When the wrong people are immune

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AFTER CATASTROPHE, WE SEEK INDIVIDUALS TO BLAME

After a disaster such as the COVID-19 pandemic, there will be an irresistible desire to blame others. People will attribute intentionality to actions that were purely accidental and deem people careless for failing to prevent unforeseeable harms.1 Even assessments of causation will be influenced by whether we think someone acted selfishly.2 We will blame our neighbors for going to the grocery store without wearing masks. We will blame those who hoarded pallets of toilet paper. We will blame the Chinese. We will blame the broken health care system. We will blame the physician who ignored our appeals for a ventilator for our dad. After so much death, we may even blame God. The post-mortems will frustratingly attempt to identify the cause of this catastrophe, as if there were that simple.

THE PRIMARY TARGET OF OUR BLAME SHOULD BE THE PRESIDENT AND HIS ADMINISTRATION

Hopefully, in the midst of this powerful need to blame, we will not forget who the primary target of our outrage should be—our federal executive branch. We are only

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1 Mark Alicke, Blaming Badly, 8 J. of Cognition and Culture 179 (2008).

2 Joshua Knobe and Scott Shapiro, Proximate Cause Explained: An Essay in Experimental Jurisprudence, forthcoming in the University of Chicago Law Review, https://ssrn.com/abstract=3544982 or http://dx.doi.org/10.2139/ssrn.3544982, at 16–17; see also Fiery Cushman, Joshua Knobe, & Walter Sinnott-Armstrong, Moral Appraisals Affect Doing/Allowing Judgments, 108 COGNITION 281 (2008).
midway through the crisis, and it is already quite clear that the president’s response has been nothing short of reckless.\textsuperscript{3} He has made a number of notable missteps that may have exacerbated the death toll; to make this plain I will canvass just a few of them here. Rather than immediately using the Defense Production Act to order companies to produce needed tests and medical supplies, the president downplayed the seriousness of the virus.\textsuperscript{4} The failure to immediately develop testing capacity led directly to an inability to conduct effective contact tracing. When tests were initially developed by the Centers for Disease Control (CDC), they were determined to be contaminated due to sloppy laboratory procedures.\textsuperscript{5} Other laboratories began developing reliable tests for the virus, but the CDC wanted to be the sole source, and Federal Drug Administration (FDA) regulations that required emergency use authorization were slow to be approved.\textsuperscript{6} These initial testing failures allowed the virus to quietly spread among the many who are asymptomatic.\textsuperscript{7} Due to the termination of the senior director for global health security and biodefense in 2018, there has not been a coordinated, authoritative federal response.\textsuperscript{8} Doctors have complained that they are not looking to the CDC for trustworthy data, and are instead relying on more informal networks and non-governmental publications.\textsuperscript{9}

The president also frequently misstated the availability of testing, leading people to bombard their local health care facilities for tests that they did not have.\textsuperscript{10} Regarding treatment, the President later claimed that the FDA had approved a ‘game-changer’ drug (hydroxychloroquine), despite the FDA later correcting that the drug was still

\textsuperscript{3} Ed Yong, How the Pandemic Will End, The Atlantic, Mar. 25, 2020, https://www.theatlantic.com/health/archive/2020/03/how-will-coronavirus-end/608719/.

\textsuperscript{4} Zolan Kanno-Youngs and Ana Swanson, Wartime Production Law Has Been Used Routinely, but Not With Coronavirus, NY Times, Mar. 31, 2020, https://www.nytimes.com/2020/03/31/us/politics/coronavirus-defense-production-act.html.

\textsuperscript{5} Sheila Kaplan, C.D.C. Labs Were Contaminated, Delaying Coronavirus Testing, Officials Say, NY Times, Apr. 18, 2020, https://www.nytimes.com/2020/04/18/health/cdc-coronavirus-lab-contamination-testing.html.

\textsuperscript{6} Bob Ortega, Scott Bronstein, Curt Devine, and Drew Griffin, How the government delayed coronavirus testing, CNN, Apr. 9, 2020, https://www.cnn.com/2020/04/09/politics/coronavirus-testing-cdc-fda-red-tape-inv/index.html.

\textsuperscript{7} David Frum, This is Trump’s Fault, Apr. 7, 2020, The Atlantic, https://www.theatlantic.com/ideas/archive/2020/04/americans-are-paying-the-price-for-trumps-failures/609532/.

\textsuperscript{8} Liz Alesse, Did Trump try to cut the CDC’s budget as Democrats claim?: ANALYSIS, ABC News, Feb. 28, 2020, https://abcnews.go.com/Politics/trump-cut-cdcs-budget-democrats-claim-analysis/story?id=69233170 (“The president fired the pandemic specialist in this country 2 years ago,” former NYC mayor Michael Bloomberg said. “So, there’s nobody here to figure out what the hell we should be doing.”)

\textsuperscript{9} Robert Baird, How Doctors on the Front Lines Are Confronting the Uncertainties of COVID-19, The New Yorker, Apr. 5, 2020, https://www.newyorker.com/science/medical-dispatch/how-doctors-on-the-front-lines-are-confronting-the-uncertainties-of-covid-19?itm_content=footer-recirc.

\textsuperscript{10} Meg Kelly, Sarah Cahan and Elyse Samuels, What went wrong with coronavirus testing in the U.S., Washington Post, Mar. 30, 2020, https://www.washingtonpost.com/politics/2020/03/30/11-100000-what-went-wrong-with-coronavirus-testing-us/ (On March 6th, President Trump: “Anybody that needs a test, gets a test. They’re there. They have the tests. And the tests are beautiful.”).
being tested for safety and efficacy.\textsuperscript{11} His frequent false statements led many to call for the networks to stop broadcasting his press-briefings.\textsuperscript{12}

Even worse, he created a bidding war between states for much needed supplies like masks and ventilators,\textsuperscript{13} with his administration apparently doling them out preferentially to the states who had given him political support.\textsuperscript{14} While private businesses stepped into the void to begin producing hand sanitizer and ventilators, White House officials “doubled down on proposed cuts to health services and the Centers for Disease Control and Prevention (CDC)”.\textsuperscript{15} Then, perhaps to deflect from these gross errors, he puzzled everyone by announcing he would be defunding the World Health Organization in the midst of the largest pandemic of our lifetimes, while he investigated its mismanagement of the coronavirus.\textsuperscript{16} This move was described by experts as ‘counterproductive’ and “leav[ing] the U.S. and the world less safe.”\textsuperscript{17}

