or other interventions based on questionable scientific data are posted, gain traction and propagated without fact checking. They may often go 'viral' to a global audience – who accept it as received wisdom. Political patronage gives it greater validity. PBM allows an item to transition from quasi-science to almost an element of faith with significant unintended consequences.

An example of PBM in the context of the COVID-19 pandemic was witnessed with the drug hydroxychloroquine. Despite conflicting results from small studies, with no or little evidence regarding prevention discussed in different reviews, it has been adopted as a therapeutic option and made its way into national guidelines.[3–5] The drug flew off the shelves causing a global shortage for lupus patients who actually would benefit from it.[6]

This was a classic example of the triumph of PBM over EBM. It reinforces the concept that there can be no shortcuts in science, particularly when so much is at stake. The inefficacy of hydroxychloroquine for the treatment of established COVID-19 infection has now been demonstrated in the large prospective RECOVERY trial.[7] ■

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DNACPR decisions

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Editor – Harrington, Price and Edmonds describe a quality improvement project of documentation and communication of do not attempt cardiopulmonary resuscitation (DNACPR) decisions via the use of an integrated electronic health records system.[1] However, it is inadequate to describe that the 2014 Court of Appeal in *Tracey v Cambridge Uni Hospital NHS FoundationTrust & Ors* ruled that Janet Tracey's human rights were breached simply as a result of a lack of communication of such a decision.[2]

Importantly, while simultaneously reinforcing the fundamental professional requirement not to harm, and that cardiopulmonary resuscitation (CPR) cannot be demanded whatever the patient's wishes, the Court of Appeal asserted that the human rights presumption for *involvement* in the decision. This involvement in a decision being a very different responsibility from the communication of a finalised one, requiring an open mind; the desire to understand and achieve wherever possible the wishes and preferences of the individual concerned; and consideration of the person's views in the final decision – which then needs to be communicated appropriately. There need to be convincing reasons not to involve the patient – patient choice would clearly be one, but distress alone would be insufficient, rather requiring a significantly higher threshold of psychological or physical harm. Ultimately, it is this involvement and knowledge of the final decision which then allows the person the opportunity to seek a second opinion if so desired.

Finally, the Tracey judgment should always be understood alongside the subsequent *Winspear v City Hospitals Sunderland NHS Foundation Trust* judgment and that if a person lacks decision-specific mental capacity at the time, the resulting best interests decision requires involvement, where practical and appropriate, with appropriate family / welfare attorney(s) irrespective of the time of day or night.[3,4] ■

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NEWS2 system requires modification to identify deteriorating patients with COVID-19

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Editor – The UK National Early Warning Score 2 (NEWS2) was developed as a track-and-trigger system to ensure a nationally uniform, evidence-based approach to early identification of the deteriorating patient in the UK. It allows monitoring of patients' vital signs and succinct reporting to clinical decision makers, facilitating early intervention in deteriorating patients.[1]

Patients with severe COVID-19 develop hypoxic respiratory failure reminiscent of acute respiratory distress syndrome (ARDS).[2] ARDS severity is measured by the Berlin criteria, where degree of severity is defined as deteriorating arterial oxygen partial pressure

(PaO_2) to fractional inspired oxygen (FiO_2) ratios.[3] The current NEWS2 system in use in NHS hospitals treats oxygen delivery as a yes/no binary score without demonstrating a graded increase from increasing oxygen demand.[1]

Consider the following two scenarios:

- Patient A is a COVID-19 patient on 1 L nasal cannula to maintain O_2 saturations >92%, a respiratory rate (RR) of 20 breath per minute and a heart rate (HR) of 100 beats per minute. This patient scores 3 on NEWS2.
- Patient B is a COVID-19 patient on continuous positive airway pressure (CPAP) on 60% FiO_2, 15 cmH_20 to maintain O_2 saturations of 92%, with RR of 20 breath per minute and HR of 100 beats per minute. This patient also scores 3 using NEWS2 despite the vast difference in clinical status.

While the Royal College of Physicians (RCP) has recognised this issue, stating that *'ANY increase in oxygen requirements should trigger an escalation call to a competent clinical decision maker'*, this statement does not differentiate acuity of a required clinical review between patients A and B should their oxygen demand increase.[4] Patient safety may be at risk when healthcare staff with only basic training are monitoring observations on the ward unaware of this problem. The window of time for recognition and escalation would be shortened if the oxygen delivery systems could be scored in an escalating ladder (see supplementary material S1).

Given the limitations of denoting oxygen on NEWS2 highlighted by guidance issued by the RCP, NEWS2 would benefit from a re-evaluation and updated scoring system in the interests of patient safety in anticipation of future waves during the COVID-19 pandemic. ■

Supplementary material

S1 – Proposed oxygen delivery scoring system.

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Legal proceedings against doctors in the COVID-19 era: an Italian phenomenon

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Editor – At the time of writing, more than 165,000 cases of SARS-CoV-2 infection have been confirmed in Italy. Although the number of new daily positives is decreasing, the situation is still severe, especially for healthcare workers who struggle every day, risking their own lives and that of their relatives. The situation is aggravated by the fact that in recent weeks in Italy, several law firms have taken advantage of the desperation of these days to advertise and bring lawsuits against doctors, making them the scapegoat for the global pandemics.

In Italy, more than 116 doctors died due to the SARS-CoV-2 infection since the beginning of the pandemic.[1] We collected data on each one of them, using local newspapers and obituaries as sources. We found out that 110 were male (95%) and only 6 were female (5%), the youngest was 49 years old, the oldest 94 years old and the average age was 70 years old. Five of these doctors had returned from retirement to help with the emergency, only 21 were retired. Eighty-two per cent of the deceased worked closely with patients at the time of the infection.

On 19 March 2020 and 26 March 2020 there were 8 deaths, the highest number in the whole month; 49 were family doctors, followed by dentists (10 deaths). Those most at risk were doctors who operate outside hospitals. General practitioners, since the emerging of more and more COVID-19 cases, have highlighted the problem of not having enough personal protective equipment or even just detergents. To cope with the problem, they have adopted various safety measures, including communications with the patients by telephone and prescriptions strictly made online. Moreover, given the shortage of medical specialists, healthcare workers had to drastically increase working hours to provide adequate assistance to the ill.

In addition to these dramatic circumstances, as the number of SARS-CoV-2 infected people grew, more and more physicians started being denounced by lawyers who wanted to speculate on this situation, requiring the intervention of the country's National Federation of Orders of Surgeons and Dentists (FNOMCeO).[2]

The moral question we would like to raise is: 'To what extent one doctor, who fights in the front lines endangering his own life, and that of his relatives, should be held accountable for the death of a patient with COVID-19?'

It should be noted that, according to the current Italian law, if a doctor is an employee of a health facility, whether private or public, he will be protected by the health facility which can move in recourse if the doctor has acted with willful misconduct or gross negligence. The current system would already provide for guarantees that contemplate emergency situations. To put these guarantees in place, however, criminal investigations would still have to be carried out.

This phenomenon, if not curbed immediately, is likely to reduce the availability of healthcare professionals, thus aggravating the shortage of health specialists and giving way to long and expensive legal proceedings that would distract doctors from their work and increase the psychological pressure on them.

For this reason, we believe that during this unprecedented global health crisis, lawyers should not be allowed to sponsor lawsuits against doctors and new measures must be taken to safeguard health professionals, not only physically and financially, but legally