

# Crisis Standards of Care and State Liability Shields

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## I. INTRODUCTION

The impact of the COVID-19 pandemic on the United States' medical system was predictable. By the time the virus was identified in patients in the United States, hospitals in northern Italy were already overwhelmed

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with patients with viral pneumonia and acute respiratory distress.<sup>1</sup> Patients were triaged by age and health status to determine who would receive ventilator therapy and ICU beds.<sup>2</sup> Of course, the reach of the virus was not confined to Italy; after first ravaging China, COVID-19 spread rapidly in Europe and beyond.<sup>3</sup>

The COVID-19 pandemic has overwhelmed many U.S. systems—including the already-strained medical system—intended to protect and care for its citizens.<sup>4</sup> In the United States, New York became the first epicenter of the pandemic, accounting for approximately five percent of global COVID-19 cases by March 2020.<sup>5</sup> Hospitals, health care providers, and policymakers soon recognized that, in New York and beyond, they faced a bleak reality that—if the spread of the virus could not be controlled—there would soon not be enough ventilators for all patients who needed them,<sup>6</sup> despite hospitals practicing “surge capacity” to reduce the need for ventilators by canceling or postponing elective procedures that require ventilators.<sup>7</sup> Across the country, alarms continue to be raised about the potential for insufficient equipment and staff, including ventilators or dialysis

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1. See Dan Diamond & Sarah Wheaton, *How the US and Italy Traded Places on Coronavirus*, POLITICO (June 22, 2020, 6:03 AM), <https://www.politico.eu/article/how-the-us-and-italy-traded-places-on-coronavirus> [https://perma.cc/X8HB-A8SU].

2. See Yascha Mounk, *The Extraordinary Decisions Facing Italian Doctors*, ATLANTIC (Mar. 11, 2020), <https://www.theatlantic.com/ideas/archive/2020/03/who-gets-hospital-bed/607807/> [https://perma.cc/5W7S-D5G2]; see also Chiari Mannelli, *Whose Life to Save? Scarce Resources Allocation in the COVID-19 Outbreak*, 46 J. MED. ETHICS 364, 364–65 (2020); Andrea Remuzzi & Giuseppe Remuzzi, *COVID-19 and Italy: What Next?*, 395 LANCET 1225, 1228 (2020).

3. PETE KINROSS ET AL., RAPIDLY INCREASING CUMULATIVE INCIDENCE OF CORONAVIRUS DISEASE (COVID-19) IN THE EUROPEAN UNION/EUROPEAN ECONOMIC AREA AND THE UNITED KINGDOM, 1 JANUARY TO 15 MARCH 2020, at 1 (2020), <https://www.eurosurveillance.org/content/10.2807/1560-7917.ES.2020.25.11.2000285> [https://perma.cc/HQ8Y-JV4Z].

4. Chelsea Janes et al., *Surge in Virus Hospitalizations Strains Hospitals in Several States*, WASH. POST (July 8, 2020, 3:40 PM), [https://www.washingtonpost.com/politics/surge-in-virus-hospitalizations-strains-hospitals-in-several-states/2020/07/08/12855e5e-c135-11ea-864a-0dd31b9d6917\\_story.html](https://www.washingtonpost.com/politics/surge-in-virus-hospitalizations-strains-hospitals-in-several-states/2020/07/08/12855e5e-c135-11ea-864a-0dd31b9d6917_story.html) [https://perma.cc/FX6W-KJSG].

5. Jesse McKinley, *New York City Region Is Now an Epicenter of the Coronavirus Pandemic*, N.Y. TIMES (Mar. 22, 2020), <https://www.nytimes.com/2020/03/22/nyregion/coronavirus-new-york-epicenter.html> [https://perma.cc/96QZ-2B2Z].

6. Brian Rosenthal & Joseph Goldstein, *N.Y. May Need 18,000 Ventilators Very Soon. It Is Far Short of That*, N.Y. TIMES (Mar. 17, 2020), <https://www.nytimes.com/2020/03/17/nyregion/ny-coronavirus-ventilators.html?action=click&module=RelatedLinks&pgtype=Article> [https://perma.cc/5J6M-UYC7].

7. Lewis Rubinson et al., *Definitive Care for the Critically Ill During a Disaster: A Framework for Optimizing Critical Care Surge Capacity*, 133 CHEST (SUPPLEMENT) 18S, 19S, 25S (2008).

machines, personal protective equipment, necessary drugs or vaccines, and trained individuals to operate the equipment and treat patients.<sup>8</sup>

In response to the very real possibility that there will be insufficient resources to properly respond to the COVID-19 pandemic, states have been developing crisis standard of care plans.<sup>9</sup> These plans often authorize the prioritization of patients for scarce resources based on changing circumstances and increased demands.<sup>10</sup> They provide a mechanism for reallocating staff, facilities, and supplies to meet needs during a public health emergency.<sup>11</sup>

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8. U.S. DEP'T OF HEALTH & HUMAN SERVS., HOSPITAL EXPERIENCES RESPONDING TO THE COVID-19 PANDEMIC: RESULTS OF A NATIONAL PULSE SURVEY MARCH 23–27 (2020), <https://oig.hhs.gov/oei/reports/oei-06-20-00300.pdf> [<https://perma.cc/Q6KK-SETY>]; see, e.g., David Matthau, *Group Warns: NJ Could Run Low on Covid-19 Drug Remdesivir*, N.J. 101.5 (Aug. 17, 2020), <https://nj1015.com/group-warns-nj-could-run-low-on-covid-19-drug-remdesivir> [<https://perma.cc/JT4Z-KPAV>].

9. See, e.g., N.Y.C. HEALTH DEP'T, COVID-19: CRISIS STANDARDS OF CARE PLANNING RESOURCES FOR CRITICAL CARE 1 (2020), <https://www1.nyc.gov/assets/doh/downloads/pdf/imm/covid-19-critical-care-crisis-planning.pdf> [<https://perma.cc/PT8B-6JFN>].

10. See, e.g., *id.* at 2.

11. See, e.g., *id.* at 1–5. In addition to providing guidelines for allocating scarce resources, like ventilators, during a pandemic, see, e.g., N.Y. STATE TASK FORCE ON LIFE & THE LAW, N.Y. STATE DEP'T OF HEALTH, VENTILATOR ALLOCATION GUIDELINES (2015), [https://www.health.ny.gov/regulations/task\\_force/reports\\_publications/docs/ventilator\\_guidelines.pdf](https://www.health.ny.gov/regulations/task_force/reports_publications/docs/ventilator_guidelines.pdf) [<https://perma.cc/XK6F-993W>], others have observed additional deviations from the nonemergency standard of care contained in crisis standards of care:

Physicians are being instructed by their states, professional associations, and institutions to do things differently, and in ways that may violate the standard of care if it were not for COVID-19. For example, during cardiac resuscitation some physicians are being told that all patients must be intubated, rather than using manually ventilation, like a bag. Intubation reduces the risk of transmitting COVID-19 to the medical team through the patient's coughing, but it creates other risks for the patient, and imposes delays. I have received reports of physicians in some areas being instructed not to use cardiac catheterization on heart attack patients, due to risks of physician exposure to COVID-19. Other policies include mandatory emergency intubation during thrombectomies for people experiencing stroke. These procedures would ordinarily not involve intubation, but for the risk of COVID-19 being aerosolized during the procedure. If there is an injury or bad outcome from the intubation, a patient who did not have COVID-19 may question the wisdom of intubating them. [¶] In addition to taking extra precautions during procedures, physicians are also being instructed by their employers to reschedule or cancel cancer, heart, and lung interventions that they think can wait several weeks.

Teneille R. Brown, *When the Wrong People Are Immune*, 7 J.L. & BIOSCIENCES 1, 10–11 (2020) (footnotes omitted) (citing *Data Shows Reduction in U.S. Heart Attack Activations During COVID-19 Pandemic*, CATH LAB DIG. (Apr. 10, 2020), <https://www.cathlabdigest.com/>).

Although scarce resource allocation protocols vary tremendously from state to state, they often are based on the principle of saving the most lives possible.<sup>12</sup> As a general rule, they focus on allocating resources solely on clinical medical criteria, in an effort to avoid making decisions based on race, gender, age, or other social criteria.<sup>13</sup> Overall, these plans should be made ethically, fairly, and transparently, in order to ensure public trust. In most instances, these triage protocols are not binding law; rather, they are state-level guidance that the governor can “trigger” at the time of, or after, a declaration of emergency.<sup>14</sup>

## II. CALLS FOR LIABILITY PROTECTIONS

In a noncrisis setting, the prevailing medical standard of care focuses on the needs of each individual patient and is centered on the principle of informed consent.<sup>15</sup> Although the exact language varies across jurisdictions, under normal circumstances, physicians or surgeons are expected to exercise “the degree of care and skill that a physician or surgeon of the same medical specialty would use under similar circumstances.”<sup>16</sup> Due to the dearth of necessary resources and trained professionals during a public health emergency, the standard of care that clinicians may be able to provide during the COVID-19 pandemic may, by necessity, depart significantly from standard nonemergency medical practice.<sup>17</sup>

Thus, clinicians, health care institutions, and policymakers have expressed concern about potential legal liability for following crisis standards of care.<sup>18</sup> Adhering to crisis standards of care may expose health care providers

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content/data-shows-reduction-us-heart-attack-activations-during-covid-19-pandemic [https://perma.cc/EUC9-SP36]).

12. John L. Hick & Daniel T. O’Laughlin, *Concept of Operations for Triage of Mechanical Ventilation in an Epidemic*, 13 ACAD. EMERGENCY MED. 223, 225 (2006); Mannelli, *supra* note 2, at 365; Rubinson, *supra* note 7, at 20S.

13. See, e.g., Brown, *supra* note 11, at 8–9.

14. See, e.g., N.Y. STATE TASK FORCE ON LIFE & THE LAW, *supra* note 11, at 202, 216. As of July 2020, only one state had “triggered” its crisis standard of care. See Jeremy Duda, *As Covid-19 Worsens, AZ is the First State to Enact ‘Crisis Care’ Standards*, ARIZ. MIRROR (July 3, 2020, 12:14 PM), <https://www.azmirror.com/2020/07/03/as-covid-19-worsens-az-is-the-first-state-to-enact-crisis-care-standards> [https://perma.cc/8EKN-CJVP]; see, e.g., Valerie Gutmann Koch & Susie A. Han, *COVID in NYC: What New York Did, and Should Have Done*, 20 AM. J. BIOETHICS 153, 154 (2020).