He then claimed he had ‘total’ authority to mandate a premature reopening of the state economies, which went against his health expert’s advice, and notably the US Constitution.\textsuperscript{18} When armed individuals in Michigan, Minnesota, and Virginia protested the continued social distancing orders and closure of non-essential businesses, he appeared to encourage insurrection, tweeting “LIBERATE VIRGINIA, and save your great 2nd Amendment. It is under siege!”\textsuperscript{19}

\textsuperscript{11} Shannon Pettypiece, \textit{Trump’s coronavirus claims have not matched response reality}, NBC News, Mar. 20, 2020, https://www.nbcnews.com/politics/white-house/trump-s-coronavirus-claims-haven-t-matched-response-reality-n1164041. During an official briefing, the President also infamously suggested that ingesting disinfectants or ultra-violet rays might be a promising treatment, despite this being a dangerous and unapproved treatment. He later said that these remarks were meant to be “sarcastic.” See, Sheera Frenkel and Davey Alba, \textit{Trump’s Disinfectant Talk Trips Up Sites’ Vows Against Misinformation}, NY Times, Apr. 30, 2020, https://www.nytimes.com/2020/04/30/technology/trump-coronavirus-social-media.html.

\textsuperscript{12} Chantal da Silva, Over 200,000 Sign Petition Calling for End to Live Coverage of Trump’s Coronavirus Briefings Newsweek, Mar. 31, 2020, https://www.newsweek.com/nearly-100000-sign-petition-calling-end-live-coverage-trumps-coronavirus-briefings-1495195.

\textsuperscript{13} Jeanne Whelan et al., \textit{Scramble for medical equipment descends into chaos as U.S. states and hospitals compete for rare supplies}, Washington Post, Mar. 24, 2020, https://www.washingtonpost.com/business/2020/03/24/scramble-medical-equipment-descends-into-chaos-us-states-hospitals-compete-rare-supplies/.

\textsuperscript{14} Manu Raju, \textit{Colorado Democrat believes Trump awarded ventilators as political favor to vulnerable GOP senator}, CNN, Apr. 9, 2020, https://www.cnn.com/2020/04/08/politics/degette-gardner-trump-ventilators-favor/index.html (“Process employed by the White House shows that the President appears to be doling out the ventilators to his allies at a time when the virus is affecting people of all political persuasions.”)

\textsuperscript{15} Niv Elis, \textit{Trump budget chief holds firm on CDC cuts amid virus outbreak}, The Hill, Mar. 10, 2020, https://thehill.com/policy/finance/486817-trump-budget-chief-holds-firm-on-cdc-cuts-amid-virus-outbreak.

\textsuperscript{16} Kai\textsuperscript{1} Kupferschmidt, Jon\textsuperscript{2} Cohen, ‘Short-sighted.’ Health experts decry Trump’s freeze on U.S. funding for WHO as world fights pandemic, \textit{Science Magazine}, Apr. 14, 2020, https://www.sciencemag.org/news/2020/04/trump-freezes-us-funding-who-world-fights-pandemic#.

\textsuperscript{17} Kai\textsuperscript{1} Kupferschmidt, Jon\textsuperscript{2} Cohen, ‘Short-sighted.’ Health experts decry Trump’s freeze on U.S. funding for WHO as world fights pandemic, \textit{Science Magazine}, Apr. 14, 2020, https://www.sciencemag.org/news/2020/04/trump-freezes-us-funding-who-world-fights-pandemic#.

\textsuperscript{18} Adam Taylor et al, \textit{Trump endorses ending coronavirus social distancing soon, against health experts’ advice}, Washington Post, Mar. 23, 2020, https://www.washingtonpost.com/world/2020/03/23/coronavirus-latest-news/.

\textsuperscript{19} Ben Collins and Brandy Zadrozny, \textit{In Trump’s ‘LIBERATE’ Tweets, Extremists See a Call to Arms}, NBC News, Apr. 17, 2020, https://www.nbcnews.com/tech/security/trump-s-liberate-tweets-extremists-see-call-arms-n1186561.
GOVERNMENT IMMUNITY INSULATES WRONGDOING

Lamentably, despite being the primary mistake-maker here, the federal government itself will enjoy broad immunity, and will be essentially protected from any tort liability related to its COVID-19 response. The concept of sovereign immunity derives from English law, where it was assumed that “the King can do no wrong.” Since the 13th century, the English monarchy could not be sued unless it agreed to waive immunity. The concept was somewhat clumsily borrowed and applied to our federal and state governments in the USA, despite our emphatic rejection of an unaccountable Crown.

There are principled justifications to federal sovereign immunity. Namely, the separation of powers supports executive agency policy decisions being protected from being second-guessed by the courts. Immunity may also be defended on instrumental grounds, as the government’s motive is to protect the general welfare, and not to maximize profits and avoid liability. While these claims have merit, there are even more powerful counterarguments, which go to the very structure and purpose of our democratic government. Erwin Chemerinsky has effectively argued that the doctrine is an ‘anachronistic relic’ and that “[n]o government - federal, state, or local - should be accorded sovereign immunity in any court.” He bases his claim on both functional and historical accounts of the Constitution. According to this view, democratic principles require maximizing governmental accountability, not reducing it, and the courts can provide an important check on the power and mismanagement of the federal government. To be sure, the presence of broad immunity may encourage defendants to “push the doctrine to its limits.” That is, knowing that immunity exists may incentivize reckless and authoritarian behavior. For this reason, immunity should be as narrow as possible to effect its policy rational. It works best when it insulates individuals from even the prospect of a lawsuit for actions that are objectively reasonable.

