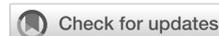


Ethicomedicolegal aspects of the COVID-19 health services in preparing regulations and intermediaries for clinical dispute resolution: a systematic review

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ABSTRACT

BACKGROUND The COVID-19 pandemic has caused many medical, ethical, and medicolegal changes, including constant adjustments in service guidelines. Continuing to revise healthcare regulations and guidelines can potentially cause clinical disputes or medical negligence that require ethical and legal solutions. This study aimed to determine the ethical and medicolegal aspects of the potential factors that cause clinical disputes during the pandemic and provide anticipative solutions to national ethicomedicolegal policies.

METHODS A systematic literature search in PubMed, ScienceDirect, ClinicalKey, and Google Scholar was performed using keywords “clinical dispute,” “ethics,” “medicolegal,” “ethicolegal,” and “COVID-19”. The inclusion criteria were articles that contained information on shortage, justice, ethical distribution in intensive care, the possibility of lawsuits and disputes among stakeholders during the pandemic, and stakeholders’ roles in managing the pandemic. Key evidence was analyzed and synthesized following national ethicomedicolegal policies.

RESULTS We identified 19 articles from the 4 databases. Based on the literature, the main ethicomedicolegal impact of the COVID-19 pandemic appears in 3 aspects: (1) a shortage of fair and ethical intensive care services with fair and ethical distribution efforts, (2) legal protection for medical personnel from legal charges while providing health services during the pandemic, and (3) the government’s role in managing the pandemic together with the stakeholders involved.

CONCLUSIONS Ethicomedicolegal clinical dispute management and its norms require an update, especially when deciding the complexity of COVID-19 service standards. Ethicomedicolegal professionals are needed as intermediaries to manage cases of clinical disputes and to implement fair malpractice criteria in Indonesia.

KEYWORDS COVID-19, dispute, ethic and medicolegal regulation, Indonesia, mediator

On January 30, 2020, the Director-General of the World Health Organization (WHO) declared the coronavirus disease 2019 (COVID-19) outbreak a public health emergency of international concern, which was the WHO’s highest level of alarm. On March 11, 2020, the WHO announced that the outbreak could be characterized as a pandemic. Since the first cases were

reported, the WHO has supported countries worldwide in preparing for and responding to the COVID-19 pandemic. This was followed by the enactment of the Presidential Decree of the Republic of Indonesia (KEPPRES) No. 12 year 2020, which declared the COVID-19 pandemic a non-natural national disaster.^{1,2} Various policies were launched by governments

worldwide to curb the massive spread of the virus and prevent deaths. The Indonesian government has released three legal products to synergize healthcare with the economy: (1) Government Regulation in Lieu of Law (PERPPU) No. 1 year 2020 on state financial policy and financial system stability for the handling of COVID-19 and the framework of dealing with threats endangering the national economy, financial system stability, or both; (2) Government Regulation (PP) of the Republic of Indonesia No. 21 year 2020 on large-scale social restrictions on accelerating the handling of COVID-19; and (3) the Presidential Decree of the Republic of Indonesia (KEPPRES) No. 11 year 2020 on establishing a public health emergency of COVID-19. These policies included merging the assignments of organizations managing the COVID-19 pandemic, mainly the National Agency for Disaster Management (*Badan Nasional Penanggulangan Bencana* [BNPB]) and the Ministry of Health, with the National and Regional Task Force (*Gugus Tugas Nasional dan Daerah*) using a special financial scheme in accordance with the law.³⁻⁵ Implementing these regulations may cause disputes at the community level, such as community refusal on large-scale social restrictions.

In medicine, several medical professional organizations have released the COVID-19 management guidelines based on science and technology and the practical experiences of each profession, which have been revised several times.⁶ The implementation of the COVID-19 management guidelines is limited due to different clinical settings in each hospital. Interactions in health facilities between doctors/medical services and patients/families, who have their own rights and obligations in the pandemic era, have created more complex dynamics. This may trigger a dispute in adjusting the medical and legal principles (in medicolegal form) in managing patients with COVID-19 compared to the pre-pandemic era. These various adjustments to healthcare regulations and guidelines have caused potential clinical disputes or medical negligence that require ethical and legal solutions. However, no ethicomedicolegal policy was established as an intermediary for clinical dispute resolution during the pandemic in Indonesia. This study aimed to determine the ethical and medicolegal aspects of health services in various countries and the potential factors that might cause clinical disputes during the COVID-19 pandemic.

METHODS

A literature search was conducted using an online database on February 15, 2021. The articles were searched systematically through PubMed, Science Direct, ClinicalKey, and Google Scholar using keywords such as “clinical dispute,” “ethics,” “medicolegal,” “ethicolegal,” and “COVID-19” and their synonyms. We have also added relevant articles found in our library and information on government regulations and presidential decrees. The inclusion criteria were articles that contained information on shortage, justice, and ethical distribution in intensive care, the possibility of lawsuits and disputes between stakeholders during the pandemic, and stakeholders’ roles in managing the COVID-19 pandemic. The articles included were research and literature review articles written in English. The articles were then screened for title and abstract relevance to the objective of the COVID-19 pandemic ethicomedicolegal policy. Finally, the selected articles were checked for duplicates and read thoroughly to assess their relevance to the study objectives.

