Liability in the Time of Coronavirus: The Ethical Necessity of Expanding the Legal Protections Afforded to Healthcare Workers During the COVID-19 Pandemic

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ABSTRACT: Although discussions have begun regarding the ways in which healthcare providers and individuals in fields adjacent to healthcare might be exposed to legal sanctions involving COVID-19, the complete scope of the legal risks is still largely unknown. This essay explores how current laws in the United States fail to offer adequate protections: (1) to healthcare workers (HCW) practicing under significantly altered standards of care, and (2) to individuals involved in the allocation of scarce resource decision-making

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process. Using research on Second Victim Syndrome and Medical Malpractice Stress Syndrome, legal protections are presented to provide HCW a form of "moral buffering" to help prevent further traumatizing them for shouldering extraordinary burdens during the COVID-19 pandemic. In so doing, this article advocates for the passage of appropriate legal protection as not merely a legal issue, but also an ethical one.

It now seems the height of cliché to say that we do not understand, nor can we foresee, all the repercussions of COVID-19. That the future looks uncertain for almost everyone, that persons of all walks of life cannot yet see how their lives will be impacted is one of the few certainties in this crisis. We are all forced to live in a liminal space—the time between the start of this pandemic and its end.

Nowhere is this liminality more apparent, however, than in the lives of those who work to see that healthcare is provided to those who need it and distributed justly when there are not enough resources to satisfy demand. The painful reality, though, is that people are going to die, despite the heroic efforts of healthcare workers (HCW) who battle to mitigate the damage.[1] While numerous HCW are acting outside of their comfort zones to keep us alive, what can be done to protect them? Shielding HCW with appropriate personal protective equipment (PPE) is a necessary first step, but as necessary is providing them legal protection to prevent harm in the aftermath of this disaster. When we ask healthcare providers to shoulder enormous risk, like we do when crisis standards of care (CSC) are invoked, we owe them basic legal protections commensurate with the amount of risk we have asked them to bear. Basic considerations of fairness require as much. What remains to be explored is why these legal protections are of such moral importance, to whom else we owe them, and what practices these protections should cover.

In our capacities as co-chairs of a county Disaster Clinical Advisory Committee and a Crisis Standards of Care Clinical Regional Triage Team, we have been alerted to the anxieties healthcare providers, triage team volunteers, and ethicists have regarding their legal liability during this crisis. Many people are pressed into service during times of crisis, and we ask these persons to shoulder the responsibility of making life-or-death decisions that may bring with them legal, ethical, and psychological consequences. We are asking them to take these risks without adequate support from their professional organizations (Grimaldi, 2007) and without adequate promises that they will be protected from legal repercussions (Hoffman, 2008; Cohen et al., 2020).

In this article we will explain what legal protections currently exist for HCW in the wake of the COVID-19 pandemic. We will advocate for enacting more liberal protec-

[1] We will be referring to this collection of persons as "healthcare workers" from here on out for the sake of simplicity, but we will include those whose work is adjacent to healthcare in our discussion of legal protections.

tions for all HCW, as well as for the individuals making scarce resource triage decisions that HCW are then asked to follow. Extending these protections not only serves a legal purpose, but also a moral one. Using research on Second Victim Syndrome and Medical Malpractice Stress Syndrome, we will advocate those legal protections can offer a form of "moral buffering" and help prevent further traumatization of those asked to shoulder extraordinary burdens.

Medical Context: Surge Capacity and the Standard of Care

HCW find themselves at increased legal risk largely due to shifting patient volumes and shortages of resources throughout this pandemic. Hospitals find themselves navigating between levels of surge capacity categorized by the Institute of Medicine (IOM) as conventional capacity, contingency capacity, and crisis capacity. At first glance, the distinctions between these different surge capacity levels seem somewhat clear. Conventional capacity is the capacity at which hospitals usually operate. There are enough resources for every patient, there is enough staff to deal with the demand, and the hospital infrastructure is sound (Institute of Medicine, 2012). Elective surgeries might be canceled and staff from different parts of a hospital might be reassigned to deal with any small surge, but standard protocols and conventional standards of care are practiced. Then, contingency capacity is invoked when spaces in a hospital are utilized differently and/or when supplies are rationed in a way that adjusts normal practices, even if standards of care remain functionally equivalent. For example, contingency capacity may require some types of hospital rooms to be used for purposes other than their normal designations (e.g., using post-anesthesia care rooms as temporary intensive care unit (ICU) rooms (Stroud, 2010)). At the end of this continuum is crisis capacity. Crisis capacity involves major changes to standard protocols and standards of care (Institute of Medicine, 2012). Healthcare practitioners may be asked to practice outside the scope of their expertise and equipment may need to be rationed and reused. Most significantly, healthcare practitioners must shift from a focus on making decisions that are in the best interest of individual patients to "public-focused" care that looks "to promote equality of person and equity in distribution of risks and benefits in society" (Berlinger et al., 2020, 1).[2]

The IOM documents make it clear that capacities and the corresponding standards of treatment exist along a continuum.

[2] This shift is one potential cause of the sort of moral burdening to HCW that we discuss later in this paper. In crisis and triage, we ask clinicians to fundamentally shift the way they reason about ethical decisions involving their patients, and this is not an uncontroversial ask. For many, the ethical call to shift from providing patient focused care to doing the most good for the greatest number is extremely troubling, even when using triage guidelines that apply utilitarian ethics. This fundamental shift in healthcare delivery can cause grave moral distress and moral injury to clinicians who need to think in utilitarian ways during crisis when their customary practice is to advocate for patient autonomy and to meet each patient's needs. Although it is outside of the scope of our paper to speak to this shift in ethical framing of medical practice necessitated by crisis and the potential harm it may cause, this insight animates our paper and concern for HCW during this time.