20 Erwin Chemerinsky, Shifting the Balance of Power? The Supreme Court, Federalism, and State Sovereign Immunity: Against Sovereign Immunity, 53 Stan. L. Rev. 1201, 1201 (2001).
21 Jameson B. Bilsborrow, Keeping the Arms in Touch: Taking Political Accountability Seriously in the Eleventh Amendment Arm-of-the-state doctrine, 64 Emory L.J. 819, 819 (2015).
22 Lawrence Rosenthal, A Theory of Governmental Damages Liability: Torts, Constitutional Torts, and Takings, 9 U. Pa. J. Const. L. 797, 798–799 (2007). This author also supports immunity on corrective justice grounds, as “the government passes its legal costs along to the taxpayers, who bear little meaningful culpability for the underlying tortious conduct . . .” However, this assumes that corrective justice is all about punishment, as opposed to also being about compensation for plaintiffs. Immunity cannot be justified on grounds of compensating individual victims of government wrongs.
23 Erwin Chemerinsky, Shifting the Balance of Power? The Supreme Court, Federalism, and State Sovereign Immunity, Against Sovereign Immunity, 53 Stan. L. Rev. 1201, 1201 (2001).
24 See, Erwin Chemerinsky, Shifting the Balance of Power? The Supreme Court, Federalism, and State Sovereign Immunity, Against Sovereign Immunity, 53 Stan. L. Rev. 1201, 1206 (2001); see also Paul Gowder, The Rule of Law Against Sovereign Immunity in a Democratic State, 93 Tex. L. Rev. Online 247, 255 (2015); and Eric Berger, The Collision of the Takings and State Sovereign Immunity Doctrines, 63 Wash & Lee L. Rev. 493, 548–549 (2006).
25 Katherine Florey, Sovereign Immunity’s Penumbras: common law, accident, and the policy in the development of sovereign immunity doctrine, 43 Wake Forest L. Rev. 765, 769 (2008).
26 This is particularly concerning given that the president has been making more statements in recent weeks indicating he believes the executive to be beyond reproach and to have complete authority: (President Trump: “when somebody is the president of the United States, the authority is total.”) See, Meghan Flynn & Allyson Chiu, Trump says his ‘authority is total.’ Constitutional experts have ‘no idea’ where he got that, WASHINGTON POST, Apr. 14, 2020, available online at [x].
under the circumstances. It works much less well when it is shielding individuals from accountability for gross negligence or abuse of discretion.\(^{27}\)

Recognizing that fairness dictates that the federal government should waive immunity in some instances, Congress passed the Federal Tort Claims Act (FTCA) in 1946.\(^{28}\) In theory, the FTCA allowed private citizens to sue the federal government for civil damages when it acted like a private party.\(^{29}\) However, the statute retains immunity in so many cases of intentional wrongdoing that in practice it continues to be quite difficult to obtain damages from the federal government.\(^{30}\)

Of relevance here, when the federal government or its agencies perform a discretionary function or duty, there is no waiver of immunity under the FTCA even if that discretion is found to be abused.\(^{31}\) Discretionary acts are those that “involve[e] an element of judgment or choice,” rather than an official merely following a directive.\(^{32}\) They thus cover a wide range of government activity. Most of the federal government’s response to COVID-19 would be described as ‘discretionary,’ as there was no rulebook dictating particular moves. Thus, immunity would not be waived, and those injured by the government’s failures cannot sue for tort damages.\(^{33}\)

While the chief mismanagement appears to be on the federal level, there are even greater barriers to holding state governments accountable should one desire to do so. States have government immunity statutes similar to the FTCA that typically retain immunity for discretionary functions. However, even if a plaintiff was able to describe a specific, non-discretionary duty that was breached, she would likely still lose due to the common law ‘public duty’ doctrine.

The public duty doctrine holds that because governments owe a duty of care to every citizen, they do not owe a duty to any one particular citizen. Both state and federal courts have interpreted this to mean that government officials such as emergency

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\(^{27}\) Thus, there is no principled reason to immunize private businesses from tort liability for behavior that might be considered objectively careless under the circumstances. See, Natalie Andrews, Mitch McConnell Wants to Shield Companies From Liability in Coronavirus-Related Suits, WASHINGTON POST, Apr. 29, 2020, https://www.wsj.com/articles/house-delays-return-to-capitol-amid-uncertainty-over-next-round-of-coronavirus-stimulus-11588091849.

\(^{28}\) 28 USCS § 2671 (West 2020).

\(^{29}\) United States v. Olson, 546 U.S. 43, 47, 126 S. Ct. 510, 513, 163 L. Ed. 2d 306 (2005).

\(^{30}\) Katherine Florey, Sovereign Immunity’s Penumbras: common law, accident, and policy in the development of sovereign immunity doctrine, 43 WAKE FOREST L. REV. 765, 765 (2008); For example, the FTCA exempts from waiver any claims "for damages caused by the imposition or establishment of a quarantine by the United States." See, 28 U.S.C.A. § 2680 (West) It also exempts actions for intentional wrongdoing like false imprisonment and battery. Even if the federal government or agencies intentionally misrepresented facts or deceived people, there would be no waiver of immunity. See, 28 U.S.C.A. § 2680(h) (2020).

\(^{31}\) 28 U.S.C. § 2680(a).

\(^{32}\) Dalehite v. United States, 346 U.S. 15, 33 (1953); see also United States v. Gaubert, 499 U.S. 315, 322 (1991).

\(^{33}\) Where the discretionary function exception applies, individuals would need to show that a government official violated their “clearly established” civil rights, which is a tall order, in order to pursue a remedy under 42 U.S. Section 1983. See, Bivens v. Six Unknown Named Agents of Fed. Bureau of Narcotics, 403 U.S. 388 (1971) See also, Howlett v. Rose, 496 U.S. 356, 358, 110 S. Ct. 2430, 2433 (1990) (holding that a state’s invocation of sovereign immunity when the petitioner alleges colorable Fourth Amendment claims violated the supremacy clause of the Constitution). Section 233(a) of the Public Health Service Act “grants absolute immunity to PHS officers and employees for actions arising out of the performance of medical or related functions within the scope of their employment by barring all actions against them for such conduct.” See, Hui v. Castaneda, 559 U.S. 799, 806 (2010); In some cases, even a Bivens remedy is precluded, such as when public health service officers or employers are sued under the Public Service Act.
responders cannot be sued in tort when they fail to perform their duties, such as sending aid in response to a 911 call. If there was no direct contact or assurance of aid to a particular individual, then there was no duty for the dispatcher, for example, to perform her functions. The public duty doctrine has astonishing consequences, and often insulates the police, emergency responders, and many state agencies from being accountable for their negligence or wrongdoing. There is nothing to suspend this doctrine during public health emergencies, and in fact, the emergency situation is likely to expand its application.

1. Political Consequences Are Insufficient

To summarize, as a result of both the discretionary function exception and the public duty doctrine, we can expect that injured individuals will not be able to seek adequate legal recourse from our federal or state governments for their failure to respond appropriately to the pandemic. Thus, one of the only ways the federal government will be accountable for wrongdoing will be if the president suffers political consequences in the next election. Relying solely on political accountability is worrisome, however.