The articles were then analyzed by understanding the possible factors of clinical disputes such as clinical judgment between medical needs and availability of hospital resources, worsening doctor-patient relationships that lead to medical negligence, imbalanced rights and obligations between the health service provider and receiver, dilemma of medical decisions, contextuality of ethical and medicolegal conflict in difficult cases, and stakeholders’ policy in implementing a standard/guideline for COVID-19 patient service in the hospital. These factors were then summarized and used to generate suggestions for developing ethicomedicolegal policies for clinical dispute management during the COVID-19 pandemic in Indonesia and prevent potential civil or criminal medical negligence. Two independent authors (AP and AD), experts in bioethics and medicolegal, analyzed each article by reviewing and summarizing the ethicomedicolegal aspects. Any differences in the results of the analyses are discussed. Article analysis was performed by examining (1) the indicators of basic ethical principles such as beneficence, non-maleficence, autonomy, and justice relevant to *prima facie* from the scope of medical decision (by doctors based on doctor-patient relationship) or clinical decision (based on medical decision and consideration of hospital resources); (2) the existing legal norms for medical

negligence and implementation; (3) the dynamics of medical development in science and technology in managing patients with COVID-19 based on biomedical principles (diagnosis), clinical management (therapy), and public health/community medicine (pandemic aspect); and (4) the real cases in legal/medicolegal clinical disputes in COVID-19 patient services in Indonesia (especially in hospitals). We also assessed whether the clinical dispute was upstream of medical negligence or at the pre-, intra-, or post-hospital phases to analyze the management of clinical disputes during the pandemic.

RESULTS

The screening was performed based on the article’s relevance to the study objectives, which resulted in 19 articles for further assessment. The search strategy for each database is shown in Figure 1.

Based on the assessment results of each article⁷⁻²⁵ in Table 1, the medicolegal aspects of patient care

during the COVID-19 pandemic, which have the potential for a clinical dispute, can be categorized into three factors: (1) shortage of intensive care and fair and ethical distribution efforts, (2) legal protection for health personnel from lawsuits while providing health services during the pandemic; and (3) the government and stakeholders’ roles in managing the COVID-19 pandemic. These medicolegal aspects have also been found in various countries, including the USA, the UK, the Netherlands, Italy, Indonesia, Thailand, Australia, Spain, and India.

Cook et al⁸ stated that in the early COVID-19 pandemic in the UK, there was widespread concern that healthcare systems would be overwhelmed, specifically an insufficient critical care capacity for beds, ventilators, or staff for patient care. In Italy, Oliva et al¹⁷ found high inflation of criminal and civil proceedings concerning alleged errors committed by healthcare professionals and decision-makers during the COVID-19 pandemic, which might be imminent due to the high increase in infection and death cases. Changes in the