> These categories [of capacity]…represent a corresponding continuum of patient care delivered during a disaster. As the imbalance increases between resource availability and demand, healthcare—emblematic of the healthcare system as a whole—maximizes conventional capacity; then moves into contingency; and, once that capacity is maximized, moves finally into crisis capacity (Dan Hanfling, et al., 2012, 1-6).

Although the IOM provided a taxonomy meant to guide states and regions in determining when conventional capacity, and thus conventional standards of care, were surpassed, this taxonomy was meant to cover all kinds of events that would cause surges. However, this taxonomy can only be but so precise in delimiting exactly how the movement between different levels of capacity might happen and how standards of care might shift in any particular surge. As Hodge and colleagues note, "Moving from abstract principles and norms to the concrete world of healthcare delivery presents translational challenges" (Hodge et al., 2012, 52). For example, in a region struck by an acute natural disaster, such as New Orleans during Hurricane Katrina in 2005, area hospitals clearly operated under CSC. However, here, with on-going COVID-19 challenges fluctuating over the course of several months, shifts between levels of capacity often lack clear delineation. Additionally, in some instances, even when it is clear that crisis capacity has been reached, local and state governments have been reluctant to declare a crisis.

While many facilities have been operating somewhere between conventional capacity and contingency capacity during COVID-19, some have at times been in crisis. State and local health districts have periodically asked doctors to shift their focus from the usual standard of care in treating individual patients to preserving PPE and resources to prepare to meet the needs of a community. The lack of clear federal and/or state guidelines outlining specific "triggers" of CSC, in addition to a lack of guidance on whom has the authority to invoke CSC, makes the surge level at a particular hospital at a particular moment difficult to determine.[3] As a result, papers were published at the beginning of this pandemic that tried to elucidate how and when to move to CSC (*c.f.*, Hick et al., 2020 and Berlinger et al., 2020).

This unclarity exists in part because of the nature of problems facing HCW during this particular pandemic. Initially, the most pressing issue involved an inadequate supply of PPE. That there was a lack of appropriate PPE across the country was clear, but how that deficiency impacted a particular region of the country, or hospital system, or HCW was harder to determine. This lack of PPE was initially what forced many hospitals to move along the surge continuum closer to crisis capacity. It raised questions about

[3] For example, in a triage team meeting that the authors attended near the onset of the pandemic, healthcare practitioners were under the belief that CSC had been invoked in their hospitals, while public health officials refuted this and verbalized that part of the job of the triage team was to help clarify when crisis standards should be invoked, and went on to state that no hospital in our region had yet invoked CSC. Discussions that day, and in the weeks and months that followed, made it clear that any movement to CSC should be coordinated between health systems in the region, as well as public health officials, and the state. However, this was not clear before the initial triage team meeting, and still remains a point of discussion, even at the time of this publication over a year later.

whether to give universal do-not-resuscitate (DNR) orders to all critically ill COVID-19 patients, regardless of patient or family wishes. It also led to bypassing the normal stages of respiratory assistance—patients were going from nasal cannulas to intubation because of fears of aerosolizing the virus when HCW lacked an adequate supply of N95 masks. In order to conserve PPE, ICU beds, and ventilators, non-emergency procedures all over the country were being canceled. This has led to great concern about the repercussions of delaying procedures that, under conventional standards of care, are considered crucial to long-term survival and improved health (*c.f.*, Shrag et al., 2020 and Bochove & Court, 2020). Although cancelations of elective procedures may fall within "conventional capacity" when it is only one hospital or region requiring such cancelations, since this involves multiple healthcare systems all over the country, this might be more indicative of contingency capacity. Most importantly, in all of these examples, healthcare practitioners have been asked to shift their focus from doing what is in the best interest of each individual patient to "doing the greatest good for the greatest number of people" (Walsh, B., & Chakravarti, A., 2021, 1).[4] This lack of certainty regarding which surge capacity healthcare practitioners are operating under, in addition to which standard of care they are being held, may lead to legal, moral, and psychological distress.[5,6]

Even more concerning than this ambiguity is the reluctance on the part of some local and state governments to declare a crisis where a crisis exists. Los Angeles County is the clearest example of this. In late 2020 and early 2021, Los Angeles County hospitals were overwhelmed with patients. Patients were housed wherever there was room in the hospitals, including cafeterias and on gurneys in the hallways. Ambulances were lined up for hours outside of emergency departments. (Lin et al., 2021). The Emergency Medical Services Agency of Los Angeles County issued a memorandum in early January 2021 requiring EMS drivers to leave patients who experienced cardiac arrest that could not be resuscitated in the field (Gausche-Hill, 2021). Although standards of practice had clearly changed, no declaration of crisis from the county or state was issued. This failure to declare a crisis potentially left HCW legally unprotected for doing the best work they could during a crisis situation. If states and counties will not declare a crisis even when hospitals are clearly at a breaking point and in-field triage decisions are being made, HCW risk being left unshielded from liability, and potentially even criminal charges, in ways that should be reconciled by legislative bodies.