15. See N.Y. STATE TASK FORCE ON LIFE & THE LAW, *supra* note 11, at 206.

16. *Medical Malpractice*, BLACK’S LAW DICTIONARY (11th ed. 2019).

17. Valerie Gutmann Koch & Beth E. Roxland, *Unique Proposals for Limiting Legal Liability and Encouraging Adherence to Ventilator Allocation Guidelines in an Influenza Pandemic*, 14 DEPAUL J. HEALTH CARE L. 467, 469 (2013).

18. I. Glenn Cohen, Andrew M. Crespo & Douglas B. White, *Potential Legal Liability for Withdrawing or Withholding Ventilators During COVID-19*, JAMA NETWORK (Apr. 1, 2020), <https://jamanetwork.com/journals/jama/fullarticle/2764239> [https://perma.cc/

and entities to considerable costs and burdens, including the risk of both civil and criminal liability. For example, health care workers are taking on significant risk running codes on patients with COVID-19, often without adequate personal protective equipment.<sup>19</sup> Calls for fair treatment of health care providers<sup>20</sup> have led to support for immunity provisions for those who sacrifice their own well-being in service of the public good.<sup>21</sup>

Most states have protections in place for unpaid volunteers who provide care during a declared emergency.<sup>22</sup> However, nonvolunteer clinicians, nurses, and other health care providers may be hesitant to conform to crisis standards of care—despite their significant public health goals—due to concerns about liability arising from injury or death. Unless proper and adequate legal protections are in place, a health care provider risks lawsuits, financial penalties and jail time, higher medical malpractice insurance rates, and damage to one’s reputation.<sup>23</sup>

These concerns are particularly acute where crisis standards of care recommend ventilator withdrawal without patient consent.<sup>24</sup> Some commentators assert that there may be a legal distinction between withholding and withdrawing life-sustaining treatments or therapies, such as ventilators, and note the potential for increased liability concerns with the latter.<sup>25</sup>

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AMH6-8563]; Jeremy Samuel Faust, *Make This Simple Change to Free Up Hospital Beds Now*, WASH. POST (Mar. 17, 2020, 5:07 PM), <https://www.washingtonpost.com/opinions/2020/03/15/make-this-simple-change-free-up-hospital-beds-now> [<https://perma.cc/FXT5-5KR7>]; Valerie Gutmann Koch, Govind Persad & Wendy Netter Epstein, *Pandemic Guidelines, Not Changed Malpractice Rules, Are the Right Response to Covid-19*, BILL HEALTH (Mar. 30, 2020), <https://blog.petrieflom.law.harvard.edu/2020/03/30/pandemic-guidelines-malpractice-covid19> [<https://perma.cc/EF8T-HEVD>].

19. See, e.g., Soumya Karlamangla, *A Nurse Without an N95 Mask Raced in to Treat a ‘Code Blue’ Patient. She Died 14 Days Later*, L.A. TIMES (May 10, 2020, 7:58 AM), <https://www.latimes.com/california/story/2020-05-10/nurse-death-n95-covid-19-patients-coronavirus-hollywood-presbyterian> [<https://perma.cc/2VR2-5N5H>].

20. Caitriona L. Cox, *‘Healthcare Heroes’: Problems with Media Focus on Heroism from Healthcare Workers During the COVID-19 Pandemic*, 46 J. MED. ETHICS 510, 512 (2020) (discussing the principle of reciprocity, which “is of significant importance to social contract theories: in return for accepting personal risk in fulfilling their duty to treat, healthcare workers expect reciprocal social obligations”).

21. Brown, *supra* note 11, at 9, 11.

22. Sara Rosenbaum, Mary-Beth Harty & Jennifer Sheer, *State Laws Extending Comprehensive Legal Liability Protections for Professional Health-Care Volunteers During Public Health Emergencies*, 123 PUB. HEALTH REP. 238, 239 (2008).

23. See Cohen, Crespo & Douglas, *supra* note 18.

24. See *id.*

25. See, e.g., *id.*; Philip D. Levin & Charles L. Sprung, *Withdrawing and Withholding Life-Sustaining Therapies Are Not the Same*, 9 CRIT. CARE 230, 230–31 (2005). *But see*

Importantly, questions of legal liability for providing care during a public health crisis predate the COVID-19 pandemic.<sup>26</sup> Many argue that such liability protections may be necessary when, due to the circumstances of the emergency, a state faces scarce resources and the state activates its crisis standards of care.<sup>27</sup> Thus, lawmakers, policymakers, and professional societies have called for laws that provide liability shields for care that may deviate from nonemergency care provided during the pandemic.<sup>28</sup> For example, on March 24, 2020, Health and Human Services Secretary Alexander Azar sent a letter to all state governors, stating, “[f]or health care professionals to feel comfortable serving in expanded capacities on the frontlines of the COVID-19 emergency, it is imperative that they feel shielded from medical tort liability.”<sup>29</sup> In doing so, he recommended that states issue public guidance, “outlining the available liability protections during the COVID-19 emergency,” and calling on states to “quickly develop a list of the relevant state liability protections and waivers for health professionals during a national or state emergency.”<sup>30</sup> Likewise, the American Medical Association recommended that states evaluate whether their “laws should be extended to fill gaps necessary to address the potential liability of physicians providing care in response to COVID-19 and/or care decisions made based on government or health care facility COVID-19 directives.”<sup>31</sup>

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Asha Devereaux et al., *Summary of Suggestions from the Task Force for Mass Critical Care Summit*, 133 CHEST (SUPPLEMENT) 1S, 6S (2008) (“Rationing should apply equally to withholding and withdrawing life-sustaining treatments based on the principle that withholding and withdrawing care are ethically equivalent.”); *Withholding or Withdrawing Life-Sustaining Treatment: Code of Medical Ethics Opinion 5.3*, AM. MED. ASS’N, <https://www.ama-assn.org/delivering-care/ethics/withholding-or-withdrawing-life-sustaining-treatment> [<https://perma.cc/G3MR-8BU4>] (“While there may be an emotional difference between not initiating an intervention at all and discontinuing it later in the course of care, there is no ethical difference between withholding and withdrawing treatment.”).

26. Sharona Hoffman, *Responders’ Responsibility: Liability and Immunity in Public Health Emergencies*, 96 GEO. L.J. 1913, 1926 (2008); Koch & Roxland, *supra* note 17, at 469.

27. *See, e.g.*, Brown, *supra* note 11, at 9–11.

28. *See, e.g.*, Letter from Alex M. Azar II, Sec’y of Health & Human Servs., to Governors 1, 3 (Mar. 24, 2020), [https://www.ncsbn.org/HHS\\_Secretary\\_Letter\\_to\\_States\\_Licensing\\_Waivers.pdf](https://www.ncsbn.org/HHS_Secretary_Letter_to_States_Licensing_Waivers.pdf) [<https://perma.cc/DAH6-39H2>] [hereinafter Azar Letter].

29. *Id.* at 3.

30. *Id.*

31. AM. MED. ASS’N & MED. PROF’L LIAB. ASS’N, COVID-19: RECOMMENDATIONS FOR PURSUING LIABILITY PROTECTIONS THROUGH STATE ACTION 1 (2020), <https://www.ama-assn.org/system/files/2020-04/state-guidance-medical-liability-protections.pdf> [<https://perma.cc/NL2L-RZ3V>].

## III. EXISTING LIABILITY PROTECTIONS FOR HEALTH CARE PROVIDERS

In the United States, states are generally responsible for the regulation of medical practice.<sup>32</sup> Thus, there are no uniform federal rules or guidelines for how to allocate scarce resources in a public health emergency. As a result, there is significant variation among states regarding if, and how, legal liability protections might be provided to physicians, nurses, and others who provide medical care during a public health emergency. No uniform legal protection exists for the provision of care under disaster circumstances or pursuant to state resource allocation guidance.

A. *State Laws Granting Liability Protections to Health Care Providers in the COVID-19 Pandemic*

Prior to the COVID-19 pandemic, many states already had legal rules or guidance regarding malpractice liability protections for care provided during a public health emergency in place.<sup>33</sup> Various laws provide different levels of protection: some laws provide civil liability immunity, some provide both civil and criminal immunity, and some states provide neither.<sup>34</sup> Further, some liability protections are ensured legislatively, through general laws that protect clinicians from legal liability, absent willful acts or gross negligence,<sup>35</sup> when they provide care pursuant to state directives or crisis standards of care. Other states have issued executive orders, or rules to be followed only during the pendency of the emergency.<sup>36</sup> In most cases, executive orders have defined expiration dates—either a date written into the law or at the termination of a declared emergency.<sup>37</sup>

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32. See, e.g., Azar Letter, *supra* note 28, at 3 (illustrating the roles of states regulating their own medical practices with the federal government in an advisory role).

33. Hoffman, *supra* note 26, at 1937.

34. See *id.* at 1947–49.

35. Generally, gross negligence is more than just an egregious form of negligence and can more appropriately be defined as willful misconduct or intentional wrongdoing. Koch & Roxland, *supra* note 17, at 474. Gross negligence differs “in kind, not only degree, from claims of ordinary negligence” and is “conduct that evinces a reckless disregard for the rights of others or ‘smacks’ of intentional wrongdoing.” See, e.g., Colnaghi, U.S.A., Ltd. v. Jewelers Prot. Servs., Ltd., 611 N.E.2d 282, 284 (N.Y. 1993) (citing *Sommer v. Fed. Signal Corp.*, 593 N.E.2d 1365, 1371 (1992)).

