Liability and Liability Shields

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SUMMARY. This Chapter first examines the liability of businesses and medical professionals for acts and omissions involving COVID-19 mitigation, treatment, and reopening. Second, it provides an analysis of the federal and state liability shields, those that were in existence before COVID-19, those introduced more recently, and calls for more and broader shields. Claims will be brought by consumers (predominantly nursing home residents) alleging that businesses failed to protect them, patients treated at the height of the pandemic when emergency departments were overrun, and consumers who contract the virus during reopening. There are few federal liability shields applying to private actors, the most important being the PREP Act of 2005. A substantial number of states have adopted some type of liability waiver specifically related to the COVID-19 pandemic, initially providing immunity protections for health care providers and more recently protecting businesses as they reopen. Many of the health care providers shields present difficult questions of interpretation, particularly with regard to whether they are limited to emergency triage decisions, mitigation, or treatment efforts in contrast to broader acts or omissions that may have contributed to the infection outbreak, such as poor hygiene control. There is no evidence that a broad federal shield is necessary. State policymakers also should resist calls for broader shields and should provide transparent, data-driven guidance on reopening which can inform the existing and appropriate reasonable care standard. Court should carefully scrutinize the constitutionality of shields and not show the same deference as given to prior tort reform legislation.

Introduction

This Chapter examines the potential liability of businesses and medical professionals for acts and omissions involving COVID-19, and provides an analysis of long-established, new and contemplated federal and state liability shields. This Chapter does not cover lawsuits against essential businesses that stayed open during the first peak of the pandemic emergency orders. Large numbers of claims are likely to be pursued by employees in high-risk industries (for example, meatpacking or warehouse fulfillment).

Potential Targets of COVID-19 Lawsuits

Typical COVID-19 lawsuits against businesses or their employees will allege either that the defendant's act or omission caused the plaintiff to contract the virus or that the defendant's act or omission in mitigating or treating the virus caused injury or death. Most lawsuits claim that the defendant's failure to act with reasonable care caused the plaintiff's injuries (negligence). The standard of care in most cases will be ordinary negligence, posing the jury question whether the defendant acted as a reasonable person in all the circumstances. Cases brought against health care providers may be categorized as medical malpractice and turn on expert testimony as to the professional standard of care. A few cases will be bought alleging intentional or willful actions, possibly in an attempt to trigger exceptions in liability shields. There may even be idiosyncratic intentional tort actions brought by persons against those they believe transmitted the virus to them intentionally or recklessly; these will resemble some of the cases brought against people living with HIV.

Businesses may be sued by customers alleging failure to protect them from COVID-19. The only substantial number of claims in this cohort likely will come from nursing home residents or their families. In most cases these will be ordinary negligence claims based on, for example, substandard infection control, failure to isolate residents with symptoms, and sub-optimal staffing. In many cases these negligence claims will be fortified by alleged breaches of state or federal regulatory standards applicable to long-term care facilities. Press reports have suggested that several nursing homes failed to report COVID-19 cases or refused to update families about residents' conditions; in such cases allegations of reckless or negligent infliction of emotional distress may have traction. Finally, nursing homes, as recipients of Medicaid funds, also are likely to face False Claims Act claims alleging inadequate care or some form of regulatory non-compliance. Such actions are often initiated by whistleblowers, are notoriously difficult to defend, and usually result in very large settlements.

Health care providers are another likely target. During pandemic peaks, emergency departments have been overrun and patient care threatened by shortages of staff, personal protective

equipment (PPE), beds, intensive care unit (ICU) beds, and ventilators. As providers, many of whom were practicing outside of their usual specialties, used improvised equipment and even prescribed untested drugs, it is highly likely that avoidable adverse events occurred. No doubt, some of those adverse events involved rationing of care.

Finally, medium to high-risk businesses reopening after the lifting of government restrictions clearly face legal jeopardy if their customers contract COVID-19. The most obvious examples are restaurants, gyms, personal care services, schools, and colleges. Similar questions apply to businesses that kept open only their essential services open while closing others. For example, as hospitals reopen for routine care or elective surgeries, patients face the risk of COVID-19 as a hospital-acquired infection.