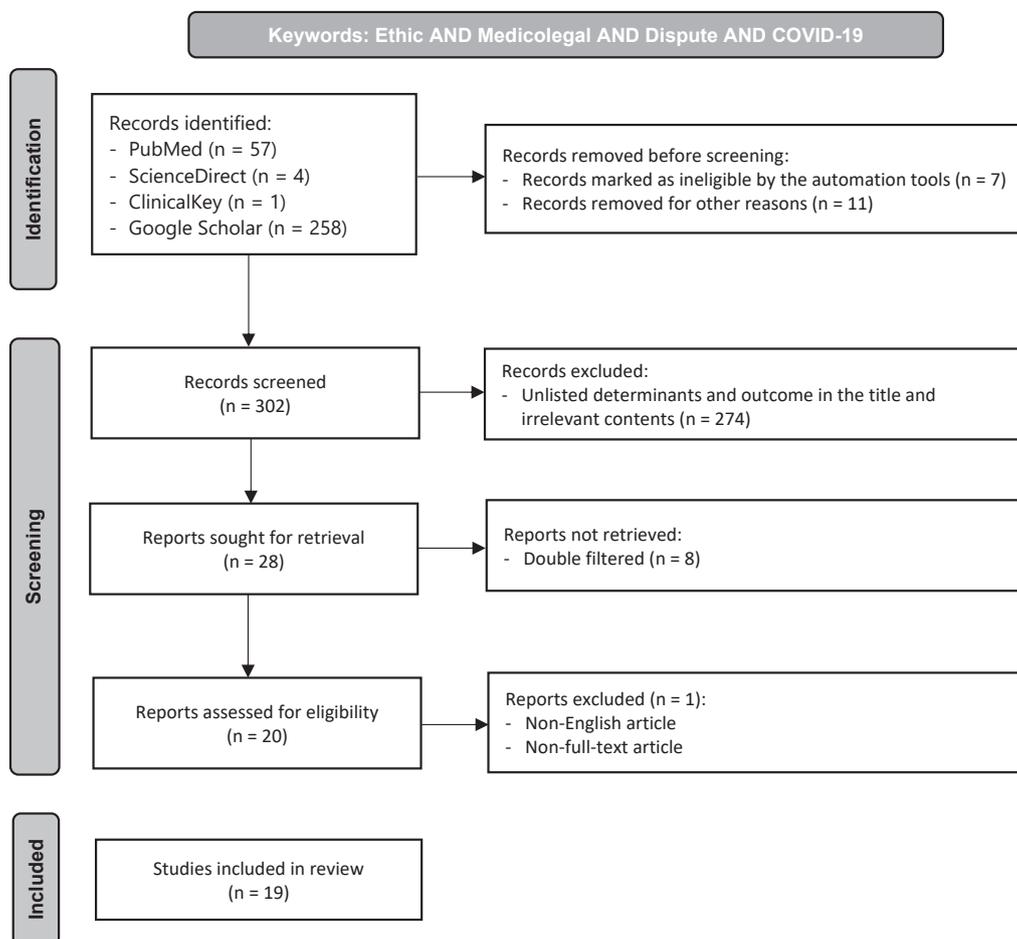


Figure 1. Flow diagram of literature search

Table 1. Article assessment results

First author, year	City/country	Main issue	Contextual setting	Basic ethical principles	Ethicomedical aspects in the article
Tolentino, ⁷ 2021*	New York/ USA	Risk management on the COVID-19 pandemic	The COVID-19 pandemic has caused medicolegal and ethical dilemmas in public health emergency services that require health care risk management on the administrative and clinical decisions for the health workers.	Non-maleficence Beneficence Justice	<p>During emergencies in public health service, new rules and adaptation of the health system are needed to secure health service capacity for patients with COVID-19. For instance, some states in the US allowed unlicensed health care workers involved in telemedicine practice, although they were not listed as an employee (waivers of state licensing laws). The New York State Department of Health also issued an order against medical advice to achieve the best possible health care system during the pandemic.</p> <p>The end-of-life care conditions of patients with COVID-19 are more complicated with a lack of the patient's will (advanced directives), rapid disease progressivity, and risk of infection spread. The doctor must quickly decide on limited communication due to the increasing number of patients and family dissatisfactions. The hospital needs to appoint a palliative team and an ethics committee to facilitate mediation whenever needed.</p> <p>Health facilities need to provide a Helping Healers Heal program to address the mental health of health workers with overload tasks during the pandemic.</p> <p>The New York State Department of Health can issue an order to hospitals to keep the patient from discharge (against medical advice) until completing the criteria for outpatient and follow-up self-isolation.</p>
Cook, ⁸ 2020*	Bath/UK	Intensive service for critical patient	Shortage of intensive service during the COVID-19 pandemic and how to address it using a structural assessment	Justice Beneficence	<p>Claims and litigations for malpractice in patients with COVID-19 can be treatment-related claims on clinical decisions, claims related to the postponement of non-essential care or procedures, lawsuits from the front-line workers or their families around PPE availability, and other failures to protect health care workers.</p> <p>Decision-making related to health during the COVID-19 pandemic must be based on the public health importance (the greater good) rather than individual needs.</p> <p>The COVID-19 pandemic management involved three layers of protection: increasing intensive capacity for intensive care, ceasing non-COVID-19 elective service activity, and forming upper-level policy, including lockdown.</p> <p>Making decisions for intensive treatment should involve other independent clinicians/the ethics committee, if possible, to make ethical decisions. A common ethical agreement is that treatment withdrawal from one patient to provide service for another patient can be ethically accepted for limited resources.</p> <p>A clinical decision has big consequences and is full of pressure when made on short time. The decision is not only made from what the patient accepts but also from what the patient or family needs.</p>

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Table 1. (continued)

First author, year	City/country	Main issue	Contextual setting	Basic ethical principles	Ethico-medical aspects in the article
Riyanto, ⁹ 2020*	Semarang/Indonesia	Review of the legal and normative rules toward the rights and obligation between the doctor and patient	Protection for the doctors, paramedics' health, and patients, with similar rights without exception	Beneficence Justice	A doctor-patient relationship is a therapeutic contract, leaning on the optimum therapy efforts regardless of the results. The doctor is responsible to the patient in adherence to professional standards. Likewise, the patient is morally or legally obliged to convey their medical conditions honestly. There is an imbalance risk between medical staff contracting COVID-19 from patients hiding their infection status and the medical staff's obligations to perform their duties due to unclear legal outcomes from the patients' dishonesty. Thus, legal protection for medical staff from patient dishonesty is needed.
Duignan, ¹⁰ 2020*	Leicester/UK	Legal immunity of medical staff related to medical negligence	Legal immunity for medical staff related to medical negligence during the COVID-19 pandemic	Beneficence Justice	Medical decisions during the COVID-19 pandemic in the coming months or years might be a potential litigation subject. Medical negligence is not easily proved because it must fulfill the 4D dimension (duty, dereliction of duty, damage, and direct cause). However, if proven, the patient must receive a compensation claim. Prioritizing the patient's best interest is the doctor's obligation. Governments and all medical personnel must maintain the service quality of the professional health staff by increasing the special service capacity for COVID-19. Thus, medical staff without clinical privilege should be given a clear task description and only allowed to perform the given task. If the staff breaches the privilege, he/she is still considered guilty.
Riley-Smith, ¹¹ 2020*	London/UK	Possibility of lawsuits in the COVID-19 pandemic service	Possibility of lawsuits in many aspects in the COVID-19 pandemic service	Justice	During the COVID-19 pandemic, doctors must work within their competency, although the practical procedure is new. If, somehow, deviation from the planned procedure is needed, it can still be performed based on medical opinion decisions by documenting the events in detail. In addition, a thorough evaluation of the context and cause of this deviation can be explained and demonstrated to the professional organization. Retired doctors can be involved in service during the pandemic following a re-registration.
Marshall, ¹² 2020*	Nonthaburi/Thailand	Legal rules	National policy for managing critical service is needed during the COVID-19 pandemic.	Beneficence Justice	A protocol is needed to ensure justice for all patients requiring ICU based on their conditions.
Sesta, ¹³ 2020*	Messina/Italy	Criteria for an equitable distribution of the available resource	Massive health needs require criteria for ethical and fair distribution.	Non-maleficence Justice	Doctors create service criteria for patients and priority methods in providing service to patients with greater life chances while still providing service to critical patients with maximum available health resources. Doctors must educate the community to maintain their health because prevention is better than treatment. Health protocols are important in preventing the spread of COVID-19 infection.

