COVID-19 Sacrifice and risk in the time of COVID-19

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ABSTRACT

The COVID-19 pandemic has changed the face of healthcare delivery. This article discusses the concept of medical sacrifice and personal risk, and how healthcare workers can apply these concepts when working outside their comfort zones, while remaining within the limits of their clinical competence. Guidance from the General Medical Council and the medical defence organisations is reviewed and considered in its practical application. We explore how a medical student, now a 'fast tracked' junior doctor, and a senior consultant, with pre-existing health issues, can feel confident working as part of the NHS response to COVID-19.

KEYWORDS: COVID-19, competence, risk, medical negligence, medical regulation

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Introduction

At the end of winter in 1888, 45-year-old Dr Hugh Gillies ignored family advice to rest with his mild symptoms of 'flu'; instead, he decided to answer a desperate call-out to a miner on a remote Scottish island. His patient was alone, had suffered a stroke and was not expected to live. Dr Gillies made the treacherous journey to the house and stayed by his patient's side all night. A storm blew up on the return leg, so it took three times longer and Dr Gillies arrived home exhausted. He developed pneumonia, dying very shortly afterwards. He paid the highest price for doing his job and his community recognised him as a man of his word and a powerful advocate for fairness and equality in healthcare. Admiration of their father's principles led two of his sons to become doctors. There are now at least 10 'Doctor Gillies' from his family line including Dr Kate Gillies, a general practitioner (GP), and Dr Alexander Gillies, his great, great grandson who is working as a GP in the COVID-19 Assessment Centre in Exmouth, Devon.[1]

Sacrifice in medicine

Dr Gillies' story illustrates his willingness to prioritise his patient's comfort above his own. Being part of the medical profession has always involved shouldering the burden of clinical risk and an implicit acceptance of personal sacrifice; both can challenge a personal sense of comfort. The current pandemic calls us to reconsider these issues within the context of additional individual and societal risk. At the start of the COVID-19 outbreak, Dr Li Wenliang, an ophthalmologist in Wuhan, China, took personal risks in the context of an authoritarian state to alert the wider medical community about the emergence of the infection. Tragically, Dr Li Wenliang died of COVID-19 on 07 February 2020.[2]

In the context of the COVID-19 pandemic, the assumptions that lie behind the recognition of medicine as a vocation rather than a career are more explicit. The current call upon healthcare workers globally is unparalleled. As healthcare workers are lauded as heroes, it is important to reflect upon the limits of comfort zones, personal sacrifice and how risk articulates with individual circumstances. As an experienced consultant and a newly qualified doctor, we consider how risk and comfort zones are reframed by the current COVID-19 pandemic.

COVID-19 is changing roles

Final-year medical students, now foundation interim year-1s (FiY1s), have voluntarily registered with the General Medical Council (GMC) early.[3] Trusts are being told to provide additional support. In addition to normal shadowing and supervision, they are asked to provide a foundation year-1 or foundation year-2 buddy, one-to-one wellness inductions, and for work within consistent team structures. Retired doctors and nurses have returned in their thousands to be re-trained and assist in the pandemic response.[4] Practice has also changed for experienced clinicians (Table 1). Face-to-face consultations for routine work have been cancelled in hospitals and GP surgeries.

Principles of practice

The principles of how doctors care for patients haven't changed; the GMC has provided updated guidance for the pandemic, described as 'extreme circumstances'.[5] Preparation for new roles for both the newest and most experienced members of the healthcare workforce requires employer-led support: multidisciplinary teamwork, appropriate induction, mentoring, training and feedback, including specific resources for staff wellbeing. Redeployed healthcare workers (HCWs) must continue to work within the limits of their competence, including consideration of what is in the patient's best interests.[6] There should not be an absolute obligation placed on anyone to work in a specific role if they do not feel able to perform outside their area of specialism.[7]

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Table 1. Personal perspectives

Jenny Vaughan	Julia Simons
As a senior consultant, with a history of recent treatment for solid organ cancer, including chemotherapy, I have felt guilty that I cannot directly care for COVID-19 patients and that others have taken that risk. Instead I have worked with various organisations to improve supplies of personal protective equipment and supported my colleagues on the frontline. My husband is a general surgeon who is exposed to COVID-19 on a daily basis but he has observed careful decontamination procedures at home. Remote consulting means than clinical assessment is more challenging, but video access still allows useful examination and observation. I rebook patients for a face-to-face meeting if required at the appropriate time or refer to a colleague if it is urgent. I ensure that my patients are aware of and are following COVID-19 government advice, especially the ones in vulnerable groups.	My final objective structured clinical examinations were cancelled and I have graduated early via email. The loss of the normal rites of passage, finals and graduation add to a sense of imposter syndrome. I'm glad we are being given the opportunity to volunteer as foundation interim year-1s. I am concerned that the final few months of preparation have been lost in exchange for starting work in a pandemic. As the newest doctors, I think it's important to recognise that, while the circumstances we are starting in are not those we ever imagined, the expectations of us are the same as if we were starting work as previously planned in August. There is comfort knowing I will be expected to work within my competence and that measures have been put in place specifically to support us. I also have concerns about whether adequate protection and support will be available in practice.