36. See Hoffman, *supra* note 26, at 1923, 1936, 1947–50.

37. See, e.g., E. Lee Bernick & Charles W. Wiggins, *The Governor’s Executive Order: An Unknown Power*, 16 ST. & LOC. GOV’T REV. 3, 6 (1984). It is important to note that following crisis standards of care that include recommendations for removal of life-sustaining treatment, such as ventilator therapy, from a patient may subject a health care

As of June 2020, thirty-seven states provide some sort of civil liability protections for physicians who provided care in a public health emergency.<sup>38</sup>

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provider to liability, even with immunity provisions. See Koch & Roxland, *supra* note 17, at 489 (“[A]rguably, immunity-conferring statutes that exempt ‘willful misconduct’ may not adequately protect health care providers who remove ventilator therapy from a patient consistent with state-promulgated guidelines. Such an act might be considered to be willful or in conscious disregard of the safety of the individual harmed and therefore beyond the protective scope of the law.” (citing Daren P. Mareiniss, Frederick Levy & Linda Regan, *ICU Triage: The Potential Legal Liability of Withdrawing ICU Care During a Catastrophic Event*, 6 AM. J. DISASTER MED. 329, 333 (2011))).

38. ALA. CODE § 31-9-16(b) (2019); CAL. GOV'T CODE § 8659(a) (West 2020); COLO. REV. STAT. § 24-33.5-711.5(1)–(2) (2020); DEL. CODE ANN. tit. 20, § 3144 (2020); IND. CODE § 34-30-13.5-1 (2020); IOWA CODE § 135.147 (2020); KAN. STAT. ANN. § 48-915(b) (2019); LA. STAT. ANN. § 29:771(B)(2)(c) (2020); MD. CODE ANN., PUB. SAFETY § 14-3A-06 (LexisNexis 2020); MINN. STAT. § 12.61(2)(b) (2019); MISS. CODE ANN. § 73-25-37 (2019); MONT. CODE ANN. 10-3-110(1) (2019); N.Y. PUB. HEALTH LAW § 3082 (McKinney 2020); OHIO REV. CODE ANN. § 2305.2311 (LexisNexis 2020); OKLA. STAT. tit. 76, § 5.9 (2020); S.C. CODE ANN. § 44-4-570 (2020); S.D. CODIFIED LAWS 20-9-3 (2020); TEX. HEALTH & SAFETY CODE ANN. § 81.007 (West 2019); UTAH CODE ANN. § 58-13-2.6 (LexisNexis 2020); VT. STAT. ANN. tit. 20, § 20(a) (2019); VA. CODE ANN. § 8.01-225.02 (2020); WIS. STAT. § 895.4801 (2020); 2020 Ky. Acts 310; S.B. 2640, 191st Gen. Court, 2019–2020 Sess. (Mass. 2020); S.B. 2333, 219th Leg., S. & Gen. Assemb. (N.J. 2020); 2020 N.C. Sess. Laws 3, § 3D.7.(a); S.B. 3002, 2020 Leg., 3d Spec. Sess. (Utah 2020); S.B. SF1002, 65th Leg., Spec. Sess. (Wyo. 2020); Ariz. Exec. Order No. 2020-27 (Apr. 9, 2020), <https://azgovernor.gov/file/34519/download?token=CMKHiHH> [<https://perma.cc/Rf59-WZ7L>]; Ark. Exec. Order No. 20-18 (Apr. 13, 2020), [https://governor.arkansas.gov/images/uploads/executiveOrders/EO\\_20-18.pdf](https://governor.arkansas.gov/images/uploads/executiveOrders/EO_20-18.pdf) [<https://perma.cc/GKP9-GLRF>]; Conn. Exec. Order No. 7V (Apr. 7, 2020), <https://portal.ct.gov/-/media/Office-of-the-Governor/Executive-Orders/Lamont-Executive-Orders/Executive-Order-No-7V.pdf?la=en> [<https://perma.cc/5E7X-4MQK>]; Ga. Exec. Order No. 04.14.20.01 (Apr. 14, 2020), <https://gov.georgia.gov/executive-action/executive-orders/2020-executive-orders>; Haw. Exec. Order No. 20-05 (Apr. 16, 2020), [https://governor.hawaii.gov/wp-content/uploads/2020/04/2004090-ATG\\_Executive-Order-No.-20-05-distribution-signed-1.pdf](https://governor.hawaii.gov/wp-content/uploads/2020/04/2004090-ATG_Executive-Order-No.-20-05-distribution-signed-1.pdf) [<https://perma.cc/DA6G-FBRZ>]; Ill. Exec. Order No. 2020-37 (May 13, 2020), <https://www2.illinois.gov/Pages/Executive-Orders/Executiveorder2020-37.aspx> [<https://perma.cc/SZEL-N8ZQ>] (expired June 27, 2020); Kan. Exec. Order No. 20-26 (Apr. 22, 2020), <https://governor.kansas.gov/wp-content/uploads/2020/04/EO-20-26-Executed.pdf> [<https://perma.cc/GRM9-GRZM>]; Mich. Exec. Order No. 2020-30 (Mar. 29, 2020), [https://www.michigan.gov/whitmer/0,9309,7-387-90499\\_90705-523481--,00.html](https://www.michigan.gov/whitmer/0,9309,7-387-90499_90705-523481--,00.html) [<https://perma.cc/M6YE-MYXD>] (rescinded); Miss. Exec. Order No. 1471 (Apr. 10, 2020), <https://www.sos.ms.gov/content/executive-orders/executiveorders/1471.pdf> [<https://perma.cc/5MA9-SRA8>] (rescinded); Nev. Exec. Order Declaration of Emergency Directive 011 (Apr. 1, 2020), [http://gov.nv.gov/News/Emergency\\_Orders/2020/2020-04-01\\_-\\_COVID-19\\_Declaration\\_of\\_Emergency\\_Directive\\_011/](http://gov.nv.gov/News/Emergency_Orders/2020/2020-04-01_-_COVID-19_Declaration_of_Emergency_Directive_011/) [<https://perma.cc/DV5E-D5WK>]; N.J. Exec. Order No. 112 (Apr. 1, 2020), <https://nj.gov/infobank/eo/056murphy/pdf/EO-112.pdf> [<https://perma.cc/B9BG-8GYG>]; N.Y. Exec. Order No. 202.10 (Mar. 23, 2020), [https://www.governor.ny.gov/sites/governor.ny.gov/files/atoms/files/EO\\_202.10.pdf](https://www.governor.ny.gov/sites/governor.ny.gov/files/atoms/files/EO_202.10.pdf) [<https://perma.cc/9MWV-XK6R>] (rescinded Aug. 22, 2020); Okla. Exec. Order No. 2020-13 (Apr. 20, 2020), <https://www.sos.ok.gov/documents/executive/1935.pdf> [<https://perma.cc/2NQG-WD6P>]; Pa. Exec. Order to Enhance Protections for Health Care Professionals (May 6, 2020), <https://www.governor.pa.gov/wp-content/uploads/2020/05/20200506-GOV-health-care-professionals-protection-order-COVID-19.pdf>

Of those, twenty-one states had promulgated new protections specifically in response to the COVID-19 pandemic.<sup>39</sup> Sixteen of those twenty-two states adopted legal liability protections through executive orders (EOs) or a directive by the governor, which carries the force of law.<sup>40</sup>

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[<https://perma.cc/N4YX-RB8Q>]; R.I. Exec. Order No. 20-21 (Apr. 10, 2020), <https://governor.ri.gov/documents/orders/Executive-Order-20-21.pdf> [<https://perma.cc/EQ2Q-K5NU>]; Vt. Exec. Order No. 01-20, Addendum 9 (Apr. 10, 2020), <https://governor.vermont.gov/sites/scott/files/documents/ADDENDUM%209%20TO%20EXECUTIVE%20ORDER%2001-20.pdf> [<https://perma.cc/ZG4V-PR3E>].

39. Wis. STAT. § 895.4801 (2020); 2020 Ky. Acts 310; SS.B. 2640, 191st Gen. Court, 2019–2020 Sess. (Mass. 2020); 2020 N.C. Sess. Laws 3, § 3D.7(a); SS.B. SF1002, 65th Leg., Spec. Sess. (Wyo. 2020); Ariz. Exec. Order No. 2020-27 (Apr. 9, 2020), <https://azgovernor.gov/file/34519/download?token=-CMKHiHH> [<https://perma.cc/RF59-WZ7L>]; Ark. Exec. Order No. 20-18 (Apr. 13, 2020), [https://governor.arkansas.gov/images/uploads/executiveOrders/EO\\_20-18.pdf](https://governor.arkansas.gov/images/uploads/executiveOrders/EO_20-18.pdf) [<https://perma.cc/GKP9-GLRF>]; Conn. Exec. Order No. 7V (Apr. 7, 2020), <https://portal.ct.gov/-/media/Office-of-the-Governor/Executive-Orders/Lamont-Executive-Orders/Executive-Order-No-7V.pdf?la=en> [<https://perma.cc/5E7X-4MQK>]; Ga. Exec. Order No. 04.14.20.01 (Apr. 14, 2020), <https://gov.georgia.gov/executive-action/executive-orders/2020-executive-orders> [<https://perma.cc/2SX8-AHP4>]; Haw. Exec. Order No. 20-05 (Apr. 16, 2020), [https://governor.hawaii.gov/wp-content/uploads/2020/04/2004090-ATG\\_Executive-Order-No.-20-05-distribution-signed-1.pdf](https://governor.hawaii.gov/wp-content/uploads/2020/04/2004090-ATG_Executive-Order-No.-20-05-distribution-signed-1.pdf) [<https://perma.cc/DA6G-FBRZ>]; Ill. Exec. Order No. 2020-37 (May 13, 2020), <https://www2.illinois.gov/Pages/Executive-Orders/Executiveorder2020-37.aspx> [<https://perma.cc/5ZEL-N8ZQ>] (expired June 27, 2020); Kan. Exec. Order No. 20-26 (Apr. 22, 2020), <https://governor.kansas.gov/wp-content/uploads/2020/04/EO-20-26-Executed.pdf> [<https://perma.cc/GRM9-GRZM>]; Mich. Exec. Order No. 2020-30 (Mar. 29, 2020), [https://www.michigan.gov/whitmer/0,9309,7-387-90499\\_90705-523481--,00.html](https://www.michigan.gov/whitmer/0,9309,7-387-90499_90705-523481--,00.html) [<https://perma.cc/M6YE-MYXD>] (rescinded); Miss. Exec. Order No. 1471 (Apr. 10, 2020), <https://www.sos.ms.gov/content/executiveorders/executiveorders/1471.pdf> [<https://perma.cc/5MA9-SRA8>] (rescinded); Nev. Exec. Order Declaration of Emergency Directive 011 (Apr. 1, 2020), [http://gov.nv.gov/News/Emergency\\_Orders/2020/2020-04-01\\_-\\_COVID-19\\_Declaration\\_of\\_Emergency\\_Directive\\_011/](http://gov.nv.gov/News/Emergency_Orders/2020/2020-04-01_-_COVID-19_Declaration_of_Emergency_Directive_011/) [<https://perma.cc/DV5E-D5WK>]; N.J. Exec. Order No. 112 (Apr. 1, 2020), <https://nj.gov/infobank/eo/056murphy/pdf/EO-112.pdf> [<https://perma.cc/B9BG-8GYG>]; N.Y. Exec. Order No. 202.10 (Mar. 23, 2020), [https://www.governor.ny.gov/sites/governor.ny.gov/files/atoms/files/EO\\_202.10.pdf](https://www.governor.ny.gov/sites/governor.ny.gov/files/atoms/files/EO_202.10.pdf) [<https://perma.cc/9MWV-XK6R>] (rescinded Aug. 22, 2020); Okla. Exec. Order No. 2020-13 (Apr. 20, 2020), <https://www.sos.ok.gov/documents/executive/1935.pdf> [<https://perma.cc/2NQG-WD6P>]; Pa. Exec. Order to Enhance Protections for Health Care Professionals (May 6, 2020), <https://www.governor.pa.gov/wp-content/uploads/2020/05/20200506-GOV-health-care-professionals-protection-order-COVID-19.pdf> [<https://perma.cc/N4YX-RB8Q>]; R.I. Exec. Order No. 20-21 (Apr. 10, 2020), <https://governor.ri.gov/documents/orders/Executive-Order-20-21.pdf> [<https://perma.cc/EQ2Q-K5NU>]; Vt. Exec. Order No. 01-20, Addendum 9 (Apr. 10, 2020), <https://governor.vermont.gov/sites/scott/files/documents/ADDENDUM%209%20TO%20EXECUTIVE%20ORDER%2001-20.pdf> [<https://perma.cc/ZG4V-PR3E>].

