Reciprocity and Liability Protections during the Covid-19 Pandemic

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During the Covid-19 pandemic, as resources dwindled, physicians were required to ration care and to put the community’s well-being ahead of the welfare of individual patients based on utilitarian considerations, such as saving the most lives. In so doing, physicians were asked, formally and informally, to follow institutional and state rules and guidelines that would deny certain patients access to beds, medications, and other interventions. As hospitals and physicians became increasingly overwhelmed, Arizona and New Mexico officially activated crisis standards of care (CSC) plans, or triage plans for scarce medical resources.1 Facing similar circumstances, other states refused to endorse draft CSC plans to guide clinical decisions during the pandemic, depriving hospitals and physicians of consistent and transparent guidelines for making almost-impossible allocation decisions.2 This failure left institutions to develop and implement their own rationing plans.

Clinicians, health care institutions, and policy-makers have expressed concern about potential legal liability for following CSC protocols. Many therefore argue that liability protections are necessary to encourage adherence to CSC plans in order to serve the goals contained therein. However, there is no robust empirical research to demonstrate that liability protections actually influence physician behavior. We argue that limited liability protections for following CSC plans may instead be justified by reliance on the principle of reciprocity.

Immunity from Liability

Many policy-makers, health law experts, and physician advocacy groups argue that immunizing health care providers from legal liability is necessary to ensure compliance with CSC plans that deviate from nonemergency standards of care. A patchwork of federal and state laws provides narrow and inconsistent immunity from civil liability for health care professionals who provide care during the Covid-19 pandemic. At the federal level, legal protections are limited, generally extending only to negligence arising from medical care provided by volunteer health care providers (the Volunteer Protections Act of 19973 and the Coronavirus Aid, Relief, and Economic Security Act of 20204 are examples of these protections) or to liability claims that arise when providers take countermeasures to prevent diseases, threats, and conditions associated with the pandemic (the Public Readiness and Emergency Preparedness Act of 2005 exemplifies this protection5). In May 2020, Congress introduced the Coronavirus Provider Protection Act to provide national comprehensive liability protections for physicians; however, the proposed legislation has not been adopted.

By mid-2020, thirty-seven states granted civil liability protections to physicians who provide care in a public health emergency. Twenty-one of these rules were adopted specifically in response to the Covid-19 pandemic.6 A majority of these laws are quite broad, extending blanket legal immunity for almost any negligence that occurs during the provision of medical care during the pandemic. And legislatures and policy-makers continue to grapple with the scope of existing immunity provisions for physicians who provide medical care during the Covid-19 pandemic, with some states considering expanding the scope of liability protections.7

The debate around the advisability and necessity of rules intended to extend liability protections for care provided during the Covid-19 pandemic is fraught with ethical concerns and political signaling. These, in turn, have led to an impasse in state legislatures regarding how, at a legal and policy level, to address these ethical concerns. On the one hand, immunity advocates argue that liability protections reduce or even eliminate the threat of lawsuits, thereby encouraging necessary deviation from existing standards of medical care.8 On the other hand, immunity opponents argue that health care workers do not need immunity during a public health emergency because they will simply be continuing to carry out their professional duties.9 Additionally, decisions about whether to provide care pursuant to CSC plans will not be affected by state statute-based liability protections because the existing standard of care is intentionally adaptable to changing circumstances.10 Moreover, blanket immunity provisions, like those included in many state statutes and executive orders, may provide immunity for ongoing negligent actions rather than focusing on encouraging good medical decisions pursuant to CSC plans.
Reciprocity: A Justification for Limited Immunity

We argue that these starkly opposed views go too far. Liability protections are necessary, but not to the extent that many states are granting. Limited immunity provisions are vital for health care professionals who follow established CSC plans that explicitly depart from the prepandemic standard of care. In such circumstances, the current standard of care is not flexible enough to encompass some of the actions that these plans mandate or to address cases when the standard of care shifts from patient-focused to population-based. For example, CSC plans may direct physicians to remove a patient from a ventilator without consent to allocate the ventilator to another patient who has a greater chance of survival.