Clinicians must consider whether it is possible to perform assessments adequately by remote review, and balance must be struck between potential risk to clinicians and the best interests of the patient, eg in treatment of maculopathy in eye clinics to prevent blindness. The medicolegal recommendation is that doctors should record the reasoning behind decisions made and the information given to patients, in case it is necessary to explain the approach taken at a later date.[6]

Best-interest decisions are made based upon the balance of risks; professionals must communicate concerns and explain these decisions to patients. Unresolved concerns can be relayed verbally to the clinician in charge and/or in writing and advice can be taken from a medical defence organisation (MDO). Doctors should also check their MDO coverage and subscriptions to ensure they have the correct type, applicable to their role.[6]

Importantly, in the wake of the Bawa-Garba case, the GMC have stated that they will take account of the full context of a doctor's work including any lack of staff or resources, which may be the reality in this exceptional situation.[8] The GMC has also requested that all organisations provide adequate resources, including staffing numbers and skill mix. All healthcare regulators have acknowledged that clinical duties may include working outside normal practice and have supported the need for staff to work cooperatively, in line with best evidence and within their competence.[9]

Redefining comfort zones: reducing risk

Comfort zones are characterised by a sense of security due to familiarity. Normal comfort zones have been erased as healthcare systems have been rapidly re-organised over recent weeks. HCWs are asked to be flexible, and to work in non-standard clinical areas for the benefit of patients.[5] Prior to the pandemic, understaffing was a concern. A recent survey found that many doctors are now working on rotas with 20% of staff absent.[10] Concern for the safety of staff, patients and families places the provision of adequate personal protective equipment (PPE) at the forefront of any discussion. Italy has recorded deaths of over 100 doctors, with HCW deaths in the UK rising steadily at the time of writing.[11] Personal experiences of morbidity and mortality combined with new clinical roles are not within normal comfort zones for most HCWs.

HCWs always aim to provide the best patient care possible with the resources available including 'in the highly challenging but time-bound circumstances of the peak of an epidemic'.[5] In the context of PPE shortages, tension arises between reducing risk (to self and to patients) through use of adequate PPE and remaining within personal comfort zones which, as the tale of Dr Gillies illustrates, have been constructed to put patients first.

British Medical Association (BMA) guidance recognises the right of a doctor to refuse to work if PPE is inadequate when they are at a high risk of infection and there is no other way of delivering care.[12] Recent changes to guidance for PPE (due to shortages), have been criticised by the Royal College of Surgeons for 'risking confusion' and for being 'wholly inadequate for an operating theatre environment'.[13,14] There is further confusion about the correct level of PPE to wear due to inconsistency regarding whether cardiopulmonary resuscitation (CPR) is an aerosol generating procedure (AGP); Public Health England guidance states CPR is not an AGP, whereas the Resuscitation Council (UK) guidance states that it is.[15,16] Conflicting definitions have led to concern that guidance is based upon the availability of PPE rather than the best available evidence for practice. This has led to organisations such as the Doctors' Association UK (DAUK) to campaign for improved PPE availability and bring to light the issue of workplace bullying attempting to silence frontline doctors on this issue.[17] Limits of sacrifice must be defined; HCWs should not be placed at higher personal risk than necessary by their employer.

Ethics in a pandemic

The published ethical framework for responding to pandemic influenza recognises the potential conflict between the needs of the individual and that of the population.[18] Understanding ethical responsibility within this context requires a layered approach. Government and employers are responsible for systems that ensure provision of adequate equipment and staff. Assessment of risk at an organisational, team and individual level requires professional judgement from HCWs, both clinical and non-clinical. The mutual goal is to ensure that patients receive safe care, consistent with accepted standards, and based on robust evidence. Variation in clinical practice may be necessary, and decisions about treatment pathways demand clear communication between clinical staff. Ethical concerns are particularly fraught with regard to resource allocation in the intensive treatment unit setting. BMA guidance supports the approach that it is both

lawful and ethical to withhold or withdraw treatment on the basis of evidence-based resource allocation to optimise outcomes.[19] However, in practice, withdrawal will 'feel different'. Removing ventilation and not providing it in the first place may not be regarded by the courts as legally equivalent. There needs to be an open and transparent national debate that results in a nationally applied approach to withdrawal that ideally has public support. This is especially important in the likelihood of further peaks and future pandemics.[20] The issue of whether immunity from civil liability should apply for any injury or death alleged to have been sustained because of any acts or omissions undertaken in 'good faith' during the COVID-19 crisis by HCWs has also been raised.[21]

Conclusions

Medical practice has always had the potential to take clinicians out of their comfort zone. This is universally evident amid the significant challenges presented by the COVID-19 pandemic, and there are many examples of courage and sacrifice. These values are not new to HCWs. We urge governments to learn and implement rapidly the improvements necessary to reduce the risk of deaths, both for the population and for staff with direct workplace exposure. As a profession, we must continue to act with courage in our patients' best interests, but in the process not neglect our own personal safety nor that of our colleagues. ■

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