40. Valerie Gutmann Koch, *How States are Protecting Health Care Providers from Legal Liability in the Covid-19 Pandemic*, BILL OF HEALTH (May 5, 2020), [981](https://blog.</a></p>
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Importantly, all applicable laws that provide civil immunity for providing medical care during an emergency do so conditionally.<sup>41</sup> In other words, if the physician has engaged in willful or intentional misconduct, gross negligence, recklessness, or has provided care in the absence of good faith, the physician would still be subject to civil liability.

Only three states—Maryland, New York, and New Jersey—provide protections to physicians from criminal liability that may result during the public health emergency.<sup>42</sup>

### *B. What Types of Actions Are Covered by States' Health Care Provider Liability Shields?*

Civil liability protections also vary significantly regarding the types of actions that are protected. Some states' liability shields immunize injury or death that occurs specifically where the health care providers comply with federal, state, local, or institutional plans, guidelines, or crisis standards of care.<sup>43</sup> For example, Colorado's law is tailored to actions taken in compliance with state crisis standards of care or pandemic-related guidelines, covering harm that occurs when the health care provider has "compl[ied] completely with board of health rules regarding the emergency epidemic and with executive orders regarding the disaster emergency."<sup>44</sup> Although this law ostensibly provides liability protections for health care providers who negligently care for both COVID-19 and non-COVID-19 patients, it is narrow in the sense that it only covers actions taken in compliance with emergency state rules. Similarly, Minnesota's law provides immunity to health care providers if the negligence occurred while the health care provider was "acting consistent with emergency plans."<sup>45</sup> Texas's law limits liability protections to those actions taken "in compliance with orders or instructions of the department or a health authority."<sup>46</sup> And Wisconsin immunizes health care professionals providing services during the state of emergency, consistent with any of the following: "1. [a]ny direction, guidance, recommendation, or other statement made by a federal, state, or local official to address or in response to the emergency or disaster" or "2. [a]ny guidance published

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petrieflom.law.harvard.edu/2020/05/05/legal-liability-health-care-covid19-coronavirus-pandemic [https://perma.cc/TD8E-V99V]; see sources cited *supra* note 39.

41. Koch, *supra* note 40.

42. *Id.*

43. See *Liability Protections for Health Care Professionals During COVID-19*, AM. MED. ASS'N (Apr. 2, 2020), <https://www.ama-assn.org/practice-management/sustainability/liability-protections-health-care-professionals-during-covid-19> [https://perma.cc/WXX6-V9CU].

44. COLO. REV. STAT. § 24-33.5-711.5(2) (2019).

45. MINN. STAT. § 12.61(2)(b) (2019).

46. TEX. HEALTH & SAFETY CODE ANN., § 81.007 (West 2019).

by the department of health services, the federal department of health and human services, or any divisions or agencies of the federal department of health and human services.”<sup>47</sup>

Some states limit their liability shields to negligent care of patients specifically diagnosed with COVID-19, for whom the standard of care may be modified due to scarce resources.<sup>48</sup> Pennsylvania grants immunity to health care professionals “engaged in disaster services activities” but only for COVID-19-related medical and health treatment or services.<sup>49</sup>

Rhode Island’s executive order from April 10, 2020 explicitly states that its law provides no immunity for “negligence that occurs in the course of providing patient care to patients without COVID-19 whose care has not been altered by the existence of this disaster emergency.”<sup>50</sup> Kentucky also has narrowly drafted its immunity-conferring provisions, restricting its protections only to negligent care of patients diagnosed with COVID-19, and then clarifying the types of actions the law contemplates.<sup>51</sup> The law provides immunity to health care providers who render care or treatment of a COVID-19 patient during the state of emergency, including prescription of medicines for off-label use to attempt to combat the COVID-19 virus in accordance with the federal Right to Try Act,<sup>52</sup> as long as the health care provider acts as an ordinary, reasonable, and prudent health care provider would have acted under the same or similar circumstances.<sup>53</sup>

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47. WIS. STAT. § 895.4801(2)(b) (2019).

48. See Susan Jaffe, *As Congress Weighs COVID Liability Protections, States Shield Health Providers*, KAISER HEALTH NEWS (May 15, 2020), <https://khn.org/news/as-congress-weighs-covid-liability-protections-states-shield-health-providers> [<https://perma.cc/B2VA-HBGK>].

49. Pa. Exec. Order to Enhance Protections for Health Care Professionals (May 6, 2020), <https://www.governor.pa.gov/wp-content/uploads/2020/05/20200506-GOV-health-care-professionals-protection-order-COVID-19.pdf> [<https://perma.cc/GV5F-ZFLX>].

50. R.I. Exec. Order No. 20-21 (Apr. 10, 2020), <https://governor.ri.gov/documents/orders/Executive-Order-20-21.pdf> [<https://perma.cc/9PMV-YREN>].

51. 2020 Ky. Acts 310.

52. Trickett Wendler, Frank Mongiello, Jordan McLinn, and Matthew Bellina Right to Try Act, Pub. L. No. 115-176, 132 Stat. 1372 (2018) (largely codified at 21 U.S.C. § 360bbb-0a).

53. 2020 Ky. Acts 310.

In contrast, many other states—including Arizona,<sup>54</sup> Arkansas,<sup>55</sup> Connecticut,<sup>56</sup> Iowa,<sup>57</sup> Maryland,<sup>58</sup> Massachusetts,<sup>59</sup> Michigan,<sup>60</sup> New Jersey,<sup>61</sup> New York,<sup>62</sup> Oklahoma,<sup>63</sup> Vermont,<sup>64</sup> and Virginia<sup>65</sup>—provide

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54. Ariz. Exec. Order No. 2020-27 (Apr. 9, 2020), <https://azgovernor.gov/file/34519/download?token=-CMKHiHH> [<https://perma.cc/6FQ6-7JYB>] (providing immunity if the harm occurred providing “medical services in support of the public health emergency”).

55. Ark. Exec. Order No. 20-18 (Apr. 13, 2020), [https://governor.arkansas.gov/images/uploads/executiveOrders/EO\\_20-18.pdf](https://governor.arkansas.gov/images/uploads/executiveOrders/EO_20-18.pdf) [<https://perma.cc/WE68-T662>] (providing immunity if the harm occurred providing “medical services in support of the State’s response to the COVID-19 outbreak or the implementation of measures to control the causes of the COVID-19 epidemic”).

56. Conn. Exec. Order No. 7V (Apr. 7, 2020), <https://portal.ct.gov/-/media/Office-of-the-Governor/Executive-Orders/Lamont-Executive-Orders/Executive-Order-No-7V.pdf?la=en> [<https://perma.cc/K74X-LJLJ>] (providing immunity if the harm occurred “providing health care services in support of the State’s COVID-19 response”).

57. Iowa Exec. Order No. 2020-19 (Apr. 1, 2020), <https://www2.illinois.gov/Pages/Executive-Orders/ExecutiveOrder2020-19.aspx> [<https://perma.cc/SQ6Z-D92Q>] (providing immunity if the harm occurred “in the course of rendering assistance to the State by providing health care services in response to the COVID-19 outbreak”).

58. MD. CODE ANN., PUB. SAFETY § 14-3A-06 (LexisNexis 2020) (providing immunity if the harm occurred under a catastrophic health emergency proclamation).

59. S.B. 2640, 191st Gen. Court, 2019–2020 Sess. (Mass. 2020) (providing immunity if the harm occurred in the course of providing health care services during the period of the COVID-19 emergency).

60. Mich. Exec. Order No. 2020-30 (Mar. 29, 2020), [https://www.michigan.gov/whitmer/0,9309,7-387-90499\\_90705-523481--,00.html](https://www.michigan.gov/whitmer/0,9309,7-387-90499_90705-523481--,00.html) [<https://perma.cc/8Y7K-AZDC>] (rescinded) (providing immunity if the harm occurred “in support of this state’s response to the COVID-19 pandemic”).