Liability Shields

The devastation caused by COVID-19, unknowns that remain regarding its transmission and pathology, and disagreements about reopening all create uncertainty. It is perhaps understandable that those facing potential lawsuits will seek immunity. Less admirable are opportunistic stakeholders with imperfect safety records seeking broad immunity for acts or omissions that caused harm. Orthogonal to shields granted by federal or state governments are those that potential defendants (particularly those in the process of reopening) are attempting to impose on their customers. Such exculpatory clauses or waivers releasing defendants from liability for injury or damages resulting from negligence are sometimes referred to as express assumption of the risk. Many states allow these waivers to operate as an affirmative defense in situations where the activity is discretionary and recreational (such as skydiving) as opposed to necessary (such as health care). There are reports of theme parks and political rallies posting notices that entrants assume COVID-19 risks, and of gyms and salons incorporating them into their contracts. This is an emerging area that may require further treatment as reopening continues.

Federal Shields. Liability shields for private actors under federal law are limited. The Public Readiness and Emergency Preparedness (PREP) Act of 2005 applies to "covered countermeasures," principally drugs, devices, and vaccines used to fight a national emergency that cause death or serious physical injury, and shields manufacturers and others in the supply chain. In addition to immunity, PREP includes the Countermeasures Injury Compensation Program (CICP) that provides benefits to individuals who sustain a serious physical injury or die. In March 2020 the PREP Act was amended by the Families First Coronavirus Response Act to include "personal respiratory protective devices."

The Volunteer Protection Act (VPA) of 1997 immunizes volunteers who work for non-profits or government entities. An emergency declaration is not required. The CARES Act of 2020 introduced a broader immunity for volunteering health care professionals without limitation as to workplace. This also has misconduct exceptions. Unlike the VPA, the CARES immunity only applies during the COVID-19 state of emergency.

This Chapter concentrates on shields providing immunity from negligence claims. In the longer term and perhaps of greater importance will be legal issues arising around a COVID-19 vaccine. Vaccines, like drug treatments for COVID-19, raise products liability issues (that is, liability for causing harm without proof of negligence). In the case of vaccines, the National Childhood Vaccine Injury Act already shields manufacturers and provides a no-fault compensation scheme for those who suffer vaccine-related injuries. That legislation could provide a useful model for expanded coverage to incentivize maximum participation in vaccination.

State Shields. In addition to the limited federal liability shields, most states provide some type of immunities that apply during declared emergencies and that were enacted prior to COVID-19. Almost all states have adopted some variant of the Model State Emergency Powers Act. Its immunity protects private actors who render "assistance or advice at the request of the State." These existing emergency immunity laws typically were triggered by the state COVID-19 emergency declaration.

A substantial number of states have adopted liability waivers related to the pandemic. The first group of waivers ("health care shields"), adopted as the threat of the pandemic became clearer, provide immunity protections for health care providers. As of early June 2020, 21 states had COVID-19-specific health care shields, some introduced by legislation, most by temporary executive or emergency orders. A second group ("reopening shields"), so far adopted by few states, leans towards more comprehensive immunity for particular industries, such as long-term care and colleges. For example, Utah's statute shields the owners and operators of premises, broadly defined, while Louisiana's first reopening shield applied only to restaurants. Beyond state shields there have been calls for a broad federal shield. Such legislation is unprecedented, would face major obstacles in Congress, and is likely unconstitutional.

Assessment

Liability

The three types of actions we can most safely predict are those alleging negligence against nursing homes and other care facilities, avoidable adverse events that occurred during the height of the pandemic, and disease transmission to consumers of reopening businesses.

Liability shields aside, these are not going to be easy cases to win. Plaintiffs will face difficulty in establishing causation. Given the nature of COVID-19, viral transmission remains possible even where reasonable care is taken; proving that a lack of care caused transmission is therefore problematic. Further, while a concurrent cause, such as a pre-existing lung disease, would not rule out liability, the unique and unknown features of the virus combined with multiple co-morbidities will create problems of proof for many plaintiffs.