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[4] While it is beyond the scope of this article to argue about the ethics of the specifics of how standards of care shift during crisis situations, others have offered admirable attempts to just such thinking during this pandemic (*See*, for instance, Emanuel et al., 2020; Peterson, et al., 2020).

[5] Although it is possible that enhanced legal protection might not reduce stress for a particular HCW, it is reasonably foreseeable that avoiding malpractice claims could help mitigate HCW stress (*See* discussion of Medical Malpractice Stress Syndrome below).

[6] It is important to note that the authors are not providing legal advice. This article is meant to educate on apparent deficiencies in the current law and to advocate for additional and/or amended laws to improve the legal protection available to HCW, ethicists, and those involved in decision-making regarding the allocation of scarce resources.

Legal Context: Medical-Legal Liability in Uncertain Times

Legally acknowledging the plaguing uncertainty—medically and ethically—of how to allocate limited resources during a pandemic, most notably during periods of crisis, is crucial to preventing unreasonable inferences of negligence. Historically, laws involving negligence and medical malpractice have been available to impute liability on providers who have failed to meet the standard of care (61 Am. Jur. 2d Physicians, Surgeons, Etc. § 331; Restatement (Second) of Torts § 328A). Yet, a mere bad result does not infer liability (57A Am. Jur. 2d. Negligence § 28; 61 Am. Jur. 2d Physicians, Surgeons, Etc. § 331). Currently, given unstandardized and at times even unknown standards of care during the COVID-19 pandemic, inferring liability for negligence based on typical standards of care is likely not reasonable. However, traditional standards remain intact in many states, left to be applied on a case-by-case basis by panels of jurors who likely have no medical background. Due to unique complexities involving pandemic standards of care, this unduly burdens juries to answer questions that the medical profession itself struggles to answer.

Legislators should send a clear message that COVID-19's alterations to the standard of care are not the fault of an individual provider, hospital, or healthcare system. While civil negligence medical malpractice laws generally seek to accomplish two main goals: (1) to deter a healthcare provider from injuring patients, and (2) to compensate a patient for injuries sustained by a negligent caregiver (Tappan, 2005), there are two significant issues with this framework during a pandemic. First, deterrence in this context may carry unforeseen consequences. HCW may be deterred from working in hospitals that are short-staffed or without adequate resources, further contributing to understaffing and the inability to meet the needs of patients. Second, this framework is intended to trigger compensation for patients only involving a provider's breach to the standard of care (61 Am. Jur. 2d Physicians, Surgeons, Etc. § 331), a standard which is somewhat uncertain and fluctuant during the pandemic.[7] If certain states continue to enforce unclear standards of care during the COVID-19 pandemic, the standard for justice also remains vague and unclear, and legislators should proactively address this.

Current Laws and Suggested Changes

Early in the pandemic, Secretary of Health and Human Services (HHS) Alex Azar asked all state governors to help shield healthcare professionals from medical liability. Azar went so far as to state, "For health care professionals to feel comfortable serving in expanded capacities on the frontlines of the COVID-19 emergency, it is imperative that

[7] Generally, the standard of care to which a healthcare provider is held is determined by state law. The following is an example of a state statute from the State of Washington that describes the traditional standard in that state: "that degree of care, skill, and learning expected of a reasonably prudent health care provider at that time in the profession or class to which he or she belongs, in the state …, acting in the same or similar circumstances" (RCWA § 7.70.040). Note, that this particular statute has recently been amended, effective May 10, 2021, to add language recognizing an altered evidentiary standard involving the standard of care during the COVID-19 pandemic which is discussed further in footnote 16 below.

they feel shielded from medical tort liability" (Azar, 2020, 3). Azar called upon all states to "issue guidance summarizing the statutory scope of protections offered under their laws" and to clearly outline "the available liability protections during the COVID-19 emergency" (Azar, 2020, 3). We agree wholeheartedly and advocate that state governments should clarify what legal protections exist for HCW during the pandemic and pursue establishing further liability protections if current liability protections seem inadequate.

Current Civil Laws and Suggested Changes

Federal laws do provide certain protections for HCW during the COVID-19 pandemic against civil liability, but these do not go far enough, and state laws on this issue are inconsistent and often inadequate. While federal law does provide some protection to healthcare volunteers, it fails to protect the vast majority of HCW who are acting in the capacity of their jobs.[8] This inconsistency is troubling. What follows is a review of applicable federal civil legal protections and suggested legal improvements.

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 extends to volunteer health professionals certain protections from civil liability, but these protections are limited (HIPAA 1996; AMA, 2020). Further, HIPAA protection only applies at certain free clinics, and it is difficult to qualify for this protection (HIPAA, 1996; AMA, 2020). Thus, HIPAA's application is too narrow to provide liability protection to the majority of HCW.

Similarly, the Uniform Emergency Volunteer Health Practitioners Act (UEVHPA), which has only been enacted by a minority of states, is too narrow in scope to be protective for the vast majority of HCW. While the UEVHPA helps grant immunity from civil liability during a declared disaster, it only does so for out-of-state volunteer health professionals, and certain exceptions apply (Uniform Law Commission, 2020; AMA, 2020). Thus, UEVHPA's application is too narrow to provide liability protection to the majority of HCW.

