [18]. The World Health Organization recommended further provision of essential medical services; however, each government can adapt to the shifting conditions in their own country: prioritizing essential health services and adapting to fast-changing needs. In an effort to diminish indirect morbidity and mortality and prevent acute episodes of chronic conditions when medical services are not available, countries should identify essential healthcare services that should be prioritized for continuation during the acute phase of the COVID-19 pandemic [1].

As worldwide healthcare systems have been confronted with increasing demand in caring for COVID-19 patients, having preventive and curative services in place, especially for the most vulnerable population groups such as children, the elderly, people with chronic conditions and disabilities, is key [14].

The risk of virus exposure within medical establishments together with the limited access to healthcare services such as surgery, treatment, and other hospital services are the main factors contributing to a noteworthy decrease in the level of access to healthcare during the pandemic. For instance, the deferral of surgical services could potentially create a significant backlog, transforming some of the previously optional cases into critical ones.

The lack of access to necessary medical care could eventually lead to life-threatening consequences. Research performed in Spain and Sweden unveiled a substantial association between increased risk of mortality among older people and healthcare needs that were unmet during this period [19].

However, healthcare systems could experience a surge in care demands in the aftermath of the COVID-19 pandemic. Adequate preparation for such a rise in demand for regular medical services includes careful planning and proper allocation of health resources whether these are medical staff, equipment, or facilities. Adopting a strategic approach as such could help with leveling the caseload and efficiently managing the patient backlog.

Telemedicine

Maintaining surveillance of patients with chronic diseases became a major challenge during this period. Telemedicine has been promoted as an economic and effective way for distance patient care with the added benefit of reducing the risk of coronavirus exposure. There is evidence of patients who have been managed by using telemedicine and expressed satisfaction with the services received, demonstrating that telemedicine helped monitoring, triaging, and treating patients, while avoiding a visit to the hospital [11].

Although telemedicine advantages are indisputable, it cannot fully replace face-to-face interactions, and increased privacy, regulatory and insurance coverage concerns must be addressed by policymakers. Professional secrecy in medical practice is tightly regulated legally and ethically. Medical information cannot be passed from the patient out of the relationship without the direct consent of the patient. Healthcare workers commit to maintain medical confidentiality, but telemedicine and the internet medium cannot provide this security in any circumstance.

In conclusion, health workers cope with physical and psychological challenges which take a toll on their mental health, wellbeing, and security. With the overload of the pandemic, fatigue and burnout syndrome are threats to the health of these professionals. Depending on personality and individual vulnerabilities, along with cognitive factors, the psychological pressure may be a contributor to suicidal behavior [20]. We must recognize that health worker safety is paramount to patient safety, one depends on the other and are inseparable. Prioritization on creating and maintaining safe working environments will lead to a better quality of service and standard of care for patients [16].

Telemedicine has great advantages, but limited applicability without an adequate legal work frame. More research is needed to assess its efficacy and quality of care it can achieve.

The chronic under-funding of hospitals generated an environment where protection equipment and supplies shortages becomes the norm. We conclude that special attention should be paid to problems related to allocation of scarce resources, the moral dilemma on who to treat, and pressing legal considerations regarding the medical practice during the pandemic and to burden and stress of the medical workers.

Conflict of interest

The authors declare that they have no conflict of interest.

References

1. Archived: WHO Timeline - COVID-19 [Internet]. [cited 2021 Dec 5]. Available from: https://www.who.int/news/item/27-04-2020-who-timeline---covid-19.

2. Lahat A, Shatz Z. Telemedicine in clinical gastroenterology practice: what do patients prefer? Ther Adv Gastroenterol. 2021;14:175628482198917.
3. Marina C, Gheoca-Mutu D, Răducu L, Avino A, Brînduşe L, Stefan C, Scaunasu R, Jecan C. COVID-19 outbreak impact on plastic surgery residents from Romania. J Mind Med Sci. 2020;212–216.
4. Mehta AR, Szakmany T, Sorbie A. The medicolegal landscape through the lens of COVID-19: time for reform. J R Soc Med. 2021;114(2):55–59.
5. Hostiuc S, Radu D, Seretean L, Tirdea C, Siminiuc R, Curcă GC. Driving under the influence of alcohol during the COVID-19 pandemic. Forensic Sci Int. 2021;329:111076.
6. McDougall RJ, Gillam L, Ko D, Holmes I, Delany C. Balancing health worker well-being and duty to care: an ethical approach to staff safety in COVID-19 and beyond. J Med Ethics. 2020 25;medethics-2020-106557.
7. Health Care Professionals Are Under No Ethical Obligation to Treat COVID-19 Patients - Journal of Medical Ethics blog [Internet]. [cited 2021 Dec 6]. Available from: https://blogs.bmj.com/medical-ethics/2020/04/01/health-care-professionals-are-under-no-ethical-obligation-to-treat-covid-19-patients/
8. Personal Protective Equipment for front-line health workers: an ethical imperative - Journal of Medical Ethics blog [Internet]. [cited 2021 Dec 6]. Available from: https://blogs.bmj.com/medical-ethics/2020/03/31/personal-protective-equipment-for-front-line-health-workers-an-ethical-imperative/
9. Chan HY. Hospitals' Liabilities in Times of Pandemic: Recalibrating the Legal Obligation to Provide Personal Protective Equipment to Healthcare Workers. Liverp Law Rev. 2021;42[2]:185–205.
10. Emanuel EJ, Persad G, Upshur R, Thome B, Parker M, Glickman A, Zhang C, Boyle C, Smith M, Phillips JP. Fair Allocation of Scarce Medical Resources in the Time of Covid-19. N Engl J Med. 2020;382(21):2049-2055.
11. Núñez A, Sreeganga SD, Ramaprasad A. Access to Healthcare during COVID-19. Int J Environ Res Public Health. 2021;18(6):2980.
12. Goddard M, Smith P. Equity of access to health care services: Soc Sci Med. 2001;53(9):1149–1162.
13. LEGE nr. 95 din 14 aprilie 2006 privind reforma în domeniul sănătăţii [Internet]. Available from: http://www.snspms.ro/images/download/juridic/legea%20nr%2095-2006%20republicata.pdf
14. Maintaining essential health services: operational guidance for the COVID-19 context Interim guidance 1 June 2020 [Internet]. Available from: https://www.who.int/emergencies/diseases/novel-coronavirus-2019/related-health-issues
15. EMERGENCY OR DISASTER TREATMENT PROTECTION ACT [Internet]. Available from: https://www.ncleg.gov/EnactedLegislation/Statutes/PDF/ByArticle/Chapter_90/Article_1L.pdf
16. Shaw A, Flott K, Fontana G, Durkin M, Darzi A. No patient safety without health worker safety. The Lancet. 2020;396(10262):1541–1543.
17. Dermengiu D, Curca GC, Ceausu M, Hostiuc S. Particularities Regarding the Etiology of Sepsis in Forensic Services. J Forensic Sci. 2013;58(5):1183–1188.
18. Oliver A, Mossialos E. Equity of access to health care: outlining the foundations for action. J Epidemiol Community Health. 2004;58(8):655–658.
19. Lindström C, Rosvall M, Lindström M. Unmet health-care needs and mortality: A prospective cohort study from southern Sweden. Scand J Public Health. 2020;48(3):267–274.
20. Constantin AM, Lupusoru MOD. Socio-demographic and economic characteristics of patients with psychiatric pathology and non-fatal suicidal behavior. Romanian J Leg Med. 2015;23(3):217–220.