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Table 1. (continued)

First author, year	City/country	Main issue	Contextual setting	Basic ethical principles	Ethicomedical aspects in the article
Netters, ¹⁴ 2020*	Zwolle/ Netherlands	Triage to receive ICU service in accordance with medical ethics	Deciding which patient needs ICU care may cause ethical conflict for health personnel.	Justice	The COVID-19 pandemic causes limited ICU service where ICU patients should be screened on the medical and ethical priorities for all parties To avoid medical futility, we need to see two important criteria: utilitarian principle (principle of achieving the greatest good for the greatest number) and egalitarianism principle (where everyone gets an equal chance). In deciding, we need to consider aspects such as (a) maximization of the number of lives, (b) maximization of the number of life years, and (c) fair innings principle.
Bolcato, ¹⁵ 2020*	Padova/Italy	Viewpoint of the COVID-19 management from Italy	Intensive care needs in Italy are very high, resulting in an imbalance of supply and demand.	Beneficence Justice	Protection for medical staff and hospital cares for patients during the pandemic, especially from lawsuit risks from patient/community. Managing integrated procedures on patient management during the pandemic, especially intensive care, internal medicine, and public health. Implementation of the health protocol rules for the community during the pandemics must be accompanied by supported resources and facilities from the government and private sector.
Mehta, ¹⁶ 2020*	Edinburgh/ UK	Medicolegal aspect in the COVID-19 pandemic	Doctors have legal immunity while performing medical negligence during the service. Medical councils should be flexible in making rules during the pandemic to protect doctors from lawsuits. Issues in racism toward Black, Asian, and Minor Ethnic are stronger during the pandemic.	Justice Beneficence	There is a debate whether a doctor can have legal immunity from civil or criminal medical negligence lawsuits while providing medical service during the COVID-19 pandemic. A fair and educational culture in the health system is needed to manage cases fairly, transparently, and with humanity. Reformative medicolegal policy during the COVID-19 pandemic should be made to a parliamentary level involving all stakeholders. The restorative approach is useful in managing incidents of medical negligence with the principle of holding people accountable by considering the repairment, medication, and prevention.
Oliva, ¹⁷ 2020*	Rome/Italy	Medical staff legal responsibility	Liability status of the medical staff during the COVID-19 pandemic	Non-maleficence Justice	Health facility management must address the civil and criminal aspects of the policies. Health services performed must have a strong scientific base to prevent errors in medical care.

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Table 1. (continued)

First author, year	City/country	Main issue	Contextual setting	Basic ethical principles	Ethicomedical aspects in the article
Barranco, ¹⁸ 2021*	Genova/Italy	COVID-19 infection as nosocomial infection	Medicolegal aspect of hospital-acquired COVID-19 infection	Beneficence	Doctors should be able to anticipate the spread of COVID-19 infection between patients or from medical staff by noticing the history of each patient. Doctors should educate the patient and family on preventing COVID-19 spread and if the patient is exposed to COVID-19 during hospital treatment.
Ferorelli, ¹⁹ 2020*	Bari/Italy	Ethical challenges in the regulation of the COVID-19 management rules	Multiple viewpoints of health service from the potential side of professional ethical breaching	Beneficence Justice	Health policy based on ethical guidelines in every decision-making process is the only way to promote equal distribution of benefits and risks in the community. During the global economic crisis, clinical risk management has a more important role in the health system.
Kumar, ²⁰ 2020*	Punjab/India	Medicolegal aspect of the COVID-19 pandemic	Health service during the COVID-19 pandemic in India	Beneficence	Doctors cannot leave their job because they are afraid of contracting the disease. There is an exception if the doctor has specific medical conditions with a higher risk of infection. Doctors are responsible for creating disease awareness in the community and following the guidelines and existing regulations.
Coghlan, ²¹ 2020*	London/UK	The ratio of facilities and health resources in the health service during the pandemic	Creating policy/government rules concerning COVID-19 pandemic management need to be medically coherent, legally robust, dan ethically justified.	Justice Beneficence Autonomy	Clinical guidelines should be established and updated according to the latest medical science. Doctors should understand the limitations and legal base of each management given to the patient. Doctors should also consider the optimum and efficient resources and avoid incorrect resources. The hospital must provide PPE needed by the doctors before the service. Public and ethical policies on clinical patient management are needed.
Bonvicini, ²² 2020*	Padova/Italy	The medicolegal aspect of the COVID-19 pandemic	The medicolegal aspect from the government's point of view	Autonomy Non-maleficence	Doctors need to provide complete education and information to the patient about their medical condition, including the reason for the COVID-19 diagnosis. Implementation of regulation is needed for greater public welfare and safety without restricting individual rights. Education and discussion about the patient or deceased management are still needed without violating the COVID-19 health protocols.