Somewhat similarly, the Volunteer Protection Act (VPA) of 1997 applies too narrowly to offer much protection as it generally only benefits nonprofit organizations and/or government volunteers. While the VPA is protective in that it does preempt state laws, the VPA fails to provide liability protection to individuals being paid for their time. Additionally, the VPA does not cover acts or omissions deemed "willful or criminal misconduct, gross negligence, reckless misconduct, or a conscious, flagrant indifference

[8] While the sudden-emergency doctrine does potentially provide some protection to some HCW, its application would be quite narrow. This doctrine provides civil liability protection involving any "prudent person", facing an "unexpected danger", and making rapid choices (Am Jur Negligence § 200, 1). However, its application is not to include situations which occur "over a period of time" (Am Jur Negligence § 203, 2), which seemingly contradicts the essence of CSC which involves "crisis operations [that] will be in effect for a sustained period" (Institute of Medicine (2012)). Therefore, the sudden-emergency doctrine should not be relied on to reduce the number of negligence claims against HCW during the pandemic to any significant degree.

to the rights or safety of the individual harmed by the volunteer" (42 U.S.C. § 14503(a) (2000)). While these exceptions are usually reasonable, during this pandemic they may create unintended windows of liability for "willful" actions related to the allocation of scarce resources. For example, removing a ventilator from one patient to use on a more salvageable patient, an action sometimes required to do "the greatest good for the greatest number of people" (Walsh, B., & Chakravarti. A. 2021, 1), may be deemed a willful act that caused the death of a patient, opening a door to potential civil liability. Thus, while the VPA is protective in preempting state civil liability laws, it is unlikely to provide liability protection to the majority of HCW and may be deficient when involving the allocation of scarce resources.[9]

Therefore, we suggest that HCW should generally not expect to receive liability protection from either HIPAA, UEVHPA, or VPA and we encourage lawmakers to focus on amending other federal statutes contained herein, such as the Public Readiness and Emergency Preparedness (PREP) Act and/or the Coronavirus Aid, Relief and Economic Security (CARES) Act.

In contrast to statutes limited in scope to apply only to healthcare volunteers, the PREP Act does offer some protection from civil liability to paid healthcare providers. While this statute seemingly provides broad immunity to "Covered Persons", it only does so involving "Covered Countermeasures" (Department of Health and Human Services, 2020, 15199). While "Covered Persons" generally include healthcare providers and individuals dealing with "public health and medical emergency response of the [a]uthority [h]aving [j]urisdiction" (Department of Health and Human Services 2020, 15201), the language of the PREP Act fails to make clear whether Covered Persons are offered protection if the activities they perform fall outside the activities specifically listed as "Covered Countermeasures". Such measures do include such things as vaccines, treatments, testing and devices involving COVID-19 (42 U.S.C. §§ 247 d-6d (2005); Department of Health and Human Services, 2020). However, the statute does not address activities involving the triaging of scarce resources, which is problematic. A notice of declaration was issued by Secretary Azar in March 2020, and was later printed in the Federal Register, to add clarity to the "Covered Countermeasures" definition. Unfortunately, Secretary Azar did not address this specific issue. We recommend that the definition of "Covered Countermeasures" be expanded to specifically include the allocation of scarce resources, and that liability protection is extended to all individuals involved in that process.[10]

[9] State laws providing greater protection from liability are not preempted by the VPA, and we encourage states to pass laws providing such protection if alternative protections are not enacted.

[10] Congress may consider an alternative means of providing financial compensation to injured patients impacted by substandard care delivered during the pandemic (specifically involving care that does not meet traditional standards of care yet does not rise to the level of gross negligence). For example, Congress may consider extending access to compensation to patients affected by these protections thru the "Covered Countermeasure Process Fund" (*See* 42 U.S.C. §§ 247 d-6e (2005)). This fund has created the Countermeasures Injury Compensation Program (CICP) to provide compensation for patients injured by Covered Countermeasures (*See* Department of Health and Human Services, 2020), which Congress could expand upon should they so choose. Somewhat similarly, Congress previously passed the National

Additionally, Congress enacted a coronavirus-era act that, to some extent, attempts to address the lack of liability protection available to HCW during the pandemic, but this too falls short. The CARES Act became law spring of 2020 and, beyond providing economic relief for individuals and businesses, the CARES Act, using Good Samaritan verbiage (AMA, 2020), federally protects healthcare volunteers from liability during the COVID-19 pandemic by preempting state medical malpractice laws. The CARES Act extends federal protection to individuals providing medical services in response to COVID-19 in a volunteer capacity (AMA, 2020) but does not protect healthcare professionals performing the same or similar duties as a part of their actual jobs (H.R. 748). Yet, compensating patients for injuries caused by HCW but not volunteers, fails to honor the second goal of medical malpractice laws, which is to compensate injured patients for injuries sustained by negligent caregivers (*c.f.,* Tappan, 2005). This failure seemingly treats injured patients, for example two hospital roommates, differently under the law by providing certain legal recourse to the roommate treated by an employee but not to the roommate treated under otherwise similar conditions by a volunteer. Options for legal recourse for an injured plaintiff/patient would be dependent on the employment status of the providers, rather than the egregiousness of their care. Thus, it may be reasonable to amend the CARES Act to provide similar legal protections during the pandemic for both paid and volunteer healthcare professionals, as both are otherwise subject to liability for situations beyond their control during this crisis.[11]

Like HCW, ethicists and other individuals who offer guidance on triage committees involving scarce resource allocation should also be extended liability protections. Besides passing laws to protect doctors, nurses, and others involved in direct patient care, more must be done to protect those working and/or volunteering in adjacent fields. COVID-19 has greatly impacted public health districts and departments in ways that require the help of certain adjunct fields, for example academic ethicists; thus, it is essential to provide adequate legal protections to individuals who serve in these roles.

