Legal aspects of COVID-19 pandemic management for community nurses

John Finch
Freelance journalist specialising in legal and ethical issues in healthcare
johnfinch176@gmail.com

At present, attention is firmly fixed on 'the community'. What does that mean in reality? The coronavirus directly impacts both the vulnerable and their carers. Deaths resulting from contracting the virus are losses to their families, and they are losses to the community, which brings community nurses into immediate focus. What does that mean in practical terms? What does it mean to say that, if you are or have reason to suspect you are infected by coronavirus, you must 'distance' yourself from it, yet still remain part of the community?

In a previous issue of the *British Journal of Community Nursing*, the author reviewed working hours and injuries caused by lifting accidents in community nursing (Finch, 2019a; 2019b). Both involve the wider duty that the law places on managers and employers to create and maintain a safe system of work. Such a system requires safe equipment, safe premises reliable employees and a safe system of working conditions.

A moment's reflection on all of the elements of a legally required safe system of work is enough to make us realise that the problems caused by the coronavirus pandemic infuse all of these aspects of legal responsibilty. This article looks at how things may develop in regard to the law on professional responsibility. The article also looks briefly at the likely increase in volunteer workers, as well as an important aspect of patient confidentiality.

Do legal obligations change in national emergencies?

In some respects they do, but in most respects they do not.

Some comments emanating from UK ministers and from parts of the media have suggested that we are on a 'war footing'. This is an unhelpful analogy in the context of a health threat, which is putting immense pressure on healthcare services, especially those in the community. One cannot declare war on a potentially deadly virus any more than one can declare 'war on terrier' (per former US President George W Bush after 9/11).

War may involve declarations of martial law—government by the armed forces—and it may well involve the requisitioning of private premises and businesses by legal decree. Wartime conditions bring with them the requisitioning of privately-owned premises as well as the suppression of freedom of information. Those stages have not been reached with the spread of COVID-19 yet, and hopefully never will.

But if the 'war-footing' is not the order of the day in the COVID-19 crisis, what is? The various approaches addressed by the numerous countries now affected appear to resolve themselves into a straight choice: voluntarism or legal rules.

Safety duties to patients and practitioners

The law relating to duties of care, whether it be those owed by practitioners to their patients or those owed by employers and managers to their staff, are predicated on reasonableness. What is reasonable is directly influenced by the availability of resources including, principally, staff and equipment.

As regards staffing levels sufficient to meet patients' needs, a number of factors need to be taken into account in assessing what is reasonable in complying with the legal duty of care. One of the greatest concerns being expressed by Government and the media is the effect on patient care caused by practitioners themselves contracting the virus. There have already been reported cases of this having happened. Ear, nose and throat and respiratory doctors who have been affected tend to make headlines, but there have been few reports so far of the effect of unavailability for work of the much larger practitioner body of nurses. Sadly, time is almost certain to tell.

Basic and essential tasks, such as lifting patients during domiciliary visits, may have to be re-planned, as may the frequency of such visits. It is a question of effecting a reasonable balance. One aspect of patient treatment in the community that must not be allowed to be adversely affected, save in the direst of circumstances, is the maintenance of a required level or frequency of necessary medication. Access to required medication must be facilitated by whatever means practicable. 'Distancing' (the precise distance tends to differ with time and across different ministers) and shielding will have to take a back seat.

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Regrettably, community nurse managers will very probably be obliged to introduce triage methods, a practice reminiscent of what is already happening in Lombardy, Italy, where the inevitable triage relates to the ultimate choice between who is to be given a continued chance to live and who is not. There is nothing unlawful in this, provided that the decision is made on the basis of a reasonable assessment of treatment facilities which are, and which are likely to be, available to patients.

In any event, even if an error is made and harm ensues, the law imposes liability only if there is a sufficient causal link between the mistake and the untoward result. So, literally, a practitioner can make all the (misjudgment) calls they like, but if harm is not caused, there is no legal liability.

Something less self-evident, though well worth adding, is that policies on the deployment of staff and the allocation of patient treatment may have to be revised or, at least, carefully examined. I have written elsewhere (Finch, 2019c) that a policy unsupported by critically argued principle is not worth the paper it is written on, and may be positively dangerous. To pursue a policy for its own sake could lead to the imposition of legal liability, both civil (action for damages) and criminal, on the part of those who obdurately persist. New circumstances may well require a thorough overhaul of community nursing care policies depending on the demographics of a particular locality as well as practical logistics.

Patient confidentiality

In our situation of a spreading virus pandemic, it is worth including a word of reassurance to practitioners who wonder whether, in particular cases, they should share their knowledge or their reasonable suspicion that a patient might present a danger of infection to others should 'distancing' and 'shielding' be impracticable, ineffective or even refused. The general rule is that it is legally permissible to share such information so far as appears necessary to reduce or eliminate the danger.

As the author pointed out in a previous issue (Finch, 2019c), there is, contrary to widespread belief across the health professions, no tort or civil wrong committed by breaking a patient's confidence. If persuasion fails, a departure from patient confidentiality may be the only practicable option available to he practitioner.

Confidentiality is a moral or, professional value, and its breach is legally actionable only in such cases of passing on trade secrets without permission and those need not concern us here. The only caveat relates to the fact that police, acting on reasonable suspicion of coronavirus infection, are to be given the power to arrest the infected person. Some difficulties created by such a power are outlined shortly.