Since so few states have adopted CSC plans, it is unknown whether physicians would actually be willing to follow such plans that directed them to reallocate a ventilator. Nor has anyone collected data on this issue; consequently, there is no empirical data to support the most common justification for immunity provisions. However, we assert that limited legal immunity can be defended by the often-overlooked ethical principle of reciprocity.

Reciprocity entails the idea that parties will treat each other in kind—that when one undertakes risks or costs that benefit the other, the other has an obligation to minimize those risks if possible and to compensate the injured party for costs or harms that they incur. In other words, society should provide assistance to individuals and communities who act for the benefit of society when doing so might be to their detriment.

The concept of reciprocity has broad appeal. It is universally found in moral codes and religious traditions, and theories of justice, particularly those that posit a social contract, also endorse it. The public health literature, and in particular the scholarship on public health emergencies, relies on reciprocity as an underlying value. Reciprocity buttresses “the social and collective roots of public health,” supporting arguments that the state or local public health authorities shoulder certain obligations when imposing restrictions on patients and health care providers.

Most examples of the application of the reciprocity principle described in the pandemic planning literature point to scenarios in which members of the public make sacrifices, such as quarantining at home, to avoid infecting others. In these circumstances, the state might provide these people with compensation for missed workdays. Similarly, some argue that the state should provide support to health care workers who, during a pandemic, risk becoming sick or transmitting a virus to members of their family. For this sacrifice, Samuel J. Huber and Matthew Wynia suggest a range of reciprocal societal obligations, including minimizing risk to health care providers, caring for those who become ill, and “reduc[ing] or eliminat[ing] malpractice threats.” Others suggest that the state might compensate, publicly recognize, or provide insurance coverage to health care providers who risk their (and their family’s) health to serve the public.

These arguments have been made in the context of physicians treating infectious patients with a lethal disease that has no or limited treatments. We assert that the principle also applies when physicians are expected to comply with public health orders that might require them not to provide care to some in order to provide it to others, thereby maximizing lives saved. In determining what the reciprocal action of the state should be, Lawrence Becker suggests two criteria for its moral legitimacy: appropriateness and proportionality. Appropriateness requires that one consider what the other party would want, and proportionality concerns what is commensurate to the risk or cost the party is undertaking.

We argue that society has a duty to respond in an appropriate and proportionate manner to physicians who are expected, during a pandemic, to deviate from socially accepted norms of medical practice. During the Covid-19 pandemic, physicians have risked their lives to care for patients. They have also suffered psychological trauma from being expected to deviate from nonpandemic standards of care. They have endured immense physical and psychological injury by treating patients with a dearth of necessary resources during the pandemic; they should be assured that they will be protected from the added trauma of lawsuits for defensible behavior.

For example, the expectation that, during a pandemic and pursuant to CSC plans, physicians might have to remove a patient from a ventilator without the patient’s consent and give the ventilator to someone who has a greater likelihood of survival constitutes a societal demand on physicians beyond the norm. Limited liability shields are both appropriate and proportionate to the risk that physicians are being asked to take in such circumstances. From a legal perspective, in most cases the existing standard of care is elastic enough to protect physicians, but without immunity, physicians carrying out those plans may still be sued, even if the plaintiff is not ultimately successful. And, under the narrow circumstances we suggest (in which a physician must remove a patient from a ventilator without the patient’s consent), it remains unclear that the standard of care is sufficiently flexible to protect physicians from liability. Given this uncertainty and the likelihood that physicians would be sued for such an act, limited protection is morally legitimate.

1. For examples of crisis standards of care plans proposed during the Covid-19 pandemic, see D. B. White and B. Lo, “A Framework for Rationing Ventilators and Critical Care Beds during the COVID-19 Pandemic,” Journal of the American Medical Association 323 (2020): 1773-74; E. C. C. Manchanda, C. Sanky, and J. M. Appel, “Crisis Standards of Care in the USA: A Systematic Review and Implications for Equity amidst COVID-19,” Journal of Racial and Ethnic Health Disparities (August 13, 2020), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7425256/pdf/40615_2020_Article_840.pdf; and A. Milliken et al., “Addressing Challenges Associated with Operationalizing a Crisis Standards of Care Protocol for the Covid-19 Pandemic,” NEJM Catalyst (2020): doi:10.1056/CAT.20.0384.