Childhood Vaccine Injury Act of 1986 in response to vaccination injuries. That injury program provides a no-fault avenue of recovery for individuals with vaccination-related injuries, allowing compensation for those injured, which seemingly decreases lawsuits against HCW while providing a means for compensation for patient injuries (*See* Health Resources & Services Administration National Vaccine Injury Compensation Program).

[11] Whether Congress has authority to create such broad civil liability protection for HCW during the pandemic involving state medical malpractice laws remains debatable. Yet, the U.S. Constitution does grant Congress authority to legislate on matters necessary and proper to regulate commerce or to spend (U.S. Const. art. I, § 8; *See* Bakera, 2014)). As such, Congress can likely financially incentivize states to enact liability protections to promote "the general welfare" if they "unambiguously" give states the opportunity to choose whether to participate (*See S. Dakota v. Dole*, 483 U.S. 203, 207 (1987)), and the incentives can be linked to a new or expanded federally funded healthcare program (*c.f., Nat'l Fed'n of Indep. Bus. v. Sebelius,* 567 U.S. 519, 574–81 (2012)). Alternatively, since Congress has "the power to regulate commerce" (*Id. at* 521), medical malpractice insurance impacts interstate commerce, and liability shields are likely to impact medical malpractice insurance rates, authority for such legislation may potentially exist through the Commerce Clause. Also, Congress has previously exercised use of constitutional authority to create civil liability protection for certain healthcare providers in the PREP Act for "Covered Persons" and "Covered Countermeasures", which does support, but does not confirm, congressional authority here.

While the Public Health Service (PHS) Act provides civil liability protection to public health officers and employees, these protections are limited (*See* Public Health Service Act, 42 U.S.C. § 247d-6d (2005)). The PHS Act does not on its face include protection for CSC triage committee members who allocate scarce resources using state approved CSC guidelines and function to support state or local health departments. Thus, individuals on triage committees may be unprotected from civil liability by the PHS Act, and we recommend amending this act to specifically extend legal protection to CSC triage committee members.

An amendment of the CARES Act could remedy this. Currently, the CARES Act likely does not extend legal protection to ethicists and others serving on committees involving the allocation of scarce resources, as these individuals do not fit nicely within the statutory definition of healthcare professionals providing healthcare. However, their function on these committees does indirectly, and significantly, affect the delivery of healthcare; hence, these committee members may face the possibility of being named as defendants in negligence lawsuits unless they are proactively protected by legislation. Ultimately, whether a triage committee member is a volunteer healthcare professional, ethicist, or other individual, the potential for being the "cause" of a plaintiff/patient's damages is similar, so the law should similarly protect them. Thus, in addition to consideration of amendment to the CARES Act that would extend protection from liability during the pandemic to all HCW, whether serving in a volunteer capacity or not, we also advocate to expand the list of professionals protected to include not only HCW but also individuals offering CSC triage recommendations.

The following is a summary of the potential legal protections we have suggested thus far, which focus on amending the CARES, VPA, PREP, and/or PHS acts.

First, the CARES Act could be expanded to include non-volunteer healthcare providers, as they are often performing the same role as employed providers, and it is neither ethical nor just that a patients' legal recourse is contingent on the employment status of their caregiver. Further, this act could be amended to specifically include protections for all individuals offering guidance related to scarce resource allocation due to COVID-19, such as ethicists and triage committee volunteers.

Second, if the CARES Act is not amended as described above, the VPA could be amended to provide liability protection beyond nonprofit and government volunteers to include those individuals being paid for their time. Further, it could be clearly state that activities related to the allocation of scarce resources are NOT acts consistent with willful or criminal misconduct, gross negligence, or reckless misconduct, and thus are not grounds for civil or criminal liability.

Third, if the above amendments are not adopted, the PREP Act could be amended to clearly include civil liability protection related to the allocation of scarce resources by adding this action as a recognized countermeasure.

Fourth, if the above suggestions are not adopted, the PHS Act could be amended to include liability protection for committee members, including ethicists, who are involved in state departments of health or local health districts CSC response efforts.

Certainly, committee members involved in decisions and/or actions regarding the allocation of scarce resource, which may lead to the death of a patient to benefit another, are deserving of protection.

If Congress is reluctant to enact the above suggestions, state legislatures should respond quickly to protect all of their HCW, not just their volunteers. They should do so by enacting legislation, if they have not done so already,[12] that clearly recognizes that the standard of care during the COVID-19 pandemic has been disrupted and providers are not to be held to a conventional standard of care; further, lawmakers should consider whether justice during the pandemic would be better served using a threshold which would require gross negligence,[13] willful misconduct, or intoxication. Generally, proving negligence in medical malpractice merely requires a "preponderance of evidence" that the defendant "deviated from good and accepted standards of medical practice" (61 Am. Jur. 2d Physicians, Surgeons, Etc. § 331). However, that may be an unreasonably low bar during a pandemic when transient shortages of space, staff, and stuff have been ongoing. Broad liability shields could resemble those set forth in the CARES Act involving healthcare volunteers (*See* H.R. 748 § 3215), if they are extended to include all HCW. Arguably, such extensions may seem overly defense-friendly, as some HCW have been practicing under conventional capacity and traditional standards of care during portions of the pandemic. Yet, there is no perfect solution and broad liability shields would serve to heighten the degree of deviation from the standard of care needed to prove malpractice, which under the circumstances is likely appropriate.[14]

