Hospital Liability during COVID-19:

Considerations for Governing Bodies of Organizations Facing Staffing and Equipment Shortages

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The COVID-19 pandemic has forced hospitals, health systems, and practitioners to cope in innovative and groundbreaking ways to keep up with the health needs of patients and communities. Creating new "standards of care" and novel approaches to practice in response to this national emergency raises concern about legal liability. While departures from historic practices may be necessary in the face of staff, equipment, and facility shortages, hospital governing boards can take actions to mitigate the risk of future liability.

Key Board Takeaways

- Review medical staff bylaws and credentialing policies to see if the board should consider adopting resolutions that allow restrictive provisions to be waived for the duration of the COVID-19 crisis.
- Strongly consider developing decision-making guidelines on the allocation of scare resources. These policies will help demonstrate when clinicians have acted in good faith and in accordance with communal decisions.
- Refresh the ethics committee and make sure it has community representation and legal input. This committee can help develop and implement the rationing guidelines mentioned above.
- Ensure that deliberations around the many challenges of this pandemic are thoughtful, transparent, and that there is clear communication so that the organization is positioned to address any unwarranted criticism.

Dealing with Staffing Shortages

Future lawsuits may be generated by two areas of concern. The first is the need for hospitals to expand their staff resources with volunteers and/or clinical professionals who have retired, inactive, or out-of-state licenses. Both state and federal governments have taken steps to allow exceptions to licensing rules during the COVID-19 state of emergency. In some states, scope-of-practice restrictions have been relaxed on non-physician practitioners (e.g., nurse practitioners) and supervision requirements may be waived. In others, retired physicians can return to practice under an expedited process from the state medical board. These various regulatory waivers can be tracked on numerous Web sites, including that of the Federation of State Medical Boards (www.fsmb.org/advocacy/covid-19).

Many medical staffs will not have an opportunity to vet (credential) and monitor the performance of these new practitioners with the rigor they might devote if not under

crisis conditions. They can, therefore, pose an increased liability risk to the hospital. Furthermore, while state or federal regulations may facilitate the expansion of practitioners at a hospital, medical staff bylaws or credentialing policies are still in effect. Boards should consider the adoption of resolutions that allow restrictive provisions in these documents to be waived for the duration of the national COVID emergency and state declarations of disaster.

Elected representatives, government officials, and policy makers are cognizant of the degree to which fear of liability creates a barrier to the delivery of needed healthcare services in a crisis. For this reason, Congress and most states have provided varying levels of liability protection to facilitate adequate responses to disasters and national emergencies. Unfortunately, these protections form a limited and patchwork set of safeguards for those engaged in delivering this care.[1] For example, under the Coronavirus Aid, Relief, and Economic Security (CARES) Act, Congress has provided liability protection to volunteer healthcare practitioners who provide care during the current national emergency. However, Congress decided not to extend this shield from liability to non-volunteer providers, leaving it to the states to provide protection for the vast majority of healthcare professionals and institutions. Various states have issued orders extending liability protection to employed or contracted healthcare workers treating patients during the COVID crisis. Notably, these are state-by-state determinations that waive certain state laws to provide immunity from

1 42 U.S.C.A. § 247d-6d (2013). The PREP Act provides immunity from suits and liability related to covered countermeasures to all covered entities and persons that manufacture, distribute, prescribe, administer, or dispense countermeasures, and program planners, as well as their agents, officials, and employees, ***absent willful misconduct***. To trigger the PREP Act's protections, the Secretary of the Department of Health and Human Services must first make a "determination" that a disease or other health condition or other threat to health constitutes a public health emergency, or that there is a credible risk that the disease, condition, or threat may in the future constitute such an emergency. Then, the Secretary may make a "declaration" recommending the manufacture, testing, development, distribution, administration, or use of one or more covered countermeasures, and stating that immunity from liability is in effect with respect to the activities so recommended.

Good Samaritan laws vary considerably by state and provide liability protections to different individuals in specific circumstances, often those providing spontaneous, uncompensated care at the scene of an emergency. However, some states provide broader protections. For example:

- Under Georgia's GA. CODE ANN. § 31-11-8, any person (including EMS personnel and licensed healthcare workers) who provides emergency care shall not be liable for damages ***if they receive no remuneration and provide care in good faith***.
- North Carolina's N.C. GEN. STAT. § 166A-19.60 provides immunity to non-profits acting pursuant to the N.C. Emergency Management Act if compensation is no greater than expenses and the organization is working either during a state of emergency or during emergency preparedness training.
- CAL. GOV. CODE § 8659. California Emergency Services Act protects **hospitals**, physicians, pharmacists, and dentists from civil liability for services provided during a state of war, emergency, or local emergency at the express or implied request of a state or local official or agency.
- Maine's ME. REV. STAT. ANN. tit. 22, § 816(1) provides immunity from civil liability for private institutions and their employees or agents as if they were a state agency or employees for actions related to the control of communicable diseases during a declared extreme public health emergency.

civil liability for certain healthcare professionals providing care during the pandemic. Hospitals and practitioners assessing their own risks of liability must look at the particular executive orders or legislative actions taken in the jurisdictions in which they operate. An example is the executive order issued by Governor Andrew Cuomo on March 23, 2020, which contains the following section:

Waiver of Provider Civil Liability

Waives civil liability for physicians, physician assistants, specialist assistants, nurse practitioners, licensed registered professional nurses, and licensed practical nurses for any injury or death alleged as a result of such practitioner's act or omission while providing medical services in support of New York's response to the COVID-19 outbreak, unless the injury or death was caused by the practitioner's gross negligence.