Volunteers

It has been reported in national news broadcasts that, even before the new situation created by the rapid spread of coronavirus, some three million volunteer workers were already helping to keep UK healthcare services working. This number is likely to increase in the face of the problem which now presents.

With this probable increase come responsibilities on employers and managers in training, not only in treatment methods but also in the precise details of how volunteers are to contribute usefully and safely to delivery of treatment and care in the community as part of what may now need to become an amended system. In particular, great care will need to be given to which tasks are suitable to be delegated and to what extent. It is fairly clear in the law that the buck of legal responsibilty will stop with the community nurse, and possibly with their manager depending on how the system of work has been established.

Do government guidelines place legal duties on community nurses?

The hallmark of the UK Government's reaction to the coronavirus crisis has been voluntarism in contract to regulation and constraint. Shielding advice was published on 21 March 2020 (Public Health England, 2020). It is, on its face, addressed to those who are particularly vulnerable, including, in particular, those who are older or already in poor health. It is unlikely that these groups spend their time glued to computer screens to see how best to handle their situation, and the question arises as to whom this messaging is aimed. The answer appears simple: inferentially, it is aimed at carers and particularly, at community nurses. Shielding is vaguely defined, and the advice is likely to add little or nothing to what a sensible community nurse is already doing.

Of far greater significance is the new, hurriedly prepared, community virus legislation scheduled to go through all its parliamentary stages on 24 March. It is clearly sensible, and humane, to restrict a person's liberty to infect others, and such a restriction accords comfortably with John Stuart Mill's essay *On liberty* published in 1859, that the only justification for restricting a person's liberty is the prevention of harm to others: 'His own good, either physical or moral, is insufficient warrant.'

And if, as is the case up to now in the UK, voluntary compliance with advice is to be preferred to positive instructions—including prohibitions—then it is to be hoped that Westminster and Edinburgh are singing from the same hymn sheet, which has not always been the case to date.

Proposed powers of arrest under the new legislation

While opinions will inevitably differ, the proposal that police be given powers to arrest people who are considered to be suffering from the virus is, to my mind, wholly out of place in laws aimed at limiting the spread of disease. An analogy may be drawn with police powers under section 136 of the Mental Health Act 1983. The practical application of section 136 has an unhappy history, and numerous deaths of mentally disordered persons have occurred while in police custody. While police receive

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some training in the presentation, and perhaps also in the management, of mental disorder, a police cell is not the place for it to happen.

Furthermore, the question arises as to where to take the coronavirus sufferer if not to a police station. GP practices are unlikely to want them, as are hospitals, which are already overburdened.

It remains to be seen what place of safety is designated, by regulations made pursuant to the Act, to which to take the arrested person. Without detailed and practical legal provision in this respect, the new measure is unlikely to be welcomed—including by the police themselves.

There are, in any case, wide powers of restriction of personal liberty contained in the provisions of the Public Health Act 1984. The powers conferred by the Act on public health authorities are predicated on a list—exhaustive, not exemplary—of prescribed diseases. These include plague and a number of other serious and highly infectious diseases, all of which have, over the years, figured in pandemics. Interestingly, while there was some 30 years ago global concern bordering in some cases on panic due to the AIDS virus, and, while there was serious debate both inside Parliament and beyond it, the decision was eventually made not to add AIDS infection to the list. The condition was popularly misunderstood and attracted many myths. The late Princess Diana did much to dispel some of them.

That having been said, there may well be pressing reasons for the inclusion of COVID-19 in the list of prescribed diseases in the 1984 Act, not least of which are its very high infectivity and its capacity to spread very rapidly. There are closer analogies with the disease on the prescribed list than there ever were in the case of AIDS. If so, it is difficult to understand why the UK Government has chosen not to take this course. It would be a simple step that carries with it more than 36 years of practical and legal experience.

A lesson from across the channel

In the UK's nearest neighbour, France, prohibiting powers are already in place. A standardised form that can be downloaded from the Ministry of Interior (Home Office) website and from other sources sets out an exhaustive list of five permitted reasons to go out in public. They include, principally, to do the shopping, to visit the pharmacy and to travel to and from work in the case of those who cannot do the same work from home. Failure to produce a completed and dated from may result in a fixed fine of 135 euros, although police appear normally to rest content with telling people to go home and be sensible. Powers of detention exist elsewhere in French law to cater to obdurate or persistent failure to comply with the law. Only time will tell whether the UK approach or that adopted in France will be more successful. Hopefully, they will be equally so. **BJCN**

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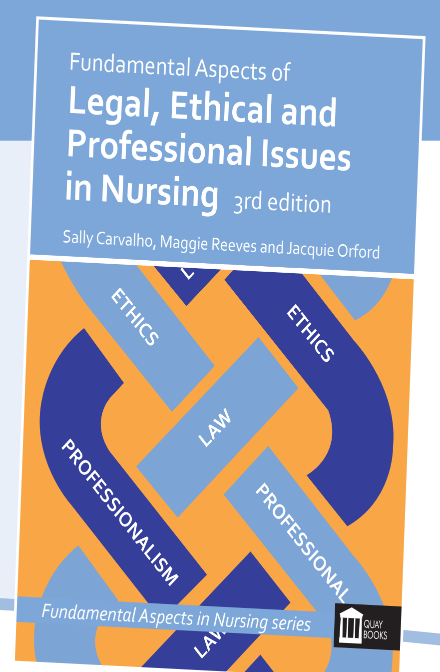

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