61. N.J. Exec. Order No. 112 (Apr. 1, 2020), <https://nj.gov/infobank/eo/056murphy/pdf/EO-112.pdf> [<https://perma.cc/RGT4-JG63>] (providing immunity if the harm occurred in the course of providing healthcare services “in support of the State’s COVID-19 response”). The state’s criminal liability protections are more limited, immunizing providers and facilities who make scarce resource allocation decisions pursuant to “a scarce critical resource allocation policy that at a minimum incorporates the core principles identified by the Commissioner of Health in an executive directive or administrative order.” S.B. 2333, 219th Leg., S. & Gen. Assemb. (N.J. 2020).

62. N.Y. Exec. Order No. 202.10 (Mar. 23, 2020), <https://www.governor.ny.gov/news/no-20210-continuing-temporary-suspension-and-modification-laws-relating-disaster-emergency> [<https://perma.cc/P6E8-8CTP>] (rescinded Aug. 22, 2020) (providing immunity if the harm occurred “in the course of providing medical services in support of the State’s response to the COVID-19 outbreak”).

63. *See* OKLA. STAT. tit. 76, § 5.9 (2020) (providing immunity if the harm occurred when the health care provider “renders emergency care, aid, shelter or other assistance during a natural disaster or catastrophic event”).

64. VT. STAT. ANN. tit. 20, § 20(a) (2019); Vt. Exec. Order No. 01-20, Addendum 9 (Apr. 10, 2020), <https://governor.vermont.gov/sites/scott/files/documents/ADDENDUM%209%20TO%20EXECUTIVE%20ORDER%2001-20.pdf> [<https://perma.cc/MQA5-DA37>] (providing liability protections for emergency management service or response activities).

65. VA. CODE ANN. § 8.01-225.02 (2020) (providing liability protections for healthcare providers for the injury or wrongful death of any person arising from “the delivery or withholding of health care when (i) a state or local emergency has been or is

civil liability protections for injury or death that occurs due to medical services that are provided in support of the state's response to the COVID-19 pandemic. This is a much broader level of protection, ostensibly covering any harms to patients, irrespective of COVID-19 diagnosis or treatment, as long as the health care provider's actions were "in support of the State's response" to the pandemic.<sup>66</sup> In other words, the health care provider's actions need not be in accordance with a specific crisis standard of care or guideline to be protected.

Mississippi's immunity-conferring provision is similarly broad, immunizing health care providers for harm that occurs due to care provided "in support of the State's COVID-19 response."<sup>67</sup> However, the law also attempts to clarify this language, stating that the protections include, but are not limited to, "acts or omissions undertaken because of a lack of resources attributable to the COVID-19 pandemic that renders the Healthcare Professional or Healthcare Facility unable to provide the level or manner of care that otherwise would have been required in the absence of the COVID-19 pandemic."<sup>68</sup> Like Vermont's executive order, which also provides a nonexclusive list of emergency response services,<sup>69</sup> Mississippi's law could be interpreted to apply to any negligent care that occurs, regardless of whether it is due to scarce resources or whether the provider is specifically following a crisis standard of care.

#### IV. EXISTING LIABILITY PROTECTIONS FOR INSTITUTIONS

Many states have instituted liability protections for institutions, such as nursing homes and other long-term care facilities.<sup>70</sup> Institutional liability

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subsequently declared in response to such disaster, and (ii) the emergency and subsequent conditions caused a lack of resources, attributable to the disaster, rendering the health care provider unable to provide the level or manner of care that otherwise would have been required in the absence of the emergency and which resulted in the injury or wrongful death at issue").

66. Koch, Persad & Epstein, *supra* note 18.

67. Miss. Exec. Order No. 1471 (Apr. 10, 2020), <https://www.sos.ms.gov/content/executiveorders/executiveorders/1471.pdf> [<https://perma.cc/F47W-FLTL>] (rescinded).

68. *Id.*

69. Vt. Exec. Order No. 01-20, Addendum 9 (Apr. 10, 2020), <https://governor.vermont.gov/sites/scott/files/documents/ADDENDUM%209%20TO%20EXECUTIVE%20ORDER%2001-20.pdf> [<https://perma.cc/MQA5-DA37>].

70. Kenneth Yood & Theresa Thompson, *Data Reporting, Patient Access and Malpractice Liability: Nursing Homes and Long-Term Care Facilities Command Federal and State Attention During the COVID-19 Public Health Emergency*, SHEPPARD HEALTH

protections certainly are not novel to the circumstances of the COVID-19 pandemic; some states extended civil immunity to nursing homes and other facilities before 2020, including Indiana,<sup>71</sup> Iowa,<sup>72</sup> Minnesota,<sup>73</sup> and Virginia.<sup>74</sup> As of late June 2020, many states had granted nursing homes and other long-term care facilities immunity from civil liability, either by executive order or statute.<sup>75</sup> Arizona,<sup>76</sup> Connecticut,<sup>77</sup> Georgia,<sup>78</sup> Hawaii,<sup>79</sup> Illinois,<sup>80</sup> Indiana,<sup>81</sup> Iowa,<sup>82</sup> Kansas,<sup>83</sup> Massachusetts,<sup>84</sup> Michigan,<sup>85</sup> Minnesota,<sup>86</sup> Mississippi,<sup>87</sup> New Jersey,<sup>88</sup> New York,<sup>89</sup> North Carolina,<sup>90</sup>

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L. BLOG (Apr. 27, 2020), <https://www.sheppardhealthlaw.com/2020/04/articles/corona-virus/ong-term-care-facilities/> [<https://perma.cc/S54Y-C5WR>].

71. See IND. CODE § 34-30-13.5-3 (2020).

72. See IOWA CODE § 135.147 (2020).

73. MINN. STAT. § 12.61(2)(b) (2019).

74. VA. CODE ANN. § 8.01-225.02 (2020).

75. Nina A. Kohn & Jessica L. Roberts, *Nursing Homes Need Increased Staffing, Not Legal Immunity*, HILL (May 23, 2020, 11:00 AM), <https://thehill.com/opinion/health-care/499286-nursing-homes-need-increased-staffing-not-legal-immunity> [<https://perma.cc/L6C9-FHYR>]. Professors Nina Kohn and Jessica Roberts evaluated state legal liability protections, and found that as of late May 2020, nineteen states granted nursing homes new immunity from civil liability either by executive order or statute. *Id.* Other states' liability protections predate this particular public health emergency.

76. Ariz. Exec. Order No. 2020-27 (Apr. 9, 2020), <https://azgovernor.gov/file/34519/download?token=-CMKHiHH> [<https://perma.cc/6FQ6-7JYB>].

77. Conn. Exec. Order No. 7V (Apr. 7, 2020), <https://portal.ct.gov/-/media/Office-of-the-Governor/Executive-Orders/Lamont-Executive-Orders/Executive-Order-No-7V.pdf?la=en> [<https://perma.cc/K74X-LJLJ>].

78. Ga. Exec. Order No. 04.14.20.01 (Apr. 14, 2020), <https://gov.georgia.gov/executive-action/executive-orders/2020-executive-orders> [<https://perma.cc/VQ3V-NLVU>].

79. See Haw. Exec. Order No. 20-05 (Apr. 16, 2020), [https://governor.hawaii.gov/wp-content/uploads/2020/04/2004090-ATG\\_Executive-Order-No.-20-05-distribution-signed-1.pdf](https://governor.hawaii.gov/wp-content/uploads/2020/04/2004090-ATG_Executive-Order-No.-20-05-distribution-signed-1.pdf) [<https://perma.cc/YJ47-MKFC>].

80. Ill. Exec. Order No. 2020-37 (May 13, 2020), <https://www2.illinois.gov/Documents/ExecOrders/2020/ExecutiveOrder-2020-37.pdf> [<https://perma.cc/9HQN-QG87>] (expired June 27, 2020).

81. See IND. CODE § 34-30-13.5-3 (2020).

82. See IOWA CODE § 135.147 (2020).

83. Kan. Exec. Order No. 20-26 (Apr. 22, 2020), <https://governor.kansas.gov/wp-content/uploads/2020/04/EO-20-26-Executed.pdf> [<https://perma.cc/5H7G-5UCG>].

84. S.B. 2640, 191st Gen. Court, 2019–2020 Sess. (Mass. 2020).

85. See Mich. Exec. Order No. 2020-30 (Mar. 29, 2020) (rescinded), [https://content.govdelivery.com/attachments/MIEOG/2020/03/29/file\\_attachments/1413927/EO%2020-30.pdf](https://content.govdelivery.com/attachments/MIEOG/2020/03/29/file_attachments/1413927/EO%2020-30.pdf) [<https://perma.cc/A5NN-UJH6>].

86. MINN. STAT. § 12.61(2)(b) (2019).

87. Miss. Exec. Order No. 1471 (Apr. 10, 2020), [https://www.sos.ms.gov/Content/documents/about\\_us/WhatsNew/1471.pdf](https://www.sos.ms.gov/Content/documents/about_us/WhatsNew/1471.pdf) [<https://perma.cc/Q4MT-DXE8>] (rescinded).

88. S.B. 2333, 219th Leg., S. & Gen. Assemb. (N.J. 2020).

89. New York Emergency or Disaster Treatment Protection Act, N.Y. PUB. HEALTH LAW § 3082 (McKinney 2020).

90. 2020 N.C. Sess. Laws 3, § 3D.7(a) (providing immunity for “civil liability for any harm or damages” caused by acts or omissions in the rendering of health care

Oklahoma,<sup>91</sup> Pennsylvania,<sup>92</sup> Rhode Island,<sup>93</sup> Utah,<sup>94</sup> Vermont,<sup>95</sup> Virginia,<sup>96</sup> Wisconsin,<sup>97</sup> and Wyoming<sup>98</sup> all granted civil liability shields to institutions, including nursing homes, for injury or death that occurs due to negligence during the COVID-19 pandemic. Just as there is tremendous variation between the types of actions that health care provider immunity-conferring laws protect, there is a similar spectrum of protections for health care institutions, including nursing homes.

Although most state statutes enacted before 2020 only provided civil immunity to health care providers and not institutions, importantly, almost half of the laws and executive orders promulgated specifically in response to the COVID-19 pandemic grant liability protections to *both* health care providers and institutions.<sup>99</sup> In response to the COVID-19 pandemic, a few states initially provided liability shields solely to health care providers, only to later amend their rules to grant similar liability protections to health care institutions.<sup>100</sup> For example, until 2020, Wyoming provided immunity

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services, if those health care services are impacted directly or indirectly by decisions made “in response to or as a result of the COVID-19 pandemic” and are provided in good faith).