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Table 1. (continued)

First author, year	City/country	Main issue	Contextual setting	Basic ethical principles	Ethicomedical aspects in the article
Camporesi, ²³ 2020*	London/UK	The controversy of scarce health service screening during the COVID-19 pandemic	Determining decisions based on triage screening	Justice	The COVID-19 pandemic has raised ethical dilemmas among medical practitioners in intensive care decision-making. There is an opposing view concerning the triage decision made by doctors. The first opinion stated that doctors should not be allowed to make their own triage decision based on criteria or recommendations by the ethics committee. The second opinion stated that there is no need for recommendations or criteria by the ethics committee because it will confuse the doctor. This second opinion is a better way to support the doctor by agreeing to the doctor's ethical decision.
Arimany-Manso, ²⁴ 2020*	Barcelona/Spain	Review of medicolegal problems associated with the COVID-19 pandemic	COVID-19 has ethical and medicolegal aspects needing special consideration.	Beneficence Non-maleficence Autonomy Justice	A doctor should manage the ethicomedicolegal conflicts that occurred during the COVID-19 pandemic with the basic four bioethical principles while considering the rights and obligations even in a non-conductive situation and condition. A doctor should always give transparent information and education to the patient, family, and community and document it to prevent ethicomedicolegal conflict.
Kelly, ²⁵ 2020*	Melbourne/Australia	Risk of litigation lawsuit for medical staff in COVID-19 service	The risk of litigation can be real or unreal.	Justice	Some countries have admitted the medicolegal risk and protected the good intention of medical staff. There is an increased lawsuit risk for doctors/clinicians. The lawsuit can be real (directly related to the clinical decision-maker for patients with COVID-19 such as giving ventilator or ICU) and unreal (referral process between health facilities and the clinical decision concerning respiratory therapy [NIV] for patients with respiratory distress but with low COVID-19 risk). In Australia, a national standard for such conditions is not available; so, a legal decision by the court and experts is needed.

COVID-19=coronavirus disease 2019; ICU=intensive care unit; NIV=non-invasive ventilation; PPE=personal protective equipment

*Review article; ¹symposium discussion

Australasian healthcare systems due to COVID-19 have increased the clinicians' risk of medical litigation. There are direct risks in decision-making for patients with known or suspected COVID-19. The government should recognize these medicolegal risks when changing policies to protect health workers who act in good faith.²⁵

DISCUSSION

The COVID-19 pandemic will cause ethical and medicolegal consequences due to the sharp increase in hospital intensive care capacity, legal protection factors, and the presence of state and related stakeholders. These factors will lead to various medical decisions and health service aspects, especially by doctors who treat patients with COVID-19. Therefore, the pandemic must be managed wisely by all parties, including health service providers and law professionals such as attorneys, judges, and legal counselors, considering its three ethical and medicolegal consequences.

Shortage of intensive care resources is one of the greatest potential causes of clinical disputes. This service is primarily provided for critically or severely ill patients and sometimes patients of a medium illness category who show signs of severity progression and require intensive care services.^{7,8} Patient management procedures in intensive care during the pandemic have limited the communication between the doctor and patient's family as online communication is preferred to prevent infection exposure, which can trigger the family's dissatisfaction. Moreover, various comorbidities in a patient involving many clinicians also raise problems owing to limited health personnel. These problems could lead to lawsuits from the patient or family to the hospital. To obtain defense according to this regulation, health service providers should act rationally, reasonably, and sensibly, and they should do the same in the future if they are faced with similar situations. This regulation benefits medical personnel, especially in using experimental medical therapy (still in research) and assigning health personnel to different health facilities in the long term.^{22,23}

The fair and ethical distribution of health services requires the establishment of criteria or procedures to assess the patient's eligibility for intensive care.⁹⁻¹¹ It also involves more clinicians, ideally the hospital ethics committee, to determine

the patient's needs.⁸ A prompt response from the intensive care unit (ICU) team is needed to exclude patients with poor prognoses and certain exclusion criteria¹² to accommodate patients with better prognoses and create a fair distribution. In this case, the ethics committee should prioritize patients with a higher chance of survival (utilitarian principle) while providing services for critically ill patients (egalitarian principle).^{8,10,13} The ethics committee should determine whether to refuse or prioritize healthcare services through discussion with two or three specialists in charge. Priority must be determined based on medical urgency, and random criteria must be implemented; a list of triage decisions must be recorded for transparency and post-pandemic evaluation.¹⁴ Zonation criteria and symptom severity for patient triage in intensive care must also be considered for a fair decision, not only individually based on science and technology but also as a population-based decision.¹⁵ A similar condition also occurs in Indonesia. Shortage of fair and ethical distribution of ICUs also occurred in many healthcare facilities across the country due to the imbalance in the number of health facilities and patients requiring treatment. To achieve an ethical and fair distribution of ICUs, many specialists in Indonesia treated patients with COVID-19 as team members rather than personal ones which they usually did in the pre-pandemic clinical practice. Therefore, every decision made based on the patient's condition will be a team's decision rather than a personal decision of one specialist.^{6,9}