Finally, should Congress and state legislatures fail to act, governors may be able to respond by issuing executive orders to help temporarily protect HCW and those involved in scarce resource triage from civil liability.[15] During the beginning of the pandemic, New York Governor Andrew Cuomo quickly issued an executive order to temporarily authorize civil liability protection for all HCW in the state, barring acts or omissions involving gross negligence (Executive Order, 2020). Similarly, since then other governors, most notably in the eastern United States, have extended immunity to

[12] By the time of this publication, most, but not all, states have enacted civil liability protections for HCW during the pandemic; these protections generally exclude gross negligence and willful misconduct, in addition to bad faith and intoxication (*See* Ferragamo, 2020).

[13] In contrast to negligence, gross negligence requires a more significant deviation from the standard of care. According to Black's Law Dictionary, gross negligence "differs from ordinary negligence only in degree" and generally does not require "a reckless disregard of the consequences" (NEGLIGENCE, 2019, *citing* W. Page Keeton et al., *Prosser and Keeton on the Law of Torts* § 34, at 211–12 (5th ed. 1984)).

[14] While medical malpractice is not a criminal claim, it may feel as such to HCW, especially those who may have been forced to practice medicine under crisis conditions. Shifting the law to require a near-criminal evidentiary standard of gross negligence and presuming innocence unless clearly proven otherwise may be reasonable under these circumstances.

[15] While governors issuing executive orders are often effective in providing temporary liability protection to HCW, not all state constitutions authorize executive orders to serve this function. For example, the Michigan Supreme Court determined on October 2, 2020, that multiple executive orders issued during the pandemic were unconstitutional. However, the Michigan legislature then passed legislation which basically retroactively enacted many of those provisions (*See* Ferragamo, 2020).

HCW by executive orders (Ferragamo, 2020). A Connecticut executive order includes immunity involving scarce resources.

> The Connecticut executive order…goes beyond the scope of the law passed in Massachusetts by protecting covered medical professionals and facilities from acts or omissions undertaken due to a lack of resources caused by the COVID-19 pandemic. In theory, this could provide immunity for acts or omissions involving a patient whose care was impacted by a lack of resources regardless of whether that patient was diagnosed with COVID-19 (Blei, 2020, 1).

In contrast, some states have ineffectively utilized executive orders in this arena. For example, the executive order by Pennsylvania Governor Tom Wolf has been reported as being "one of the weakest in the nation" by Curt Schroder, executive director of the Pennsylvania Coalition for Civil Justice Reform (Santoni, 2020, 3). There, the executive order fails to protect against claims of malpractice involving forced delays in elective procedures to conserve scarce resources, and the allocation of scarce resources, among other deficiencies. This example should be avoided in the future.

Therefore, if federal and state legislators fail to act, and if their state constitutions allow, governors should consider issuing executive orders similar to Connecticut's which helps ensure that HCW and those involved in scarce resource decision-making are shielded from liability to prevent further traumatization.

Addressing Opposition to the Suggested Civil Law Changes

Ralph Nader and others have argued that blanket liability protection against coronavirus liability represents a problematic extension of the law. They argue that offering broad liability protection to "institutions and personnel…for casualties caused in 'good faith,' is not necessary, and actually a potential 'legal contagion'" (Nader et al., 2020). We disagree and will handle both claims in turn.

The belief that these protections are unnecessary is incorrect for four reasons. First, Nader and coauthors fail to consider the potential harms caused by unnecessary lawsuits. While the authors claim "medical professionals are already insured against claims and losses" and "existing judicial and legal structures can and do already handle claims of this sort" as long as physicians are operating under the appropriate standards of care (Nader et al., 2020), such statements overlook that lawsuits often cause detrimental emotional distress, even when insured against losses. Doctor Curtis Miyamoto, Chair of Radiation Oncology at Temple Health in Philadelphia, stated, "A lot of us are being expected to do things we don't normally do," and the fear of malpractice is "a significant deal" (Bryan, 2020, 3-4). Pre-pandemic, results from a Medscape survey, as reported by Patricia Salber, MD, MBA, already noted that medical malpractice "take[s] a heavy toll on doctors" (Salber, 2015, 3). Many doctors acknowledged some form of long-term emotional injury (e.g., anxiety and/or depression) and over half became preoccupied with being sued again (Salber, 2015). Sadly, 30% stated they "no longer trust patients; I treat them differently" (Salber, 2015, 4). More will be said about the toll

of malpractice lawsuits on HCW below, but these are not insignificant findings, for both doctors and the patients they treat.

Second, it is an inaccurate assumption that all HCW serving during this crisis have adequate or any individual liability protection. Nader and coauthors do not consider non-physician HCW at all in their argument, but consideration of non-physician HCW is necessary. As Wayne Guglielmo explains, often nurses do not have such protection (Guglielmo, 2020). Similarly, it remains unclear what percentage of medical ethicists have liability insurance, especially those acting in the capacity of volunteers. Furthermore, Guglielmo argues that even doctors with liability protection are in a precarious situation. Many medical malpractice liability plans have clauses that exclude doctors from coverage when they are not practicing in the facility by which they are employed or are doing procedures for which they are not normally covered (which can be necessary for doctors practicing under CSC). Thus, Nader and coauthors' claim that doctors are adequately protected by current tort law is unsupported by facts.