For one, political accountability has been significantly watered down in the last decade, in part due to almost unlimited corporate money in political campaigns, and the distortions of representation in the electoral college. This is also fueled by information asymmetry; we cannot assume that the electorate has the bandwidth to pay attention to the many conflicting news stories and evidence of political wrongdoing. Political accountability requires a great deal of focus and time that many voters simply do not have. This may be in part why it has taken considerable presidential mismanagement to move the needle at all. The president’s approval ratings were at an all-time high despite some major mistakes in his response to COVID-19. They only very recently have started to decline. Importantly, however, even if the president suffers significant political consequences from his mishandling of the pandemic, almost none of this will trickle down to the agency executives or career bureaucrats who did his bidding. While political accountability in theory provides a check on shoddy political decision-making, it provides a very weak check on agencies.

Perhaps most important of all, political accountability, even if perfect, does absolutely nothing to compensate those who were individually injured by executive recklessness. The need to compensate injured parties provides the strongest basis for remov-

34 Deborah J. Brooks, and Michael Murov, Assessing Accountability in a Post-Citizens United Era: The Effects of Attack Ad Sponsorship by Unknown Independent Groups, 40 American Politics Research, 383–418 (2012).

35 Katherine Florey, Losing Bargain: Why Winner-Take-All Vote Assignment Is the Electoral College’s Least Defensible Feature, 68 Case W. Res. L. Rev. 317, 328 (2017).

36 Despite the documented failures on the part of the federal government to respond to COVID-19, as of April 16th, 43 per cent of American adults still approve of the way Trump is handling his job as president, while 54 per cent say they disapprove. See, Justin Wise, Trump job approval slips 6 points in past month: poll, The Hill, available online at https://thehill.com/homenews/administration/493165-trump-job-approval-slips-6-points-in-past-month-poll.

37 “[S]ome policy decisions must be insulated from politics — and, conversely, that insulating decisions too much creates accountability problems.” Miriam Seifter, Understanding State Agency Independence, 117 Mich. L. Rev. 1537, 1541 (2019).

38 Lisa Schultz Bressman & Robert B. Thompson, The Future of Agency Independence, 63 Vand. L. Rev. 599, 600 (describing the desired insulation of independent agencies, as compared to executive agencies).
ing immunity. If government is responsibly conducting their risk benefit analyses, there will not be many plaintiffs seeking compensation. But the complete lack of a remedy for carelessly inflicting personal harm flies in the face of our democratic principles of government.

TARGETED IMMUNITY FOR PARTICULAR GROUPS

In addition to governmental immunity, there are a patchwork of immunities that attach to various groups for their undertakings in response to COVID-19. On March 17th, the Secretary of Health and Human Services issued an emergency declaration that triggered broad immunity protections contained in the Public Readiness and Emergency Preparedness Act (PREP Act) of 2005.39 This Act immunizes, from all federal and state lawsuits, health care professionals who administer or use specified countermeasures as antiviral medications during declared public health emergencies such as COVID-19.40 So long as health care providers administer the approved treatments during the window of the declared emergency, they can only be liable under the PREP Act if they engaged in willful misconduct.41

Some states have passed similar immunity for providers who prescribe unapproved drugs, such as hydroxychloroquine.42 This is concerning. Immunity should be used to remove the threat of a lawsuit when providers act in ways that are objectively reasonable, given the circumstances. Prescribing treatments that are not yet proved to be safe or effective, even in a pandemic, could violate the standard of care. Therefore, this is not the kind of conduct that should be categorically protected from tort liability.43

On March 27th, the president signed the “Coronavirus Aid, Relief, and Economic Security Act” (CARES Act) into law.44 The Act provides broad liability immunity for companies that manufacture respiratory protective devices. It also preempts state law to immunize volunteer health care workers from tort liability for negligence in actions or omissions in the course of providing volunteer health care services related to COVID-19.45 The constitutionality of the latter preemption will no doubt be challenged, as the states typically regulate intrastate tort liability. Indeed, most states already

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39 Public Readiness and Emergency Preparedness Act, 42 U.S.C.A. § 247d-6d (West 2020).
40 https://www.govinfo.gov/content/pkg/FR-2020-03-17/pdf/2020-05484.pdf, https://www.phe.gov/Preparedness/legal/prepact/Pages/default.aspx.
41 42 U.S.C.A. § 247d-6d (West).
42 Utah Emergency Health Care Access and Immunity Amendments, https://legiscan.com/UT/text/SB3002/2020/X3; see also Associated Press, Utah Buys Malaria Drugs Touted by Trump, Panned by Doctors, Apr. 21, 2020, https://www.usnews.com/news/best-states/utah/articles/2020-04-21/utah-buys-malaria-drugs-touted-by-trump-panned-by-doctors.
43 The Utah statute places the burden on the individual patients, by suggesting that so long as they provide informed consent, immunity is appropriate for prescribing unapproved medications. This appears to be linked with the “Right to Try” movement. However, there are sound reasons why we do not permit individuals to be treated with medications that are not proved as safe or effective, even if an individual’s cost-benefit analysis skew toward welcoming greater risk, and we certainly should not absolve providers from liability when their off-label use is negligent. See, Abigail All. for Better Access to Developmental Drugs v. Von Eschenbach, 373 U.S. App. D.C. 386, 389 (2006).
44 S.3548—CARES Act 116th Congress (2019–2020), https://www.congress.gov/bill/116th-congress/senate-bill/3548/item55570/text.
45 See, Section. 4216. Limitation on liability for volunteer health care professionals during covid-19 emergency response, CARES ACT, https://www.congress.gov/bill/116th-congress/senate-bill/3548/text#toc-idSB4AC6639BF64A26916E41980A9BC7EB.
immunize volunteer health care workers for carelessness when they respond to an emergency. 46 Even so, the immunity provisions in the PREP and CARES Acts speak to Congressional recognition that the fear of liability might stymie our pandemic response, both at the state and federal levels.

2. Paid Health Care Providers Are Left Out from These Targeted Immunity Provisions

Of all of the predictable defendants to be sued after a pandemic, there is one group that is glaringly absent from this list: non-volunteer health care workers. 47 Even when they work for a state hospital, nurses, and physicians are typically not protected under the state’s governmental immunity, as they “exercised medical judgment, regardless of whether it related to policy decision.” 48 As parties will be looking for someone to hold accountable for the terrible outcomes they have experienced, physicians are the only group that is out in front, with enormous bullseyes on their backs.