Medical and hospital staff are at risk of lawsuits from the patients or community.^{7,16} Malpractice lawsuits may include clinical decisions,^{7,17} delays of non-essential procedures, lawsuits from families of medical staff who do not receive proper personal protective equipment, or failure to protect medical staff from COVID-19 infection.⁷ In this case, hospital management or government must consider the principle of beneficence in providing healthcare to patients while considering the non-maleficence principle in protecting the risk of infection to the medical staff. Considering that the gold standard for COVID-19 diagnosis and therapy could be changed at any time regarding the continuing COVID-19 science and research and the ongoing pandemic, the government should establish legal regulations to protect health providers. Periodically updating regulations is not only needed

but also legally and ethically mandatory, including the legal protection for medical personnel toward lawsuits based on government regulations⁷ and discipline from the Medical Council.^{18,19} In Indonesia, medical personnel also need legal protection from a patient's dishonesty.²⁰ The ethics committee requires legal interpretation flexibilities on health service providers to avoid potential ethical dilemmas among medical personnel and patients on COVID-19 management.

Debate on whether doctors can have immunity toward the claim of civil or criminal medical negligence for medical services during the COVID-19 pandemic is still ongoing.^{18,21} Medical personnel who treat patients with COVID-19 as the frontline defense of humanity against the pandemic need peace of mind in the workplace, including immunity rights and defense against civil or criminal lawsuits such as medical negligence. In Kentucky, the USA, a new regulation, adopted from the principle of the "Good Samaritan Law," was issued to ensure that medical service providers had proper legal protection during the COVID-19 pandemic. The regulations stated that all service providers with good intentions to provide services for patients with COVID-19 must have legal grounds as a civil responsibility for negligence that causes any injury due to the given medical service or failure to provide or perform further medical care/referral.^{22,23} This legal defense mainly includes health service providers prescribing or giving off labeled medication, which is still being studied as a potential COVID-19 therapeutic. It also applies to all medical personnel assisting health services in a healthcare facility or certain public health organizations regardless of employment status. Furthermore, it includes using non-medical or standard equipment to supply facilities and health provisions.^{22,23}

Based on the timeline, immunity is possible for certain therapies with potential benefits to the community and must not be obstructed by litigation threats. Legal immunity is the legal defense efforts against medical personnel by considering the proportionality and transparency principles.^{15,24} In providing health services for patients with COVID-19, medical practitioners must have a strong scientific base²⁵ and responsibility toward service tasks.²⁶ Breach of authority by unprivileged medical personnel can still be considered an error.¹⁷

If the error in the procedure cannot be avoided or if the doctor must act beyond their competency, a

chronology of events and evidence of consideration for an acceptable medical decision must be demonstrated when requested.²⁷ In cases of proven medical negligence, the patient will receive compensation claims from the hospital. Increased compensation for a patient's injury may be considered if unfairness occurs.¹⁷

In the COVID-19 pandemic, updating regulations or government policy may curb the pandemic.¹⁵ Government policies should be based on the public interest while considering the private interests of each community. Hence, health policy based on the ethical framework is the only way to create an equal distribution of benefits and risks for the community.²⁸ The existing regulations and public policies are created, amended, and dismissed according to contextual needs.⁷ Policies and regulations for COVID-19 management must be medically coherent, legally robust, and ethically correct.²² The government should respond to government policies at the national or regional level for better healthcare services, especially in response to limited medical experience and scientific evidence. The community's regulations on health protocols during the pandemic must be accompanied by resources and supporting facilities from the state or private sector.¹⁶ Besides, rules on a clear task description for medical personnel without the clinical privilege to manage COVID-19 cases must also be addressed because they are most prone to error. The limitations of healthcare resources, including medical staff, should not worsen the quality of healthcare services. Therefore, additional medical staff without clinical privileges who manage COVID-19 cases must be given a clear task description and may only perform healthcare services on the described tasks. Staff who breach the privilege are considered guilty.¹⁷

The law is expected to handle private or inter-citizen disputes in accordance with the objectives of normative and practical procedures. The legal norm that includes reward and punishment in fair implementation (the fair dealing norm) can help intermediate disputes more objectively while facing the complexity of COVID-19 management. Extensive studies by social scientists in pluralism support a variety of legal practices, although the legal regulations and conditions are similar. One of the implications of legal pluralism is the potential for different implementations depending on the locality

of community groups and their values as a priority, regardless of behavior or ideology in facing the changing norms of COVID-19 management.