Nursing homes admissions contracts frequently include binding arbitration clauses that bar lawsuits. Health care providers also

benefit from decades of state legislative action making them more difficult to sue or reducing damages. Cases that involve care or treatment will often require plaintiffs to introduce expert testimony from other health care providers as to the standard of care. In contrast, cases involving the maintenance of premises, including infection control, are less likely to be classified as professional negligence, leaving the question of "reasonable care" to the jury. The standard of ordinary or professional care also is qualified by the phrase "in all the circumstances." Evidence of extenuating circumstances at the height of the pandemic such as emergency rooms operating well above capacity and shortages of ICU beds and ventilators likely would be admissible to prove the defendant's behavior was reasonable.

Reopening businesses are likely at greater legal risk. Those that cannot comply with reopening protocols because their size or architecture makes social distancing or other established reopening norms impossible face difficult choices. The reasonable care standard, based on balancing risks and benefits, suggests it would be negligent for them to reopen: financial suffering, while real, does not feature in negligence law's analysis. In contrast, those who reopen in conformity with state-level guidelines should be able to point to their compliance as evidence of non-negligence. More difficult questions will arise where plaintiffs argue that local or state guidelines are themselves deficient (or mutually inconsistent) and that they do not reflect reasonable care.

Shields

The effectiveness and appropriateness of the shields turns on their scope. Written as they were during a rapidly emerging pandemic, they are not always clear as to their (usually limited) intent nor do they use common phraseology. Those written during reopening are broader in scope. The scope questions most likely to arise for judicial determination are which cohorts are protected and the extent to which the defendant's conduct must arise from COVID-19 emergency treatment or state ordered mitigation.

Overall, the intent of most of the early provisions is reasonably clear; they are designed to protect front-line health care workers and health care facilities from negligence liability. Almost without exception the shields negate the immunity in cases of willful, criminal, or reckless conduct.

The broadest health care liability shield, and one that that health care provider and nursing home lobbyists reportedly helped draft, is New York's Emergency or Disaster Treatment Protection Act of 2020. It explicitly immunizes health care professionals and facilities, including nursing homes, home care services, and even health care facility administrators and executives. However, most health care shields have narrower lists of protected persons. While generally more restrictive, most shields apply to health care workers and facilities, but few expressly include nursing homes or EMTs.

Perhaps the most difficult interpretative issue and one certain to be litigated, is the extent to which the immunity is tied to or arises from pandemic-related services. For example, most tie the immunity to "providing medical services in support of the state's public health emergency for COVID-19," although few go further, applying to the treatment of "a patient for the illness or condition that resulted in the declared major public health emergency." This "arising from" type of question will lead plaintiffs to argue shields only protect from lawsuits involving emergency triage decisions, mitigation, or treatment efforts. In contrast, defendants such as nursing homes will argue the immunity also applies to liability for acts or omissions that contributed to an outbreak, such as poor hygiene control.

Reopening shields are less likely to pose such interpretative questions. These broad modifications to premises liability will employ language similar to that used in the Utah statute: "a person is immune from civil liability for damages or an injury resulting from exposure of an individual to COVID-19 on the premises owned or operated by the person." However, reopening shields may face constitutional challenges. State tort reforms, particularly medical malpractice reforms, generally have survived due process and equal protection scrutiny. However, those reforms stopped at adding procedural barriers or capping pain and suffering damages. Banning all lawsuits against a large number of businesses is a far more radical step and lacks a strong rationale. It is difficult to see the public interest in immunity when reopening using reasonable care as laid out in public health protocols will better serve the public.

The public interest question goes to the heart of the normative questions raised by liability shields. Liability models (whether framed in strict liability, ordinary negligence, or professional negligence) reflect how we wish to distribute risks between cohorts (e.g., nursing homes and residents). Negligence liability (particularly professional liability) favors defendants over plaintiffs. Defendants such as health care providers and retail businesses can externalize some risks through the purchase of liability insurance, while injured patients and consumers have no equivalent mechanisms beyond the uncertainties surrounding their own health insurance. Does a pandemic require recalibration of those models to further favor defendants?