91. See OKLA. STAT. tit. 76, § 5.9 (2020); S.B. 1496, 57th Leg., 2nd Reg. Sess. (Okla. 2020).

92. Pa. Exec. Order to Enhance Protections for Health Care Professionals (May 6, 2020), <https://www.governor.pa.gov/wp-content/uploads/2020/05/20200506-GOV-health-care-professionals-protection-order-COVID-19.pdf> [<https://perma.cc/SGX7-H89P>].

93. R.I. Exec. Order No. 20-21 (Apr. 10, 2020), <https://governor.ri.gov/documents/orders/Executive-Order-20-21.pdf> [<https://perma.cc/5794-GY5N>].

94. See UTAH CODE ANN. §§ 58-13-2.6 to -2.7 (LexisNexis 2020).

95. Vt. Exec. Order No. 01-20, Addendum 9 (Apr. 10, 2020), <https://governor.vermont.gov/sites/scott/files/documents/ADDENDUM%209%20TO%20EXECUTIVE%20ORDER%2001-20.pdf> [<https://perma.cc/8XNV-48L>]; see VT. STAT. ANN. tit. 20, § 20(a) (2019).

96. VA. CODE ANN. § 8.01-225.02 (2020) (defining “Health care provider” as “a person, corporation, facility or institution licensed by this Commonwealth to provide health care . . .”).

97. WIS. STAT. § 895.4801 (2020).

98. See S.B. SF1002, 65th Leg., Spec. Sess. (Wyo. 2020).

99. See, e.g., Miss. Exec. Order No. 1471 (Apr. 10, 2020), [https://www.sos.ms.gov/Content/documents/about\\_us/WhatsNew/1471.pdf](https://www.sos.ms.gov/Content/documents/about_us/WhatsNew/1471.pdf) [<https://perma.cc/Q4MT-DXE8>] (rescinded). But see, e.g., Ark. Exec. Order No. 20-18 (Apr. 13, 2020), [https://governor.arkansas.gov/images/uploads/executiveOrders/EO\\_20-18.pdf](https://governor.arkansas.gov/images/uploads/executiveOrders/EO_20-18.pdf) [<https://perma.cc/CXW7-Q6T6>]; Nev. Exec. Order Declaration of Emergency Directive 011 (Apr. 1, 2020), [http://gov.nv.gov/News/Emergency\\_Orders/2020/2020-04-01\\_-\\_COVID-19\\_Declaration\\_of\\_Emergency\\_Directive\\_011/](http://gov.nv.gov/News/Emergency_Orders/2020/2020-04-01_-_COVID-19_Declaration_of_Emergency_Directive_011/) [<https://perma.cc/X29R-ZHVV>]. No state has granted immunity provisions to only institutions and not health care providers.

100. See Randall R. Fearnow et al., *COVID-19: Illinois Executive Order Grants Civil Immunity to Assisted Living Providers*, QUARLES & BRADY LLP (May 11, 2020),

from liability to “health care provider[s] or other person[s]” who respond to the public health emergency.<sup>101</sup> On May 20, 2020, in response to the COVID-19 pandemic, the state amended its existing law, adding “business entit[ies]” to the those covered by the provision.<sup>102</sup>

Likewise, New York State’s extension of liability protections to facilities such as nursing homes and other long-term care facilities is representative of the lobbying power these institutions have.<sup>103</sup> In late March 2020, Governor Cuomo issued an executive order providing broad civil and criminal liability protections for health care professionals, including physicians and nurses, if the injury or death occurred “in the course of providing medical services in support of the State’s response to the COVID-19 outbreak.”<sup>104</sup> However, after “aggressive” advocacy by the Greater New York Hospital Association (GNYHA),<sup>105</sup> language was included in the state’s annual budget that also provided broad immunity provisions to nursing homes as well.<sup>106</sup>

Just like with civil immunity provisions for health care professionals who provide care during the pandemic, almost without exception, states’ civil immunity provisions for health care institutions exclude willful or intentional misconduct, gross negligence, recklessness, or the provision of care in the absence of good faith.

Further, New York<sup>107</sup> and New Jersey<sup>108</sup> extend criminal immunity to health care facilities that provide care during the pandemic. However, New

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<https://www.quarles.com/publications/covid-19-illinois-executive-order-grants-civil-immunity-to-assisted-living-providers/> [https://perma.cc/V3NT-89SD]; Tara Sklar & Nicolas Paul Terry, *States Are Making It Harder to Sue Nursing Homes Over COVID-19: Why Immunity from Lawsuits Is a Problem*, CONVERSATION (June 9, 2020, 8:19 AM), <https://theconversation.com/states-are-making-it-harder-to-sue-nursing-homes-over-covid-19-why-immunity-from-lawsuits-is-a-problem-139820> [https://perma.cc/VZ2F-L5B6]; Laura Strickler & Adiel Kaplan, *Nursing Home Industry Pushes for Immunity from Lawsuits During Coronavirus Emergency*, NBC NEWS (Apr. 27, 2020, 3:00 AM), <https://www.nbcnews.com/health/health-care/nursing-home-industry-pushes-immunity-lawsuits-during-coronavirus-emergency-n1192001> [https://perma.cc/B7BT-NNTA].

101. WYO. STAT. ANN. § 35-4-114(a) (2020).

102. S.B. SF1002, 65th Leg., Spec. Sess. (Wyo. 2020).

103. David Sirota, *Cuomo Gave Immunity to Nursing Home Executives After Big Campaign Donations*, GUARDIAN (May 26, 2020), <http://theguardian.com/us-news/2020/may/26/andrew-cuomo-nursing-home-execs-immunity> [https://perma.cc/3LHM-DG4J].

104. N.Y. Exec. Order No. 202.10 (Mar. 23, 2020), [https://www.governor.ny.gov/sites/governor.ny.gov/files/atoms/files/EO\\_202.10.pdf](https://www.governor.ny.gov/sites/governor.ny.gov/files/atoms/files/EO_202.10.pdf) [https://perma.cc/33BR-2GL3] (rescinded Aug. 22, 2020).

105. Sirota, *supra* note 103.

106. Emergency or Disaster Treatment Protection Act, N.Y. PUB. HEALTH LAW § 3082 (2020).

107. *Id.*

108. S.B. 2333, 219th Leg., S. & Gen. Assemb. (N.J. 2020).

York’s criminal liability protections are broader than New Jersey’s.<sup>109</sup> New York’s law seems to allow for more discretion for providers and facilities, providing criminal liability protections for facilities who

(a) . . . arrang[e] for or provid[e] health care services pursuant to a COVID-19 emergency rule or otherwise in accordance with applicable law; [and] (b) the act or omission occurs in the course of arranging for or providing health care services and the treatment of the individual is impacted by the health care facility’s or health care professional’s decisions or activities in response to or as a result of the COVID-19 outbreak and in support of the state’s directives.<sup>110</sup>

In contrast, New Jersey’s criminal immunity provision is limited to injury or death that occurs “[i]n connection with the allocation of mechanical ventilators or other scarce medical resources, if the health care facility . . . adopts and adheres to a scarce critical resource allocation policy that at a minimum incorporates the core principles identified by the Commissioner of Health in an executive directive or administrative order.”<sup>111</sup>

#### V. WHEN –AND TO WHOM–SHOULD STATES GRANT IMMUNITY?

Immunity provisions are justified, but in limited circumstances. This Part will (1) propose the most appropriate use of liability shields and (2) provide support for this proposal.

##### *A. The Proposal*

Liability protections are most appropriate in instances where health care providers—including, but not limited to, physicians and surgeons, nurse practitioners, nurses, and physicians’ assistants—and, in limited circumstances, hospitals and other health care institutions, follow, in good faith, state crisis standards of care. Immunity provisions are appropriate when care is provided pursuant to local, state, or federal rules, guidance, or protocols that are modified from the “norm” and necessitated by emergency circumstances. Blanket provisions providing nursing home immunity are inappropriate. Rather, we should determine liability protections based on whether (1) the federal government, state government, local government, professional society, or medical institution has provided rules, guidance, or crisis standards of care, elucidating the modifications to the existing standard of care required

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109. Compare PUB. HEALTH § 3082, with N.J. S.B. 2333.

110. PUB. HEALTH § 3082.

111. N.J. S.B. 2333.

during the state of emergency; and (2) there is an identified need to extend legal protections to providers or institutions, based on perceived reluctance to follow crisis standards of care intended to save lives, due to fear of liability. In other words, liability protections are only appropriate when providers provide care pursuant to rules, guidance, or protocols intended to respond to the circumstances of the emergency.

Further, immunity provisions should serve the following purposes: they should (1) have the goal of saving the most lives by ensuring or increasing bed, equipment, and staffing capacity, and provide the highest standard of care possible, given the circumstances of the pandemic; (2) avoid placing blame on providers for events beyond their control, and (3) ensure fair treatment of frontline health care providers who risk their health and lives during a public health emergency.

### *B. The Justification*

Although this proposal for liability protections is much narrower than what many states and some other policymakers have proposed, it is more likely to ensure accountability and protect vulnerable patients.

Importantly, many legal experts agree that the common law legal standard of care is adaptable to changing circumstances, and therefore would adjust to the needs of medical care in a pandemic.<sup>112</sup> The standard of care is, by necessity, flexible. So it is technically unnecessary to provide immunity for good faith decisions made by institutions or health care providers who provide care during the pandemic.<sup>113</sup> Rather, activating and publicizing

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112. Koch, Persad, & Epstein, *supra* note 18; *see, e.g.*, George J. Annas, *Standard of Care—In Sickness and in Health and in Emergencies*, 362 *NEW ENG. J. MED.* 2126, 2128 (2010); Hoffman, *supra* note 26, at 1926; Kristi L. Koenig, Hoon Chin Steven Lim & Shin-Han Tsai, *Crisis Standards of Care: Refocusing Health Care Goals During Catastrophic Disasters and Emergencies*, 3 *J. EXPERIMENTAL & CLINICAL MED.* 159, 161 (2011) (“Being a flexible doctrine, it is the same regardless of the circumstances—understood simply as doing what you can under the circumstances, with the patient’s informed consent.” (citing Annas, *supra*, at 2126–31)); Kohn & Roberts, *supra* note 75 (“Conduct that would be negligent in normal times may be permissible during a pandemic.”); Mark A. Rothstein, *Malpractice Immunity for Volunteer Physicians in Public Health Emergencies: Adding Insult to Injury*, 38 *J. L., MED. & ETHICS* 149, 150 (2010) (“[I]n stark contrast to suggestions by some ‘altered standards of care’ advocates, the current standard of care applied to all medical malpractice cases is sufficiently flexible and situation-specific that it need not be altered.”). *But see* Marciniiss, Levy & Regan, *supra* note 37 (arguing that relying on the flexibility of the legal standard of care may be inadequate and therefore special immunities and protections may be required).