2. V. G. Koch and S. A. Han, “COVID in NYC: What New York Did, and Should Have Done,” American Journal of Bioethics 20 (2020): 153-55; H. Gwon et al., “Maryland’s Experience with the COVID-19 Surge: What...
Worked, What Didn't, What Next?, "American Journal of Bioethics" 20 (2020): 150-52.
3. Volunteer Protection Act, 42 U.S.C. §§ 14501-14505 (1997).
4. CARES Act, S.3548, 116th Congress (2019-2020).
5. Public Readiness and Emergency Preparedness Act, 42 U.S.C.A. § 247d-6d (West 2020).
6. V. G. Koch, "Crisis Standards of Care and State Liability Shields," San Diego Law Review 57 (2021): 973-98.
7. See, for example, Maryland Health Care Heroes Protection Act, S.B. 311 (2021).
8. I. G. Cohen, A. M. Crespo, and D. W. White, "Potential Legal Liability for Withdrawing or Withholding Ventilators during COVID-19," Journal of the American Medical Association 323 (2020): 1901-2; T. R. Brown, "When the Wrong People Are Immune," Journal of Law and the Biosciences 7 (2020): doi:10.1093/jlb/lsaa018.
9. As of March 2021, many malpractice suits have been filed throughout the country in response to care provided during the Covid-19 pandemic. See Hunton Andrews Kurth, "COVID-19 Complaint Tracker," https://www.huntonak.com/en/covid-19-tracker.html. However, because, generally, states have (with limited exceptions) attempted to avoid implementation of crisis standard of care plans, malpractice suits in response to such plans have been thus far avoided.
10. G. J. Annas, "Standard of Care—in Sickness and in Health and in Emergencies, New England Journal of Medicine 362 (2010): 2126-31; V. G. Koch, G. Persad, and W. N. Epstein, "Pandemic Guidelines, Not Changed Malpractice Rules, Are the Right Response to COVID-19," Bill of Health (blog), March 30, 2020, https://blog.petrieflom.law.harvard.edu/2020/03/30/pandemic-guidelines-malpractice-covid19/.
11. A. W. Gouldner, "The Norm of Reciprocity: A Preliminary Statement," American Sociological Review 25 (1960): 161-78, at 171.
12. Institut National de Sante Publique, Quebec, National Collaborating Centre for Healthy Public Policy, "The Principle of Reciprocity: How Can It Inform Public Health and Healthy Public Policies?," October 2014, p. 3, https://www.nccphp.ca/docs/2014_Ethique_ResumeReciprocity_En.pdf.
13. The National Ethics Advisory Committee, "Getting through Together: Ethical Values for a Pandemic," Wellington: Ministry of Health (2007), https://necac.health.govt.nz/system/files/documents/publications/getting-through-together-jul07.pdf; University of Toronto Joint Centre for Bioethics, "Stand on Guard for Thee: Ethical Considerations in Preparedness Planning for Pandemic Influenza," Toronto: University of Toronto Joint Centre for Bioethics (2005), https://jcb.utoronto.ca/wp-content/uploads/2021/03/stand_on_guard.pdf; A. M. Viens, "Public Health, Ethical Behavior, and Reciprocity," American Journal of Bioethics 8, no. 5 (2008): 1-3.
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15. P. A. Singer et al., "Ethics and SARS: Lessons from Toronto," British Medical Journal 327 (2003): 1342-44; World Health Organization, Ethical Considerations in Developing a Public Health Response to Pandemic Influenza (Geneva: WHO, 2007), 1343.
16. L. C. Becker, "Reciprocity, Justice and Disability," Ethics 116 (2005): 9-39, at 18.
17. A. Jacobs, "A Parallel Pandemic Hits Health Care Workers: Trauma and Exhaustion," New York Times, February 4, 2021; E. A. Muller, E. V. Hafstad, and J. P. W. Himmels, "The Mental Health Impact of the Covid-19 Pandemic on Health Care Workers, and Interventions to Help Them: A Rapid Systematic Review," Psychiatric Research 293 (2020): doi:10.1016/j.psychres.2020.113441. DOI: 10.1002/hast.1255