Lawyers typically hesitate to consider legal norms alone. The representatives such as judges or head attorneys can reduce the difference in unwanted legal practice.²⁹ Ethicomedicolegal approach may act as the intermediary norm to manage clinical disputes due to the changing situations and conditions of the legal pluralism contextuality. This approach is based on ethical decisions and bioethical justice in balancing efforts to manage the sharp increase in intensive care capacity, which collides with medical personnel protection in hospitals. Both can use the bioethical principle of beneficence or non-maleficence³⁰ through the empowerment of the hospital ethics committee. For example, in managing clinical disputes, the hospital should include a palliative team and ethics committee to facilitate intermediation between medical personnel and the patient's family regarding the patient's medical condition and therapy,^{7,22,31} provide education to patients and their families exposed to COVID-19 at the hospital,^{31,32} and provide ethical decisions on critically ill patients.⁸ This can be accomplished through a special unit to hold regular family meetings once or twice a week. During the pandemic, the norms used in this family meeting should be different from those in the pre-pandemic era. Legal certainty in the pre-pandemic era is easier to achieve, whereas it is relatively contextual during the pandemic. Kyriakakis³³ observed that direct punishment from corporate entities, compared with individuals, is widely debated to produce sustainable results. According to bad barrel theory, hospitals as institutions that manage COVID-19 should have moral responsibility.³³

Therefore, we suggest that during the COVID-19 pandemic, hospitals and medical personnel with good intentions should perform their duties and professional responsibilities to manage patients according to medical procedures and ethics. For the community, this health service should be conducted by prioritizing transparency, effectiveness, and nondiscriminatory principles to minimize the potential for clinical disputes. In facing ethical and medicolegal conflicts, doctors should uphold the four basic ethical principles while considering the rights and obligations in service needing the right ethical decisions. In resolving ethicomedicolegal conflicts, an intermediary team is needed before entering litigation, which usually comes

from the medical profession. Healthcare services are still the primary aspect of COVID-19 public service, and the medical professionals contribute to the practical legal problems; thus, medicolegal aspects should be considered to serve humanity.

In conclusion, ethicomedicolegal clinical dispute management and its norms require an update, especially when deciding the complexity of COVID-19 service standards. Furthermore, ethicomedicolegal professionals are needed as intermediaries to manage cases of clinical disputes and to implement fair criteria for malpractice in Indonesia. This study aimed to provide a policy basis for future regulations regarding the case management of clinical disputes in Indonesia.

Conflict of Interest

The authors affirm no conflict of interest in this study.

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REFERENCES

1. World Health Organization regional Office for Europe. Coronavirus disease (COVID-19) pandemic. Copenhagen: World Health Organization Regional Office for Europe. Available from: <https://www.euro.who.int/en/health-topics/health-emergencies/coronavirus-covid-19/novel-coronavirus-2019-ncov#>.
2. President of the Republic of Indonesia. Decree of the President of the Republic of Indonesia number 12 of 2020 concerning the determination of non-natural disasters spreading of corona virus disease 2019 (COVID-19) as a national disaster [Internet]. 2020. Available from: <https://peraturan.bpk.go.id/Home/Details/135718/keppres-no-12-tahun-2020>. Indonesian.
3. President of the Republic of Indonesia. Government Regulation of the Republic of Indonesia number 21 of 2020 concerning large-scale social restrictions in the context of accelerating handling of corona virus disease 2019 (COVID-19) [Internet]. 2020. Available from: <https://peraturan.bpk.go.id/Home/Details/135059/pp-no-21-tahun-2020>. Indonesian.
4. President of the Republic of Indonesia. Government Regulation in Lieu of Law of the Republic of Indonesia number 1 of 2020 concerning state financial policy and financial system stability for handling the COVID-19 pandemic and/or in facing threats which endanger the national economy [Internet]. 2020. Available from: <https://peraturan.bpk.go.id/Home/Details/135060/perpu-no-1-tahun-2020>. Indonesian.
5. President of the Republic of Indonesia. Decree of the President of the Republic of Indonesia number 11 of 2020 concerning the determination of public health emergency of corona virus disease 2019 (COVID-19) [Internet]. 2020. Available from: <https://peraturan.bpk.go.id/Home/Details/135058/keppres-no-11-tahun-2020>. Indonesian.
6. Ministry of Health of the Republic of Indonesia. Guidelines for the prevention and control of coronavirus disease