113. The standard of care is adaptable to emergency circumstances in non-pandemic circumstances, particularly in the context of triage decisions. *See, e.g.*, Jonathan Glauser, *Rationing and the Role of the Emergency Department as Society’s Safety Net*, 8 *ACAD. EMERGENCY MED.* 1101, 1101 (2001); Susan L. Albin et al., *Evaluation of Emergency Room*

pandemic response plans and crisis standards of care, which authorize the prioritization of patients for scarce resources based on their capacity to benefit from treatment, may be sufficient to provide legal protections for those who follow such guidelines.<sup>114</sup>

Despite the relative consensus regarding the legal protections afforded by the activation or implementation of crisis standards of care, by shifting the degree of care expected under the circumstances, those who provide medical care on the frontlines of a public health emergency might remain concerned about deviating from the nonemergency standard of care. Consequently, the intention behind immunity provisions for health care providers who administer care during a pandemic is to encourage frontline health care providers, when confronted with difficult or seemingly impossible decisions, to do their best during the worst of circumstances.<sup>115</sup> Although immunity provisions may not be technically required to protect providers who provide medical care pursuant to crisis standards of care during a public health emergency, local governments should work to alleviate doctors' and other health care providers' uncertainty about malpractice liability when providing appropriate medical care to patients during the COVID-19 pandemic. Not only will laws that provide liability protections potentially encourage adherence to crisis standards of care in a pandemic, thereby resulting in more lives saved, we also owe a responsibility to those physicians, nurses, and other health care providers who risk their own health and lives to save others.<sup>116</sup> Protecting health care providers from legal liability will ostensibly result in them being more likely to follow crisis standards of care and saving the most lives possible, without fear of punishment for doing so. Otherwise, even more people may die.

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*Triage Performed by Nurses*, 65 EMERGENCY ROOM TRIAGE 1063, 1063 (1975) (noting that, historically, triage has been a common part of emergency care for nurses).

114. Koch, Persad, & Epstein, *supra* note 18.

115. See Brown, *supra* note 11, at 9–12 (“This article advocates for removing the possibility of a medical malpractice claim for individual physicians and independent health care providers, when they are complying with published state, professional, or institutional COVID-19 policies in good faith.”).

116. *Id.* at 12–13 (“Health care providers are under an inordinate amount of stress as they expose themselves to a serious or deadly disease, often while working incredibly long hours. The extenuating circumstances of a pandemic necessitate immunity for physicians who are doing their best to bravely make critical decisions, with imperfect information, institutional and professional directives that run against the normal standard of care, and with highly constrained resources.”).

Thus, because these scarce resource allocation protocols and other crisis standards of care depart significantly from standard nonemergency medical practice, it is appropriate that states formalize these plans, thereby providing some degree of legal protection—perhaps immunity—for following them.<sup>117</sup>

However, calls for protections for health care providers and institutions, in order to encourage them to follow modified or crisis standards of care in emergency circumstances, are being co-opted by politicians and lobbying groups in an effort to extend legal immunity to those who would provide substandard care.<sup>118</sup> Immunity provisions for nursing homes and other institutions have been embraced by some proponents as an extension of protections for frontline “heroes” in the fight against COVID-19.<sup>119</sup> For example, in late April 2020, Senator Mitch McConnell made headlines, announcing that he would not support the federal stimulus package if Congress did not include liability protections against COVID-related suits for businesses, including nursing homes.<sup>120</sup>

But the justification of encouraging good medical decisions pursuant to crisis standards of care is not served by the broad provisions contained in many state laws that provide immunity for all care. Thus, advocacy groups, patients’ rights advocates, and others have argued that extending liability protections to long-term care facilities, including nursing homes—which account for more than half of coronavirus-related deaths<sup>121</sup>—is at best ill-advised, and at worst, deadly. Generally, immunity provisions for nursing homes are not directed at encouraging providers to follow state guidelines or crisis standards of care in a public health emergency in order to save

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117. Koch, Persad, & Epstein, *supra* note 18.

118. *See id.*

119. Debbie Cenziper et al., *As Nursing Home Residents Died, New Covid-19 Protections Shielded Companies from Lawsuits. Families Say That Hides the Truth*, WASH. POST (June 8, 2020, 2:13 PM), <https://www.washingtonpost.com/business/2020/06/08/nursing-home-immunity-laws/> [<https://perma.cc/FP9V-7FB8>]; *Faced with 20,000 Dead, Care Homes Seek Shield from Lawsuits*, FOX 11 NEWS (May 3, 2020), <https://fox11online.com/news/coronavirus/faced-with-20000-dead-care-homes-seek-shield-from-lawsuits-05-03-2020> [<https://perma.cc/5EHF-PH8K>].

120. Siobhan Hughes & Jacob Gershman, *Liability Shield Is Next Coronavirus Aid Battle in Congress*, WALL ST. J. (May 4, 2020, 6:58 PM), <https://www.wsj.com/articles/liability-shield-is-next-coronavirus-aid-battle-11588589100> [<https://perma.cc/79ZB-5CZP>] (“McConnell . . . has called liability protections a must-have ‘red line’ for Republicans, saying he won’t support Democrats’ calls for further state and local aid without it.”).

121. *In 18 States, Deaths in Long-Term Care Facilities Account for at Least Half of Their COVID-19 Deaths*, KAISER FAM. FOUND. (May 18, 2020), <https://www.kff.org/coronavirus-covid-19/slide/in-18-states-deaths-in-long-term-care-facilities-account-for-at-least-half-of-their-covid-19-deaths/> [<https://perma.cc/6NKR-VFS8>]. By mid-June, there were over 50,000 coronavirus deaths in nursing homes in the United States. *Coronavirus Deaths in U.S. Nursing, Long-Term-Care Facilities Top 50,000*, FOX BUS. (June 16, 2020), <https://www.foxbusiness.com/healthcare/coronavirus-deaths-in-u-s-nursing-long-term-care-facilities-top-50000> [<https://perma.cc/F3YR-ZLD2>].

the most lives; rather, they provide blanket protections institutions who are often already struggling to adequately serve their residents due to “years of neglect and chronic underfunding.”<sup>122</sup> As a result, even before the COVID-19 pandemic, many nursing homes did not meet “basic health, safety and staffing standards.”<sup>123</sup> New liability shields—shields that nursing homes have continuously lobbied for even under nonemergency circumstances—may immunize institutions from ongoing negligent actions<sup>124</sup> that may have even begun before the pandemic.<sup>125</sup>

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122. Michael Cantor et al., *Reducing COVID-19 Deaths in Nursing Homes: Call to Action*, HEALTH AFFAIRS BLOG (May 27, 2020), <https://www.healthaffairs.org/doi/10.1377/hblog20200522.474405/full/> [<https://perma.cc/78HD-QVQP>].

123. Cenziper et al., *supra* note 119 (“Watchdog groups say the industry used the coronavirus emergency to push a longstanding agenda to limit liability and lawsuits.”).

124. “Standards violations in facilities are common. As many as 3 million infections occur in skilled nursing facilities every year, killing 380,000 residents, according to the Centers for Disease Control and Prevention. Last year, infection control and prevention problems were the most frequently cited issue at nursing homes, and 63% of nursing homes were cited for at least one infection control violation in the last two inspection cycles, which go back to 2016, according to data analyzed by Kaiser Health News.” Abigail Abrams, ‘A License for Neglect.’ *Nursing Homes Are Seeking – and Winning – Immunity Amid the Coronavirus Pandemic*, TIME (May 14, 2020, 2:40 PM), <https://time.com/5835228/nursing-homes-legal-immunity-coronavirus/> [<https://perma.cc/SY5Z-NQ85>].

125. *Faced with 20,000 Dead, Care Homes Seek Shield from Lawsuits*, *supra* note 119 (“What you’re really looking at is an industry that always wanted immunity and now has the opportunity to ask for it under the cloak of saying, ‘Let’s protect our heroes.’”). Although “nursing homes are not the only players with troubling safety records predating COVID,” Jacqueline Stevens, *The Problem with Pritzker’s Pandemic Immunity Orders*, CHI. READER (June 12, 2020), <https://www.chicagoreader.com/chicago/pritzker-pandemic-immunity-orders-health-care/Content?oid=80608564> [<https://perma.cc/863U-VBCY>], this Article focuses primarily on addressing immunity provisions for nursing homes because of the high incidence of COVID-19 in nursing homes, the fact that nursing homes often already struggled to provide adequate care to residents before the pandemic, and nursing homes are subject to less oversight—both formal and informal—than other health care institutions. See Bernard Condon & Candice Choi, *Nursing Home Outbreaks Lay Bare Chronic Industry Problems*, PBS (Mar. 21, 2020, 11:48 AM), <https://www.pbs.org/newshour/health/nursing-home-outbreaks-lay-bare-chronic-industry-problems> [<https://perma.cc/V3FB-FZ2Y>] (“Burgeoning coronavirus outbreaks at nursing homes in Washington, Illinois, New Jersey and elsewhere are laying bare the industry’s long-running problems, including a struggle to control infections and a staffing crisis . . .”); Ina Jaffe, *Ideal Nursing Homes: Individual Rooms, Better Staffing, More Accountability*, NPR (May 21, 2020, 5:01 AM), <https://www.npr.org/2020/05/21/855821083/ideal-nursing-homes-individual-rooms-better-staffing-more-accountability> [<https://perma.cc/GWW5-XKNA>] (explaining that “nursing homes haven’t had to worry about inspectors citing them for those failings” because of small fines and minimal oversight); Chris Kirkham & Benjamin Lesser, *Special Report: Pandemic Exposes Systemic Staffing Problems at U.S. Nursing Homes*, REUTERS (June 10, 2020, 4:12 AM), <https://www.reuters.com/article/us-health->

