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CHEST

Legal Immunity for Physicians During the COVID-19 Pandemic

Needs to Address Legal and Ethical Challenges

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Recently, several states have considered or enacted statues to grant health-care institutions and providers immunity from criminal and/or civil lawsuits regarding treatment of coronavirus disease 2019 (COVID-19) patients.[1,2] However, many questions and challenges about these provisions have emerged.

The eventual number of US COVID-19 patients in the current and subsequent surges of the pandemic remains unknown, but critical care and other physicians in the United States and elsewhere have already confronted dilemmas regarding current and possible future shortages and allocations of resources, including ICU beds, ventilators, staff, and personal protective equipment. If resources are limited, related difficulties arise, with one example being the use of CPR. This is because the chances that COVID-19 patients in ICUs undergoing CPR will survive to discharge are often exceedingly low and, especially given ongoing shortages of personal protective equipment at many institutions, performing CPR increases the risk of medical staff themselves becoming infected.

ABBREVIATIONS: COVID-19 = coronavirus disease 2019; SOC = standards of care; SOFA = Sequential Organ Failure Assessment

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COVID-19 thus forces a consideration of existing and possible statutes regarding these decisions. Previous US state laws differ significantly in whether physicians can unilaterally withhold or withdraw care without the patient's or a surrogate's consent. In the state of New York, an initial epicenter of the US pandemic, relevant laws do not address unilateral Do Not Resuscitate orders, and many hospitals and providers therefore provide futile CPR to patients, if the family wishes it. Many states (eg, Wisconsin) lack explicit laws addressing this issue, and some hospitals have developed their own policies, often permitting two physicians to decide to refrain from CPR on a patient, despite the family's wishes, if it is futile.

In states without explicit laws allowing unilateral Do Not Resuscitate decisions, COVID-19 patients or their surrogates may want all treatment, even if futile, and physicians who do not provide it are legally liable. After Hurricane Katrina, New Orleans nursing homes received criminal indictments for improperly caring for patients, despite providers proceeding as they thought best, given the disaster.[3] The COVID-19 pandemic thus creates moral distress for many physicians, debating whether to perform futile CPR that endangers their own lives.

Numerous hospitals and physicians have therefore sought crisis standards of care (SOC), which are permissible changes in SOC in an emergency, given shortages of staff and supplies,[4] and statues granting immunity from criminal and civil lawsuits in treating COVID-19 if such shortages exist, assuming providers follow these standards, act in good faith, are not negligent, and do not intentionally harm patients.

These statutes, however, often unfortunately lack key details, and crucial questions surface regarding what they should include. Many states have previously developed crisis SOC, but these standards vary widely. In 2009, the Institute of Medicine recommended that these standards contain five elements (eg, community and provider engagement, assurances regarding legal authority, definitions of triggers, strong ethical grounding and evidence-based processes and operations). However, only five states have included all five elements.[4] In 18 states, the standards were specific only to pandemic influenza.

Connecticut, Kentucky, and Illinois recently provided immunity from civil but not criminal liability. In several states (eg, New Jersey), relevant statutes contain ambiguities. New York specifies that health-care workers are immune from liability if they are providing care "pursuant to COVID-19 emergency rules,"[2] but no such rules have yet been issued. In New York, guidelines for triaging ventilators, drawing on Sequential Organ Failure Assessment (SOFA) scores, with triage committees making the final triage determinations, have been proposed but lack legal status. Political leaders in many states appear hesitant, fearing that critics will view triage committees as "death panels," which have previously generated political controversy. In states without clear, relevant crisis SOC, groups of hospitals have pursued developing such standards on their own, but numerous hospitals' lawyers and leaders must concur, posing hurdles. In Florida, hospital associations adopted SOC but failed to persuade the state's governor to grant legal immunity for providers following these standards.

Legal questions have already emerged about the potential limits of these laws.[5] How these legal immunity laws will become operationalized and with what effects in current or future waves of COVID-19 or other emergencies remain unclear. Disability advocates fear discrimination in triage decisions and have criticized SOFA scores for containing implicit biases. Individuals with various comorbid conditions have increased SOFA scores, and hence lowered triage priority, and they could argue that these conditions constitute disabilities that physicians are thus using against them. Federal Medicaid guidelines and the Americans with Disabilities Act bar discrimination based on disabilities but have not yet been applied to triage decisions in public health emergencies, creating legal uncertainties. The pandemic has also disproportionately affected African-American individuals, recent immigrants, and the poor, who may therefore also fear that they will receive significantly lower triage prioritization, and that providing legal immunity to physicians making these decisions removes important possible legal recourse.

Questions arise of how judges and juries will later interpret and apply these statues' legal immunity and define relevant terms; for example, whether "shortage" means a shortage in a particular hospital ward, or hospital, larger hospital system, or city, and how short-staffed a hospital needs to be to receive legal immunity from lawsuits for providing care that is less than the previous SOC.

Numerous physicians are thus having to make their own decisions; for example, forgoing CPR on COVID-19 patients and/or providing only single doses of vasopressors or attempts at chest compressions. Physicians face challenges concerning whether and how to prioritize public health benefits over individual patient autonomy and benefit. In addition, families of patients denied CPR may become angry and even litigious, distressing providers.

Importantly, state and local hospital and professional medical associations should strongly encourage state governments to address these issues and should provide input regarding details. Questions emerge, for instance, of when immunity laws should end. Despite proposals that such statutes automatically expire at 120 days,[1] pandemics could continue longer. Dilemmas arise about how few cases and what level of resources justify ending a "state of emergency" and thus legal immunity. In addition, some hospitals in a region may return to adequate levels of resources sooner than others, which may have had fewer resources to start. SOC may thus vary within cities. Immunity statutes should therefore include criteria and mechanisms for determining and periodically reviewing the necessary expiration dates, and specify who should decide and how.

Transparency and professional, patient, and public input and education about these laws are also crucial. Hospitals and physicians should consider how best to communicate these issues to patients. Providers may need training on how, specifically, to follow these laws and standards. These issues are crucial to address not only to combat the current COVID-19 wave but to prepare for future emergencies.

Thus, legal immunity laws being considered and enacted in the COVID-19 pandemic can assist health-care institutions and providers now and in the future. They pose challenges, however, and require careful ongoing attention, development, and implementation, as well as professional and public education.

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