This situation is particularly distressing as there is a huge asymmetry between the risks health care workers are undertaking, and the legal protections afforded them. Due to multiple government failures in the early days of SARS-cov-2 virus, physicians and nurses have been rendered particularly vulnerable. In addition to not being able to be tested themselves before reporting to be overworked in the ICUs, shortages in personal protective equipment have exposed many of them to the deadly virus. 49 Nearly 20 percent of all confirmed COVID-19 cases in the USA are in health care workers, 50 and worldwide more than a hundred have died so far from the infection. 51

What’s more, again due in part to government failures, some hospital’s resources may soon be overwhelmed—with insufficient ventilators, blood products, and personnel to meet the demand. Physicians may have to decide whom to admit, whom to ventilate, and whom to treat with extracorporeal membrane oxygenation (ECMO). Ad hoc decision-making leads to discrimination against people of color, people with

46 “Many jurisdictions extend immunity to all persons administering emergency care; others limit coverage to specified medical personnel, or to physicians alone.” See, Danny R. Veilleux, Construction and application of “good Samaritan” statutes, 68 A.L.R.4th 294 (Originally published in 1989).

47 Immunity is often discussed in terms of physicians, because nurses and physician assistants are typically indemnified by their employer, and their negligence is imputed to the attending physician or institution. However, where health care providers are independently overseeing clinical care, they too could be sued for medical malpractice; thus, the targeted immunity should cover them as well.

48 See, Lather v. Beadle County, 879 F.2d 365 (8th Cir. 1989).

49 Somini Sengupta, A NY. Nurse Dies. Angry Co-Workers Blame a Lack of Protective Gear, NY Times, Mar. 26, 2020, https://www.nytimes.com/2020/03/26/nyregion/nurse-dies-coronavirus-mount-sinai.html; Michael Rothfeld et al., 13 Deaths in a Day: An ‘Apocalyptic’ Coronavirus Surge at an NYC Hospital, New York Times, Mar. 25, 2020, https://www.nytimes.com/2020/03/25/nyregion/nyc-coronavirus-hospitals.html; see also, Hannah Rappleye, Andrew W. Lehren, Laura Strickler and Sarah Fitzpatrick, ‘This system is doomed’: Doctors, nurses sound off in NBC News coronavirus survey, NBC News, Mar. 20, 2020, https://www.nbcnews.com/news/us-news/system-doomed-doctors-nurses-sound-nbc-news-coronavirus-survey-n1164841.

50 Centers for Disease Control and Prevention, Characteristics of Health Care Personnel with COVID-19—United States, February 12–April 9, 2020, Apr. 17, 2020, https://www.cdc.gov/mmwr/volumes/69/ww/mm6915e6.htm?s_cid=mm6915e6_x “Among 315,531 U.S. COVID-19 cases reported to CDC during February 12–April 9, data on HCP occupational status were available for 49,370 (16 per cent), among whom 9282 (19 per cent) were identified as [health care providers].

51 Medscape, In Memoriam: Healthcare Workers Who Have Died of COVID-19, Apr. 1, 2020, https://www.medscape.com/viewarticle/927976.
disabilities, and people who simply lack the entitlement to question their denial of care. It also places significant moral responsibility on the individual physician, who may struggle to shoulder this weight.

3. Rationing Policies, and Lack of Institutional Policies, Expose Physicians to Liability

To encourage more ethical decision-making and relieve the pressure on individual physicians, several working groups, states, and institutions have developed triage protocols, or Crisis Standards of Care plans (CSCs) based on different notions of distributive justice. For example, the American College of Chest Physicians (CHEST) Task Force for Mass Critical Care has published suggestions for rationing ICU beds and treatments that have been adopted by some institutions. According to this consensus statement, patient groups with a life expectancy of less than 1 year or with a predicted mortality rate of over 90 per cent should not be admitted to an ICU when resources are overwhelmed during a pandemic. Other protocols prioritize short-term clinical factors, but then suggest using life-cycle considerations as a tiebreaker, with priority going to younger patients. There is a robust debate occurring about the ethics and potential illegal discriminatory impacts of these policies. The purpose of this article is not to advocate for a particular framework, but rather to provide legal immunity for physicians who make decisions in compliance with a documented policy. If an institution has no documented policy, and leaves rationing up to the individual physician, they expose both the physician and the institution to legal liability from discriminatory or substandard decisions. Implementing a policy that complies with anti-discrimination law is prudent in these situations to reduce this risk.

Despite strong recommendations to do so, many institutions have failed to develop CSCs, or if they have their specific requirements are unclear. Even hospitals that have developed plans are struggling with how to incorporate emerging data regarding

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52 Necia Hobbes, Out of the Frying Pan Into the Fire: heightened discrimination and reduced legal safeguards when pandemic strikes, 72 U. Pitt. L. Rev. 779, 784 (2011).
53 The psychological impacts of treating COVID-19 patients have proved to be devastatingly real. See, Eric Levenson, Stress on health care workers is creating ‘second victims’ in the coronavirus pandemic, CNN, Apr. 29, 2020, https://www.cnn.com/2020/04/29/us/coronavirus-health-care-mental-health/index.html.
54 While the initial emphasis of these protocols was on rationing ventilators, the propriety of mechanical ventilation for COVID-19 patients is being questioned, and rationing for future outbreaks might focus instead on nursing resources, beds, and other medications such as sedation or antivirals.
55 Michael D. Christian et al., Care of the Critically Ill and Injured During Pandemics and Disasters: CHEST Consensus Statement, 146 CHEST e61S–74S (2014) Policies vary, and could advocate for prioritization based on different grounds, such as need, equity, or protecting the most vulnerable. See, James Tabery et al., Ethics of Triage in the Event of an Influenza Pandemic, 2 DISASTER MED PUBLIC HEALTH PREPAREDNESS, 114–118 (2008).
56 Douglas White and Bernard Lo, A Framework for Rationing Ventilators and Critical Care Beds During the COVID-19 Pandemic, J. AM. MED. ASSOC. Mar. 27, 2020. DOI: 10.1001/jama.2020.5046.
57 Colorado Department of Public Health and Environment. CDPHE All Hazards Internal Emergency Response and Recovery Plan: Annex B: Colorado Crisis Standards of Care Plan. Published 2018 (accessed Mar. 21, 2020).
58 This proposal does nothing to alter liability under federal statutes such as 42 US Section 1983, or anti-discrimination law, such as that contained in Section 1557 of the Affordable Care Act. See, 42 U.S.C. §18116 (2020).
59 “[A]uthorities should ensure that there is a legislative framework and structure to support critical care triage. The legislative and legal frameworks to address issues, especially rationing, during a disaster or public health emergency are highly complex and in many jurisdictions, are unclear or nonexistent.” See Michael D. Christian
COVID-19 risk factors and urgent requests for deviation from the protocol. While often not part of any CSC, there is also the problem with a kind of ‘soft’ rationing, where patients are not even offered transfers from a nursing home to an ICU. The lack of institutional or legal guidance leaves a lot of unwanted discretion within the hands of individual doctors. For example, if an institution supports a ‘lottery’ system once near-term survival is taken into account, it is not clear how that would actually be operationalized in practice.