The easiest question to answer is the call for immunity from the nursing home industry. Nursing homes did not cause the pandemic, but poor infection control, inadequate staffing and sluggish mitigation allowed the virus to spread. And skilled nursing homes have received a $4.9 billion distribution from the CARES provider fund. There is no evidence that the lawsuits filed are "frivolous," the reasonable care standard is overly burdensome, or that damage awards are out of control. This is simply an opportunistic move by an industry with a terrible safety record (Sklar and Terry, 2020).

The question of freeing health care providers from liability while working in emergency rooms and the like is more finely balanced. On one side, there is some evidence that too many facilities were unprepared for any serious emergency. Also, the "in all the circumstances" portion of the reasonable care standard should keep the number of lawsuits in check without any special immunity. Further, there is already abundant evidence that COVID-19 has disproportionally impacted already vulnerable populations and persons of color; should the legal system pile on by immunizing some actors?

On the other hand, the way clinicians were pressed into service in northeastern states suggests that it is appropriate to cut off liability predicated on technical issues such as a lack of licensure in that state or exceeding the scope of practice. Recalibration is particularly meritorious in cases of volunteers drafted in from other states who may not have liability coverage in the state they end up working. It may also be appropriate to reduce the malpractice anxiety for providers facing novel and extreme conditions, like reusing PPE, or having to prioritize one patient's survival over another's, that neither training nor customary standards address.

Finally, there are some arguments in favor of reopening shields. To a large extent calls for shields are born of uncertainty about what precautions will protect from liability. Some, but by no means the majority of states are performing data-driven reopening with calibrated safeguards. To what extent do liability rules synchronize with those policies? Are the risks liability rules impose on businesses inconsistent with reopening, thus justifying a shield? Will immunities for businesses encourage customers or drive them further away?

The answer, of course, depends on the shield. Blanket immunities protect irresponsible businesses at the expense not only of their consumers but also their responsible competitors. Equally, equity considerations suggest that, if any businesses should be shielded, they should not be large, well-resourced corporations but small locally-owned ones owned by those in the community. While the sensible conclusion must be that the reasonable care standard is appropriate even (and maybe even particularly) in a pandemic, non-blanket reopening immunities may have a role to play. Legislation that premises immunity on compliance with generally accepted reopening standards, such as those from the CDC are more appropriate. However, to keep the playing field level, the burden of showing compliance with external, objective standards should remain with the business seeking to rely on them.

Recommendations for Action

Federal government:

- There is no evidence that a broad federal shield is necessary. Demands for such not only are unwarranted but also typify unconscionable, opportunistic behavior by industries with poor safety records.
- A broad federal shield is unprecedented, would face major obstacles in Congress, and is likely unconstitutional.
- Any limited immunity granted at the federal level (for example, to protect vaccine manufacturers and prescribers) should be carefully calibrated and include a federal compensation scheme.

State governments:

- Calls for broader immunity shields should be resisted, particularly where the conduct for which the shield is sought was not in mitigation of the pandemic but actually increased the transmission.
- State policymakers would better serve businesses and other stakeholders not by providing immunity from unreasonable care but by reducing uncertainty with transparent, data-driven guidance on reopening and allowing that to inform the existing and appropriate reasonable care standard.

Courts:

- Should interpret emergency COVID-19 shields narrowly to avoid creating unjustifiably broad immunities, recognize they were designed to protect front-line workers during a limited period of unprecedented demand, stress, and shortness of supplies.
- Should carefully scrutinize the constitutionality of shields and not show the same deference to legislative action given to malpractice reform.
- Courts should void the exculpatory clauses being inserted into theme park and other contracts. First, they should be denied applicability unless they explicitly exclude liability for failing to take reasonable care. Second, where they impact services of general public interest (such as political rallies) or necessity they fall outside the narrow category of recreational activities and should be voided.

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