During the pandemic, broad institutional immunity provisions remove the last line of protections for residents; due to scarce resources and the need to ease some restrictions during emergency circumstances, some states have already eased institutional oversight.<sup>126</sup> Inspections and other oversight mechanisms have been suspended during the pandemic.<sup>127</sup> Visitors are also restricted during the pandemic, and therefore family members and friends are unable to check in and help hold facilities accountable if things appear improper,<sup>128</sup> resulting in little to no institutional accountability and

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coronavirus-nursinghomes-speci/special-report-pandemic-exposes-systemic-staffing-problems-at-u-s-nursing-homes-idUSKBN23H1L9 [https://perma.cc/GL3D-NZ4T] (“Insufficient staffing and frequent turnover have caused quality-of-care problems at nursing homes for decades, studies and government inquiries have shown.”); Richard Mollot, *Nursing Homes Were a Disaster Waiting to Happen*, N.Y. TIMES (Apr. 28, 2020), https://www.nytimes.com/2020/04/28/opinion/coronavirus-nursing-homes.html [https://perma.cc/CD8A-79D7] (“The weaknesses in patient care and oversight at nursing homes that made those deaths more likely were longstanding, widespread and well known.”); Jordan Rau, *Coronavirus Stress Test: Many 5-Star Nursing Homes Have Infection-Control Lapses*, KAISER HEALTH NEWS (Mar. 4, 2020), https://khn.org/news/coronavirus-preparedness-infection-control-lapses-at-top-rated-nursing-homes [https://perma.cc/MCS3-8G77] (“Long before the novel coronavirus made its surprise appearance, the nation’s nursing homes were struggling to obey basic infection prevention protocols designed to halt the spread of viruses and bacteria they battle daily.”); Jordan Rau & Anna Almendraia, *COVID-Plagued California Nursing Homes Often Had Problems in Past*, KAISER HEALTH NEWS (May 4, 2020), https://khn.org/news/covid-plagued-california-nursing-homes-often-had-problems-in-past/ [https://perma.cc/9VFE-R7D6] (“On average, the homes that have had coronavirus cases had more complaints lodged against them and were fined 29% times more often. In addition, Medicare also calculated that their health violations of all types were 20% more serious.”); Maria Sacchetti & Jon Swaine, *Wash. Nursing Home Faces \$611,000 Fine Over Lapses During Fatal Coronavirus Outbreak*, WASH. POST (Apr. 2, 2020, 2:51 PM), https://www.washingtonpost.com/investigations/wash-nursing-home-faces-611000-fine-over-lapses-during-fatal-coronavirus-outbreak/2020/04/02/757cee76-7498-11ea-87da-77a8136c1a6d\_story.html [https://perma.cc/8FD8-F39M] (“CMS said the facility ‘did not have effective systems in place’ to prevent the infection or respond to it.”).

126. See Abrams, *supra* note 124.

127. *Id.*; see also Nina Kohn, *Addressing the Crisis in Long-Term Care Facilities*, HILL (Apr. 23, 2020, 3:00 PM), https://thehill.com/opinion/civil-rights/494337-addressing-the-crisis-in-long-term-care-facilities?amp [https://perma.cc/BMU6-4AUV] (“In normal times, there are three key sources of oversight for nursing homes: state surveyors, ombudsmen and family members of residents. CMS has now banned visits by family and ombudsmen except in very limited situations. It has also hobbled surveyors’ efforts by, among other things, waiving key disclosure requirements related to staffing that are used to assess compliance with quality of care standards. Even enforcement tools have been deliberately idled: CMS has suspended enforcement of most regulatory violations by nursing homes, as well as processes for responding to complaints raised by residents or family members.”).

128. Letter from Am. Ass’n for Justice Nursing Home Litig. Grp. et al., to Mitch McConnell, Majority Leader, U.S. Senate, & Charles Schumer, Minority Leader, U.S. Senate (May 28, 2020), https://theconsumervoice.org/uploads/files/issues/senateleadership-immunityltr.pdf [https://perma.cc/JMP2-TY7Q].

eliminating the deterrent effect of the law.<sup>129</sup>

Opponents of broad institutional immunity provisions argue that because nursing homes are already a major source of negligence in normal times, immunity provisions will excuse regularly-occurring negligence based on the state of emergency.<sup>130</sup> Thus, they advocate that “troubled facilities ought to remain subject to litigation resulting from life-threatening failures in infection control and patient care, and families offered a chance to pierce the layers of secrecy that often surround unexpected or unexplained deaths.”<sup>131</sup> In essence, many institutional liability provisions cover actions that are not taken in furtherance of the state’s response to the circumstances of the pandemic. Thus, as one article explained, nursing homes should continue to be held accountable for negligent behavior.<sup>132</sup> Among those that should be held accountable are

Homes that flouted federal guidelines to screen workers, cut off visitations and end group activities; those that failed to inform residents and relatives of an outbreak; those that disregarded test results; and homes like one in California, where at least a dozen employees did not show up for work for two straight days, prompting residents to be evacuated.<sup>133</sup>

Thus, immunity provisions are really only appropriate when they are intended to encourage adherence to crisis standards of care—institutional or state guidelines that depart from ordinary standards of care but are

129. Stevens, *supra* note 125 (“‘The deterrence value from the threat of litigation is part of what you’re losing due to the EO, even if at the end of the day certain cases are viable in court,’ Kohn explained.”). *But see* Michelle M. Mello & Troyen A. Brennan, *Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform*, 80 TEX. L. REV. 1595, 1598 (2002) (finding some, but limited, evidence of the deterrent effect of malpractice litigation on medical errors); Nathaniel Hupert et al., *Processing the Tort Deterrent Signal: A Qualitative Study*, 43 SOC. SCI. & MED. 1, 1 (1996) (identifying potential “impediments to the receipt and processing of the tort deterrent signal by individual physicians” and calling for institutional liability).

130. *See* Cenziper et al., *supra* note 119.

131. *Id.* Further, Kohn and Roberts argue that existing liability protections may be sufficient to protect nursing homes from lawsuits. Kohn & Roberts, *supra* note 75 (“This rhetoric exaggerates the industry’s vulnerability to litigation. Even without legal immunity, COVID-19 could ravage a nursing home—killing most residents—without the facility being liable. This is because, consistent with established tort law doctrines, facilities that operate reasonably are unlikely to be liable for COVID-19 related harms, including residents’ deaths.”).

132. *See Faced with 20,000 Dead, Care Homes Seek Shield from Lawsuits*, *supra* note 119.

133. *Id.*

intended to save lives during the pandemic.<sup>134</sup> Although this proposal may not provide immunity to health care providers or institutions in circumstances where they are simply overwhelmed by the number of cases presenting at a given moment, the state has not provided guidelines or rules for addressing that particular situation. In such circumstances, the inherent flexibility of the standard of care should sufficiently protect providers and institutions who do their best in the worst of situations from liability, while also allowing patients and their loved ones to seek recourse for injuries or deaths that occur due to poor decision-making.

Rather than encouraging nursing homes to provide the best care possible under difficult circumstances, predicating readmission of residents after hospitalization for COVID-related care on liability shields<sup>135</sup> holds legislators and policymakers hostage. In such cases, immunity provisions for institutions like nursing homes—which are often for-profit—do not protect the health care providers themselves who do their best to care for individuals with fewer resources, nor do they protect residents.<sup>136</sup>

Further, even during a declaration of emergency, at times viral spread may become controlled and hospitals may experience less resource scarcity. At those times, health care providers and entities will be able to provide care at the “normal” nonemergency standard of care. Thus, broad protections that are in effect during the entire duration of the pandemic shield physicians and health care institutions from liability even in instances where those providers and institutions could have provided care pursuant to nonemergency circumstances.

This proposal does not exclude all nursing homes from liability shields in all circumstances. Rather, where institutions follow crisis standards of care intended to protect their residents and save lives, immunity provisions may be appropriate. For example, experts have called for various innovations intended to reduce deaths due to COVID-19 in nursing homes.<sup>137</sup>

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134. See, for example, New Jersey’s law, which limits criminal immunity to injury or death that occurs due to adherence to a crisis standard of care governing the allocation of mechanical ventilators or other scarce medical resources. S.B. 2333, 219th Leg., S. & Gen. Assemb. (N.J. 2020).

135. See Stevens, *supra* note 125 (Nursing home’s CEO’s e-mail to Illinois Governor’s chief of staff “implied [nursing home’s] facilities would refuse readmittance of their own residents following hospital COVID care unless ‘litigation relief’ were ordered.”).

136. See *id.*

137. See, e.g., Cantor et al., *supra* note 122 (offering Massachusetts’ initiatives as a model, and recommending “1) enhancing infection control with an individualized plan for each nursing home that incorporates both regulatory guidance and current literature and is feasible to implement; 2) ensuring necessary resources to implement infection control plans, especially adequate staff, training, personal protective equipment (PPE), COVID-19 testing, creation of units for COVID-19 positive patients, and access to onsite ancillary services (labs, imaging, intravenous (IV) management); 3) mirroring the federal Coronavirus Commission for

Conditioning institutional immunity on following guidance intended to protect residents would justify liability protections.<sup>138</sup> Finally, instead of providing broad institutional immunity to these already-underfunded and understaffed institutions,<sup>139</sup> thereby almost completely insulating providers from liability, sufficient resources and support should be afforded so that they can provide the best care possible during difficult times.

Thus, blanket immunity-conferring laws provide liability shields for decisions made that may have no connection to resource allocation due to COVID-19, but rather may simply protect an institution or individual health care provider behaving negligently. In such cases, immunity provisions remove the last thing that keeps institutions accountable.

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Safety and Quality in Nursing Homes by establishing state-level task forces focused on improving communication and collaboration between nursing homes and families, health care providers (hospitals, health systems, home health agencies, physician organizations), and government agencies”); *see also* Jaffe, *supra* note 125 (providing “innovating ideas” from “[l]ong-time nursing home analysts”); Kohn, *supra* note 127.

138. *See* Abrams, *supra* note 124.

139. Kohn & Roberts, *supra* note 75.