There are only so many physicians and nurses, and only so many beds. The possibility of a medical malpractice lawsuit will do nothing to prevent the need to ration. If there is only one ICU bed available, and 10 patients vying for it, the possibility of ex post tort liability will not instantly create nine more beds. Perhaps if the government could be accountable for this failure, more beds and ventilators could be produced or reallocated from regions that are not as hard hit by COVID-19. But the physicians on the frontlines cannot be expected to create additional resources while fighting this pandemic. The normal incentives of deterrence will thus not work to create better rationing or to remove the need for rationing. Indeed, the possibility of liability will only make the necessary rationing more discriminatory and unfair, as physicians cater to the loudest, wealthiest, or most educated patients who fight the hardest, and who seem most likely to sue.60

4. COVID-19 Specific Protocols Expose Health Care Workers to Liability

There will be many institutional policies related to COVID-19 that will expose individual physicians to liability, and these instances may be even more common than the need to ration scarce resources. 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-19.61 For example, during cardiac resuscitation some physicians are being told that all patients must be intubated, rather than using manual 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-19.62 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

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60 For an argument against providing immunity for health care providers in these situations (though focusing on volunteers) see George Annas, Standard of Care—In Sickness and in Health and in Emergencies, 362v N Eng. J. Med 2126 (2010).
61 “[B]y definition, the standard of care in an emergency would take into account the exigent conditions in which providers were working.” See, Sharona Hoffman, Responders’ Responsibility: Liability and Immunity in Public Health Emergencies, 96 Geo. L.J. 1913, 1926 (2008).
62 Cath Lab Digest, Data Shows Reduction in U.S. Heart Attack Activations During COVID-19 Pandemic, Apr. 10, 2020, https://www.cathlabdigest.com/content/data-shows-reduction-us-heart-attack-activations-during-covid-19-pandemic.
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. This is done both to reduce the risk of the immune-compromised from being infected at the hospital, as well as to reserve ventilators and beds for COVID-19 patients who might later need them. Of course, prognosticating is difficult, and physicians have no crystal ball to assess whether an individual patient really can wait several weeks before having a tumor resected or fluid drained. It is possible that patients who had a delayed diagnosis or treatment might sue the physicians who made this call, if it turns out not to have been clinically appropriate for them. While these decisions might all be perfectly reasonable during a pandemic, the fear (or reality) of having to defend these utilitarian decisions in court might add undue stress on the physicians who are doing their best to follow state or institutional policy. The value of immunity comes not just from rejecting the second-guessing of emergency decisions that were thrust upon an overwhelmed industry. There is also considerable value in giving physicians peace of mind that the forced choice between two terrible possibilities will not later be penalized in court.

During normal times, emotions run high when a loved one is denied medical treatment or injured during a procedure. The resulting break-down of communication may lead to a lawsuit, as many people will be unhappy with how resources were rationed or decisions made. Under ordinary circumstances, a physician may be liable for a clinical judgment that could foreseeably cause a patient’s death. However, these are not ordinary circumstances, and health care providers are being asked to make impossible decisions that may aid our ability to respond to COVID-19, but which might increase the risk to individual patients. There is often no third option that avoids putting a particular patient at risk to help others. Immunity is appropriate in these situations, where the providers’ decisions are objectively reasonable and defensible ex ante, and for which there would be great psychological value in removing the possibility of suit.

While it might seem unlikely that many families will sue, as they should appreciate that the extenuating circumstances of the pandemic, not all families will be so understanding or reasonable. To be sure, there may be greater distrust of physician decision-making and increased incentives to sue in the wake of this pandemic, as people are more isolated and anxious, and may be suffering from severe economic instability. Additionally, as the social distancing measures cities and states have adopted to “flatten the curve” are working, the lack of a big surge in infections as was seen in New York might anger those patients who assume that the precautionary measures were not necessary.

63 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).
64 Lawrence Gostin et al., Standard of Care—In Sickness and in Health and in Emergencies, response to George Annas, 363 N ENG. J MED 1378 (2010) (“Liability claims can and do flow from emergencies, illustrated by ongoing civil litigation against Dr. Anna Pou and others after Hurricane Katrina.”
65 Kaylee DeWitt, Salt Lake County Mayor Jenny Wilson says social distancing measures are working in flattening the curve, ABC4 News, Apr. 2, 2020, https://www.abc4.com/coronavirus/salt-lake-county-mayor-jenny-wilson-says-social-distancing-measures-are-working-in-flattening-the-curve/; Kristen Schorsch, Chicago
Given this, we can expect that some number of families will claim that a physician who denied their family member treatment, or performed a procedure differently due to COVID-19 precautions, caused them a compensable injury. Depending on the circumstances, a judge and jury may agree. Causation and breach are not discoverable facts of nature, but rather are morally laden and susceptible to hindsight bias. Hindsight bias could be particularly severe here. Cases likely will not be litigated until after the chaos of the pandemic has subsided, which might permit juries to forget just how extenuating the circumstances appeared to be \textit{ex ante}. Therefore, even if physicians were doing their best at the time to fairly allocate resources and follow institutional policies, a jury could find them liable for making an intolerable choice that caused harm. Indeed, even if the possibility of an award is remote, the very prospect of this possibility may create unfair and paralyzing fear for physicians, who as a group already overestimate the risk of being sued.