- (COVID-19) [Internet]. Jakarta: Directorate General of Disease Prevention and Control; 2020. Available from: https://infeksiemerging.kemkes.go.id/download/KMK_No._HK.01.07-MENKES-413-2020_ttg_Pedoman_Pencegahan_dan_Pengendalian_COVID-19.pdf. Indonesian.
7. Tolentino VR, Derevlany L, DeLaMothe C, Vick S, Chalyavski L. The effects of the COVID-19 pandemic on risk management practice: a report from the epicenter of the epicenter in New York City. *J Healthc Risk Manag*. 2021;40(4):46–57.
 8. Cook T, Gupta K, Dyer C, Fackrell R, Wexler S, Boyes H, et al. Development of a structured process for fair allocation of critical care resources in the setting of insufficient capacity: a discussion paper. *J Med Ethics*. 2020;47(7):456–63.
 9. Riyanto OS, Ardyantara DM, Wardhana RS, Lungan L. Legal protection for doctors against dishonesty of patients in providing information during COVID-19 pandemic. *Int J Sci Technol Manag*. 2021;2(1):289–99.
 10. Duignan K, Bradbury C. Covid-19 and medical negligence litigation: immunity for healthcare professionals? *Med Leg J*. 2020;88(1_suppl):31–4.
 11. Riley-Smith Qc T, Heppinstall A, Foster F. Is Covid-19 sowing the seeds for future litigation? *Med Leg J*. 2020;88(2):90–7.
 12. Marshall AI, Archer R, Witthayapipopsakul W, Sirison K, Chotchoungchatchai S, Sriakpokin P, et al. Developing a Thai national critical care allocation guideline during the COVID-19 pandemic: a rapid review and stakeholder consultation. *Health Res Policy Sys*. 2021;19(47).
 13. Sesta L, Mondello C, Cardia L, Modello E, Baldino G, Spagnolo EV. COVID-19 in Italy. Clinical emergency and bioethical perspectives. *EuroMediterranean Biomed J*. 2020;15(30):121–5.
 14. Netters S, Dekker N, van de Wetering K, Hasker A, Paasman D, de Groot JW, et al. Pandemic ICU triage challenge and medical ethics. *BMJ Support Palliat Care*. 2021;11(2):133–7.
 15. Bolcato M, Aurilio MT, Aprile A, Di Mizio G, Della Pietra B, Feola A. Take-home messages from the COVID-19 pandemic: strengths and pitfalls of the Italian National Health Service from a medico-legal point of view. *Healthcare (Basel)*. 2020;9(1):17.
 16. 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):55–9.
 17. Oliva A, Caputo M, Grassi S, Vetrugno G, Marazza M, Ponzanelli G, et al. Liability of health care professionals and institutions during COVID-19 pandemic in Italy: symposium proceedings and position statement. *J Patient Saf*. 2020;16(4):e299–302.
 18. Barranco R, Vallega Bernucci Du Tremoul L, Ventura F. Hospital-acquired SARS-Cov-2 infections in patients: inevitable conditions or medical malpractice? *Int J Environ Res Public Health*. 2021;18(2):489.
 19. Ferorelli D, Mandarelli G, Solarino B. Ethical challenges in health care policy during COVID-19 pandemic in Italy. *Medicina (Kaunas)*. 2020;56(12):691.
 20. Kumar A, Kapila M, Pankaj R. Medicine and law in the times of COVID-19 pandemic: understanding the interphase. *Indian J Crit Care Med*. 2020;24(10):971–4.
 21. Coghlan N, Archard D, Sipanoun P, Hayes T, Baharlo B. COVID-19: legal implications for critical care. *Anaesthesia*. 2020;75(11):1517–28.
 22. Bonvicini B, Cecchi R, Parisi SG, Masotti V, Viero A, Cecchetto G, et al. Legal scenarios in the coronavirus time: medico legal implications in the aspects of governance. *Leg Med (Tokyo)*. 2021;48:101832.
 23. Camporesi S, Mori M. Ethicists, doctors and triage decisions: who should decide? And on what basis? *J Med Ethics*. 2020;47:e18.
 24. Arimany-Manso J, Martin-Fumadó C. [Medico-legal issues regarding from the COVID-19 pandemic]. *Med Clin (Barc)*. 2020;155(8):344–6. English, Spanish.
 25. Kelly AM. COVID-19 and medical litigation: more than just the obvious. *Emerg Med Australas*. 2020;32(4):703–5.
 26. Sugiharto AF, Purwadianto A, Madjid AS, Budiningsih Y. [Distributive justice in intensive care: ethicolegal review in the reposition of doctor–patient treating relationship] [dissertation]. Jakarta: Universitas Indonesia; 2018. Indonesian.
 27. Riva L, Petriani C. Ethics of triage for intensive-care interventions during the COVID-19 pandemic: age or disability related cut-off policies are not justifiable. *Clin Ethics*. 2021;16(3):228–33.
 28. Gostin LO. Pandemic Influenza: public health preparedness for the next global health emergency. *J Law Med Ethics*. 2004;32(4):565–73.
 29. Xavier F. Disciplinary proceedings in the medical profession: part I. Singapore: Rajah & Tann Publication; 2000.
 30. American Medical Association. COVID-19: recommendations for pursuing liability protections through state action [Internet]. American Medical Association; 2020. Available from: <https://www.ama-assn.org/system/files/2020-04/state-guidance-medical-liability-protections.pdf>.
 31. Budiningsih Y. [The methodological foundation of ethical decision doctor mediators in preventing and resolving medical dispute] [dissertation]. Jakarta: Universitas Indonesia; 2012. Indonesian.
 32. Brown DK. Criminal procedure entitlements, professionalism, and lawyering norms. *SSRN Electronic Journal*. 2000;61(2):867–8.
 33. Kyriakakis J. Developments in international criminal law and the case of business involvement in international crimes. *International Review of the Red Cross*. 2012;94(887):981–1005.