Notably, the waiver does not provide protection from corporate negligence lawsuits, which target the hospital rather than individual practitioners. Once the crisis abates, such lawsuits may be more likely since a patient injured during the pandemic may not have the ability to seek damages from a practitioner who is alleged to have committed malpractice.[2]

Most of the measures undertaken to shield healthcare professionals from liability exclude protection when injury or death is caused by reckless or gross negligence or through willful misconduct. Even without specific executive or legislative protections, it has been rare for juries and courts to find liability for negligence in the face of disasters. For example, during Hurricane Katrina extraordinary efforts were made to provide adequate care to patients under disaster conditions. Where injury or death occurred despite the sincere efforts of providers, lawsuits were uncommon and adverse rulings or judgements even rarer. However, where actions that harmed patients were seen as intentional infliction of harm or death, it was a different story. The prosecution of two nurses and a doctor for intentional euthanasia in the face of the hurricane received much media attention and has been the subject of compelling reading.[3]

Addressing Equipment/Facility Shortages

The COVID-19 pandemic is presenting healthcare organizations with frightening challenges on multiple fronts. Perhaps the most fearful possibility facing providers is the need to determine who will receive treatment in the face of a shortage of ICU beds and critical medical supplies such as ventilators. Any such "rationing" decisions can be characterized as willful misconduct by those who oppose such decisions. Hospitals and health systems should strongly consider the development of decision-making guidelines

2 On April 3, 2020, NY Governor Cuomo signed into law the Emergency Disaster Treatment Protection Act, which extends his previous executive order—immunizing doctors and nurses—to extend liability protections to healthcare facilities, administrators, and volunteer organizations working to address the COVID-19 crisis.

3 See the excellent reporting in Sheri Fink, *Five Days at Memorial: Life and Death in a Storm-Ravaged Hospital,* New York: Crown Publishers, 2013.

on the allocation of scarce resources. Such policies will help demonstrate when clinicians have acted in good faith and in accordance with considered communal decisions should patients and their attorneys later question allocation decisions that were made during the COVID-19 crisis.

Hospital ethics committees are a valuable resource for both the development and implementation of rationing guidelines. Unfortunately, most hospitals today either have no established ethics body or have let these entities lie dormant in recent years. Hospital boards should quickly rectify this situation and assure that these committees have both community representation and legal input. While there are many external resources to which a hospital can turn to obtain examples of rationing protocols,[4] such guidelines should be vetted by hospital ethics committees to ensure local appropriateness. Ethics committees should be an integral part of operationalizing any approach to the allocation of vital, but scarce resources. Should a decision need to be made that a patient will not be the recipient of a scarce resource (e.g., a ventilator or a medical treatment in short supply), such determinations are best made by an informed ethics committee, triage body, or a triage officer guided by clear protocols. An individual practitioner, acting on her own initiative, may subject herself and the hospital to increased liability for claims of intentional infliction of harm and willful misconduct. The hospital will be best served in its defense by demonstrating that its requirements and expectations in a time of crisis were not capricious and arbitrary.

In mandating and overseeing the creation and implementation of guidelines for dealing with resource allocation during a time of crisis and scarcity, the board must take care that it acts fairly and equitably. Recently the state of Alabama agreed to eliminate its ventilator rationing guidelines after HHS' Office for Civil Rights found that they could result in patient discrimination based on age or disability. In fashioning their own protocols hospitals must remain cognizant to stay within the parameters set by various laws. Knowledgeable legal counsel should always be consulted.

Of course, preparing to respond to COVID-19 challenges is not just a matter of reducing the risk of liability. Governing boards should demand that their institutions are ethical leaders in facing the many challenges of this pandemic. Thoughtful, transparent, and well-communicated deliberations by hospital leaders (including the board) will ensure their institutions come out of the current crisis prepared to deflect unwarranted criticism and better able to face inevitable future crises.

The Governance Institute thanks Todd Sagin, M.D., J.D., President and National Medical Director, Sagin Healthcare Consulting, and Governance Institute Advisor, for contributing this article. He can be reached at tsagin@saginhealthcare.com.

4 Numerous healthcare systems and states have adopted rationing protocols. Many are based on work done by a critical care physician at the University of Pittsburgh Medical Center (UPMC), Dr. Douglas White. New York is an example of a state that has addressed this issue: *Ventilator Allocation Guidelines*, New York State Task Force on Life and the Law, New York State Department of Health, November 2015.