\textbf{HEALTH CARE PROVIDERS NEED STATE-CONFERRED TORT IMMUNITY WHEN FOLLOWING PROFESSIONAL, INSTITUTIONAL OR STATE POLICIES RELATED TO COVID-19}

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. This would include deviations from normal practice to reduce the risk of SARS-cov-2 transmission, as well as rationing decisions that comply with pre-existing policy directives. Ideally, as part of any emergency response packages that are passed, legislatures should either develop, or require hospitals to develop, protocols for rationing ventilators, ECMO machines, ICU beds, and personnel. It would be best if the policies were mandatory at the state level, to encourage cooperation between health care facilities. Further, and more to the point, when enacting these statutes, legislatures should incorporate tort immunity for health care workers who comply with COVID-19 treatment protocols in good faith. In the absence of a state directive, this article also advocates for immunity for individual physicians when they comply with a recognized professional organization’s guidance related to COVID-19, or institutional policies related to their COVID-19 response. This is not merely to limit the liability of a powerful group. It is to recognize the unbearable situation that health care workers face during a pandemic, which is not at all of their own creation. It is also to recognize that certain decisions might appear unreasonable \textit{ex post}, but they were not unreasonable \textit{ex ante}. Health care providers are

\begin{itemize}
  \item Has ‘Flattened The Curve’ Of COVID-19 Cases, Mayor Lori Lightfoot Says, WBEZ News, Apr. 15, 2020, https://www.wbez.org/stories/chicago-has-flattened-the-curve-of-covid-19-cases-mayor-lori-lightfoot-says/cee77a42-b01f-4138-bf79-d1e681928eed.
  \item Joshua Knobe and Scott Shapiro, \textit{Proximate Cause Explained: An Essay in Experimental Jurisprudence}, forthcoming in the University of Chicago Law Review, https://ssrn.com/abstract=3544982 or http://dx.doi.org/10.2139/ssrn.3544982, at 16–17; see also Fiery Cushman, Joshua Knobe, & Walter Sinnott-Armstrong, \textit{Moral Appraisals Affect Doing/Allowing Judgments}, 108 COGNITION 281 (2008).
  \item Ann Lawthers et al., \textit{Physicians’ Perceptions of the Risk of Being Sued}, 17 J HEALTH POLIT POLICY LAW 463 (1992).
  \item Brooke Courtney et al., \textit{Legal Preparedness: Care of the Critically Ill and Injured During Pandemics and Disasters: CHEST Consensus Statement}, 146 CHEST e134S (2014).
\end{itemize}
When the wrong people are immune

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. We should not put physicians in the position of having to choose between the pre-COVID-19 standard of care, and violating their institutional policies. Importantly, as the hospitals and institutions are the ones making the cost-benefit analysis regarding triage and mandatory intubations, immunity should not attach to them. Patients could still sue institutions and hospitals for policies that, under the circumstances of the pandemic, were not state-mandated and were objectively unreasonable.

There is precedent for this sort of immunity. Many state statutes extend immunity to volunteer health care workers under so-called Good Samaritan laws, as the CARES Act does. However, these volunteers often have to be responding to an emergency clinical situation, and must be unpaid, so these laws would not immunize ordinary health care workers during a pandemic.

Medical futility statutes provide some guidance, as they have been enacted in many states to shield physicians from negligence claims if they refuse to offer ineffective life-sustaining treatment. However, medical futility statutes should not be used during the COVID-19 pandemic to confuse medically ineffective care with care that would be appropriate if there were not resource constraints. Indeed, physicians who put pressure on particular groups to reconsider their end-of-life plans, to discourage only certain groups from refusing life-sustaining treatment, should emphatically not be immunized from tort liability. Further, given our experience with medical futility statutes, it would be prudent to afford clearer protection from suit than what the medical futility statutes typically provide. For examples targeted at providing physicians immunity in response to a pandemic, we can also look to laws in effect in Maryland and New York.

69 If the practice is physician-owned this means that practicing physicians may still be liable, albeit through their partnership rather than individually, and this would sound not in medical malpractice but in corporate negligence. See, With respect to entities—including hospitals, clinics, and health care organizations—claims are likely to sound in corporate negligence and vicarious liability. See, Valerie Guttmann 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, 474–75 (2013).

70 See Evan D. Anderson & James G. Hodge, Emergency Legal Preparedness Among Select US Local Governments, 3 (Suppl. 2) DISASTER MED. & PUB. HEALTH PREPAREDNESS S1, S5 (2009); Valerie Gutman Koch & Beth Roxland, Unique Proposals For Limiting Legal Liability and Encouraging Adherence to Ventilator Guidelines in an Influenza Pandemic, 14 DePaul J. Health Care L. 467, 483 (2011).

71 Teneille R. Brown, Medical Futility and Religious Free Exercise, 15 FIRST AMEND. L. REV. 43, 44 (2016). One way to do this would be to require gross negligence or more before a physician could be liable for refusing someone hospital resources, rather than immunizing them from negligence only when their conduct was reviewed as “reasonable.” The reasonability review embodied in medical futility statutes guts them of their immunity protection and removes the desired peace of mind they are intended to bestow.

72 A policy that permitted categorical age discrimination would violate Section 1557 of the Affordable Care Act.

73 Thaddeus Pope, Medical Futility States: no safe harbor to unilaterally refuse life-sustaining treatment, 75 TENN. L. REV. 1, 58 (2007).
IMPROVING UPON THE MARYLAND AND NEW YORK PROVIDE EXAMPLES

At least two states have passed targeted immunity laws, which would protect paid health care providers during a pandemic, for different kinds of activities. The Maryland statute immunizes health care providers from civil or criminal liability when “acting in good faith and in accordance with a catastrophic health emergency disease surveillance and response program.” 74 This is part of a law focused on penalizing non-compliance with public health directives. This immunity focuses on protecting clinicians who follow the state-approved ventilator rationing protocols, “regardless of the negative consequences arising from the withdrawal of a patient’s ventilator.” 75 It does not provide immunity for institutional or personal medical decisions that are not prescribed by the state’s public health emergency response program. In this sense, the immunity is fairly limited. It also does not attach in cases of willful misconduct, or when the physician acts in bad faith. 76

New York’s immunity law came by way of executive order. On March 23, 2020, Governor Cuomo issued an order revising an education law to provide:

“that all physicians, physician assistants, specialist assistants, nurse practitioners, licensed registered professional nurses and licensed practical nurses shall be immune from civil liability for any injury or death alleged to have been sustained directly as a result of an act or omission by such medical professional in the course of providing medical services in support of the State’s response to the COVID-19 outbreak.” 77

The immunity does not attach if the injury was caused by gross negligence, but it is otherwise much broader than the Maryland statute. For one, it provides immunity for actions that are not performed in accordance with any state public health directive, but are rather just ‘in support’ of the state’s response. It also provides for immunity in non-emergency situations. A reasonable interpretation could include immunizing providers who have personally decided to delay treating their non-COVID-19 patients, in order to prioritize COVID-19 patients. This would be an act or omission in the course of providing medical services to support the state’s response, but it may not be the kind of immunity intended. Thus, if a health care provider decided to cancel all non-COVID-19 procedures, in order to keep ventilators available for COVID-19 patients, this order may prohibit the non-COVID-19 patient from suing in tort, even if that decision was unreasonable under the circumstances. Of course, the order says nothing about immunizing health care institutions who make and enforce similar policies.