Third, Nader and coauthors claim incorrectly that since standards of care will be altered by the facilities and systems in which physicians practice, these physicians will not be legally held to conventional standards of care.

> To the extent then, that medical/legal/ethical committees draw up new standards, new guidelines for appropriate medical decision-making, even when it comes to rationing or allocating ventilators, physicians who follow those guidelines would be within the standard of care, and not liable for malpractice (Nader et al., 2020).

However, that statement cannot be counted as true, as there is no master medical/legal/ethical committee that has declared what "the" standard of care is for each state and/or the nation during contingency or CSC. Additionally, there is confusion and a lack of clarity about how and when the shift to CSC is activated, as well as who has the authority to declare CSC standards. HCW may well be operating under CSC *de facto* before the institutions and communities they are serving have acknowledged the shift. Bureaucratic systems move more slowly than emergencies. Further, there is no national standard on how courts use clinical practice guidelines in determining the standard of care (*See* Moffett & Moore, 2011); thus, it is unlikely that CSC guidelines would universally offer liability protection to HCW. Some lawmakers are taking notice of this deficiency in the law and taking action, as demonstrated by the State of Washington recently enacting SSB 5271[16] which has amended the description of the standard of

[16] This recently enacted statute in the State of Washington recognizes alterations to the standard of care during the COVID-19 pandemic and clarifies that to determine "whether the health care provider followed the standard of care" considers good faith and "guidance, direction, or recommendations, including in interim or preliminary form, published by the federal government, the state of Washington or departments, divisions, agencies, or agents thereof, or local governments in the state of Washington or departments, divisions, agencies, or agents thereof, in response to the COVID-19 pandemic and applicable to such health care provider"; additionally, the standard of care during the COVID-19 pandemic is altered if there is "a lack of resources including, but not limited to, available facility capacity, staff, and supplies, directly attributable to the COVID-19 pandemic" (State of Washington SSB 5271 § 2 (2021)).

care in RCW 7.70.040. Other lawmakers should be moved to address this deficiency as well.

Fourth, Nader and coauthors likely overstate reality when they write that "a judge or jury *would* make significant allowances for health care providers" (Nader et al., 2020, emphasis added). Our belief that our current legal system is inadequate to deal with the claims that may come out of this pandemic is conjectural, but so are Nader and his coauthors' claims. There is no evidence that their claim is true, as there is no way to determine in advance that judges and juries would indeed make such allowances. Moreover, if Nader and coauthors are suggesting that significant allowances in courtrooms are justified for HCW during contingency and crisis capacity, and that judges and juries would indeed make these allowances, it is logical to put such allowances into statutes. Besides promoting justice by setting a clear standard on this issue, this would help decrease the number of HCW being named as defendants, enduring emotional trauma, and awaiting leniency years later at trial.

In response to Nader and coauthors' second argument, the legal contagion claim against extending legal protections to HCW, is a slippery slope argument and thus, fallacious. While industries and special interest groups outside of medicine may similarly appeal for liability protection, fear of future requests of this sort is not a valid reason to deny protection where it is warranted. Moreover, there is a morally significant difference between the healthcare industry and other industries in this crisis. If any industry deserves liability protection during the pandemic, it is the healthcare field. Society has asked HCW to take on special risks, not only to their physical health, but also to their emotional well-being, by practicing under situations that are unfamiliar and unconventional to save lives and protect public health. No such ask has been made of the industries that Nader and coauthors fear will seek liability protection (specifically, airlines, cruise companies, and restaurants). This difference creates the most significant defense against the statement those authors claim.

Criminal Protections Should Be Considered

Criminal laws generally create consequences for unreasonable behaviors deemed immoral against society (Samah, 2017, 9), yet providing healthcare in good faith during the COVID-19 pandemic, even if there is a poor outcome, should likely not be criminalized by society. As such, criminal protections are reasonable involving two issues: CSC guidelines and medical errors.

First, CSC guidelines exist to benefit society during a dire healthcare situation which has been created by the pandemic itself, not by a lack of morality of HCW. Almost by definition CSC involve patients unable to get the care that they need due to a scarcity of resources (*See* Institute of Medicine 2012). This is a function of the crisis at hand, irrespective of fault. As such, HCW should not fear criminal liability for attempting to follow CSC guidelines, when done in good faith, even though lives are likely to be lost. For example, during CSC an insufficient supply of life-sustaining resources may lead to HCW removing ventilators from certain patients to use on patients with a

higher likelihood of survival. The removal of the ventilators may lead to death. Death may open the door to prosecution for crimes such as manslaughter for the HCW. This foreseeable risk to HCW, especially those involved in scarce resource triage, needs to be addressed proactively. Shields from criminal prosecution under such circumstances would not devalue the lives lost. Rather, liability shields should help incentivize HCW to utilize rather than fear CSC guidelines, which by their very nature seek to equitably and fairly do the greatest good for the greatest number of people at a time when there is not enough space, staff, or stuff to meet the healthcare needs of patients.