The Maryland statute is both too narrow and too broad. It is too narrow as it focuses only on immunizing rationing decisions that are part of the state’s public health directive, and not care that is provided in conformity with institutional or professional recommendations. It is too broad in that it immunizes physicians from criminal charges and intentional wrongs. In general, immunity from criminal charges, or even anything
above gross negligence, is both unnecessary and unwise. Prosecutors are exceedingly unlikely to bring charges against physicians who are making these kinds of pandemic-related decisions, and in any event if a prosecutor could show that a physician acted with an intent to kill, then a criminal action seems completely appropriate. A civil action also seems appropriate, if unlikely, where a plaintiff can make out a prima facie claim that the physician acted with gross negligence or worse. Immunity should only cover negligence claims to strike the right balance between protecting physicians and compensating plaintiffs who were clearly wronged. Denying actions for criminal, or grossly negligent actions, provides too much immunity and has the potential to absolve, or even encourage, bad actors.

The New York order is also overly broad, but for different reasons. It immunizes everything related to the state’s response to COVID-19, which might include too many clinical decisions that are not within the standard of care, and which are not required by a physician’s institution or even recommended by her professional organization. Providing physicians negligence immunity for good faith decisions that are made either in response to professional guidance, state law, or institutional policy related to COVID-19 best balances the need to recognize (a) the extenuating circumstances of the pandemic, (b) the conflicting obligations to the individual patient, themselves, other patients, and institutional obligations, (c) the heavy toll of hindsight bias in negligence actions, and (d) the need for liability for decisions that are grossly negligent or not in good faith.

In summary, states should pass statutes now that immunize individual physicians and other health care providers from negligence liability when, in good faith, they comply with an institutional or state directive, or clear professional guidance, in response to the COVID-19 pandemic, or future pandemics. This recognizes that in many cases physicians are not responding to state-level legal directives, but are rather complying with institutional or professional policies that either mandate or strongly encourage certain kinds of action. While plaintiffs could ordinarily sue both the nurses, institution, and physicians together, these laws would limit negligence suits to the institutions that are making and enforcing COVID-19 specific policies. Physicians would not be immunized for every personal clinical decision related to COVID-19. That level of immunity is too broad, encourages too much carelessness, and denies appropriate compensation to injured patients. While under my proposal, institutions would remain liable for policy decisions they implement, this might be unsatisfactory as it is harder for a plaintiff to prove that a policy, as opposed to an individual physician’s decision, violated the standard of care.

CONCLUSION

Ideally, the cost of making difficult decisions during a pandemic should not fall on individual patients. Those who are injured by others’ carelessness should have some legal resource when they are wronged. But our powerful desire to correct a potential injustice, and to shift the cost elsewhere, should not come at the expense of holding

78 There may be more than one professional organization, and each might provide guidance that is inconsistent with another organization. Rather than permitting liability in these circumstances, this is a perfect example of how difficult these clinical decisions are. So long as a physician can show that a recognized professional society issued guidance that she followed in good faith, this should trigger the negligence immunity.
individual health care workers responsible for decisions that were reasonable *ex ante*. There is great risk of hindsight bias, where juries might forget the very real and conflicting pressures physicians were facing, especially if communities do not experience the overwhelming surges that were predicted, but do experience significant financial hardship.

The summary judgment standard of “no reasonable juror could find breach” provides a good guide for tailoring immunity to those situations where it can do the most good and the least harm. Immunity laws recognize that even if a plaintiff is properly denied recovery at the summary judgment stage, getting to this point imposes considerable emotional and financial costs on the individual physicians. In addition to having to review case files, be deposed, and respond to interrogatories, health care providers often have to report all medical malpractice complaints, regardless of the outcome, every time they seek new credentials. Providing negligence immunity for decisions in good faith conformity with state, professional or institutional guidelines, should significantly curb the number of meritless cases that are filed. 79 Physicians did not create this pandemic situation. While they are intimately involved in its mitigation, these heroic efforts should not expose them to unnecessary malpractice liability, merely because government immunity makes them the last target standing.

Our state and federal governments should be accountable, as public health agencies and government figures have a moral and legal duty to protect their citizens and prepare for health emergencies. 80 There is a possibility that the federal government could waive immunity for personal injury related to its response to the pandemic. Following the threat of a previous H1N1 pandemic, Congress passed the Swine Flu Act, which created a private right of action against the USA from injuries resulting from swine flu inoculation. 81 Or, the government could set up a compensation fund for families adversely affected by rationing decisions. While removing immunity—where the government acted recklessly or in ways that abused its discretion—would be a sensible way to provide accountability, it also seems politically quite unlikely.

We can hope for some political recourse, as the executives and their agencies that failed to prepare or respond may be removed from office. However, for the reasons described above, this is an enormously imperfect check. Crucially, it provides no remedy for the parties who are injured by carelessness or wrongdoing. If a corporation develops a defective product that injures thousands, removing the executives in charge does nothing to compensate those who were harmed.

We are learning many lessons from this pandemic, some welcome and some not. One lesson we might take away from this is the need for better remedies against government officials when they completely fail to perform their public duties. The time has come to pass legislation that more significantly waives immunity in line with our

79 However, importantly, immunity statutes cannot reduce these meritless lawsuits to zero. While immunity statutes provide a clear signal to plaintiffs’ attorneys, especially the majority of them working on a contingency fee basis, that they are quite likely to lose and not be paid, there may still be some who fail to internalize that risk and sue. There does not seem to be a principled way to remove this risk, without over-correcting and unconstitutionally eliminating access to the courts.

80 Brooke Courtney et al., *Legal Preparedness: Care of the Critically Ill and Injured During Pandemics and Disasters: CHEST Consensus Statement*, 146 CHEST e134S, e136S (2014).

81 *Swine Flu Act*, 42 U.S.C. Section 247b(k)(2)(A) (Lexis, 2020).
democratic ideals. Now, more than ever, we must fight the dangerous notion that our leaders are kings.