Second, while criminal charges involving medical errors resulting in patient harm may be rare, they are becoming "less unusual every year" (Gordon 2019, 3), and should be addressed. According to Kirstin Manges, a University of Pennsylvania nurse and researcher on patient safety, prosecution of nurses related to medical errors tend to involve systemic problems during "busy, unpredictable circumstances" (Gordon 2019, 3). During the pandemic, HCW are often experiencing system-wide busy and unpredictable work conditions (Roth 2020; Begun & Jiang 2020), which foreseeably increase the risk of medical errors and resultant patient harm (*c.f.,* Gordon 2019). This increase in risk supports the need for consideration of criminal liability shields for HCW during the pandemic. "Doubts have [already] been raised about the fairness of criminalizing errors that are made in the course of executing normal professional duties with no criminal intent and the capriciousness of criminal prosecution" (Dekker 2017, 92). Specifically, nurses have been noted as being at risk for medical errors that lead to prosecution (Gordon 2019; Dekker 2017). With understaffing and busy work conditions during the pandemic, this foreseeable risk, especially to nurses, needs to be addressed.

Yet, at the time of this publication, only three states (Maryland, New York, and New Jersey) have enacted laws that largely provide criminal immunity for HCW during the pandemic (*See* MD Public Safety Code section 14-3A-06, New York Emergency or Disaster Treatment Protection Act, New Jersey SB 2333).[17] It is reasonable that the remaining 47 states consider protecting HCW from criminal prosecution when HCW are acting in good faith. Good faith is by no means a perfect standard even during the pandemic public health emergency, as it does have certain limitations; however, it is a reasonable standard to apply. One limitation may be the appearance of a somewhat blanket defense. Such a blanket defense may be inappropriate in situations involving "battlefield euthanasia", which in war has been found to violate the Geneva Convention (Neuhaus, 2011). However, scarce resource triage or the occurrence of medical errors leading to death do not equate to euthanasia.

> Euthanasia, particularly in a military setting, must be distinguished from "triage", which provides an ethical framework for deciding on priorities of care in resource-limited (predominantly mass-casualty) environments. There is no doubt that in these situations, patients with overwhelming injuries may be triaged to "expectant care". The overriding priority in all such cases is care, compassion and respect for

[17] Exceptions to these protections include such things as intoxication and/or intentional harm.

> human dignity and human life. The patient is provided with comfort until he or she either dies or the situation changes and resources become available to provide treatment. (Neuhaus, 2011).

Unlike euthanasia, where an action is taken with the purpose of ending life, scarce resource triage involves the allocation of scarce resources to certain patients with the purpose of saving the most lives. HCW do not intend any patients' deaths when they allocate resources to those who are most salvageable, although these deaths might be the consequence of not being the chosen recipient of a scarce resource. Unlike soldiers during war, HCW in the pandemic are forced to take on a role which resembles Good Samaritan status. Good Samaritan status can carry certain legal protection to help encourage members of society to render care during an emergency. Here, even when acting in an employed role, HCW may be forced to render care under risky conditions without adequate resources within strained healthcare systems. If in the setting of the COVID-19 public health emergency HCW and/or individuals involved in scarce resource triage are acting in good faith, society should recognize the extreme conditions in which they have been called to provide services and help to protect them. If those rendering care have the mindset of good intentions, it is reasonable for society to extend to them immunity from criminal prosecution.

Such legal protections serve to protect HCW from further trauma for being called on to provide care during a time when medical errors and/or the allocation of scarce resources are foreseeable risks caused by strains on healthcare systems during the pandemic.

Moral Buffering: Reduction of Trauma and Retraumatization for Healthcare Workers

Although the legal risks we ask HCW to face at this time are significant, as concerning are the moral risks that are attached to these legal risks. What we are proposing are clear, reasonable protections from liability for those involved with healthcare work done in good faith during periods of crisis. This includes not only doctors and nurses, but also public health workers, applied ethicists, and others who make decisions crucial to functioning in a taxed healthcare system. These legal protections serve four primary purposes. Most obviously, these laws provide legal protection, as discussed above. Given the current circumstances, the potential risk to providers of civil, even criminal, liability seems unfathomable, yet the risk is real. Currently, we are requiring HCW to deal with shortages of equipment and surges of capacity with which almost none of them have previously dealt. Similarly, we are asking individuals working in fields adjacent to healthcare to help healthcare providers make ethical decisions about rationing resources during times of crisis. In allocating scarce resources, some patients will die, not because an individual provider caused their death, but because the taxed healthcare system could not save everyone. Generally, liability is based on fault. Here, fault lies with a virus that the world was ill-prepared to treat. Federal and state-level legislation should

recognize this and authorize legal protections for those doing necessary and difficult work under extraordinary circumstances.

The second purpose of the proposed laws is the enforcement of new societal norms. A change in the law can be understood as societal recognition of the responsibility that has been placed on healthcare providers and those in fields adjacent to healthcare. As Eric Posner argues, laws are critical to enhance social norms and to undermine bad norms (Posner 2002). By passing laws that clearly exempt those acting in good faith when making decisions about healthcare and healthcare rationing during contingency and crisis capacities, we enforce new norms that are only beginning to be part of the cultural consciousness. With the public decreeing the label of "hero" to those on the frontlines of healthcare and healthcare planning, we see the beginnings of this new norm. This label belies a widespread public recognition that what we are asking of those involved in healthcare falls outside of their normal duties. Passing laws which delineate the protections society owes them for taking on this work further reinforces and defines this new norm.

The third purpose of these laws is reciprocity. When we call HCW heroes, what we mean is that HCW are going above and beyond their normal duties in order to protect the health of the public (Cox, 2020). HCW are working longer hours, under more strenuous and dangerous conditions, in order to provide care to those who are sick. They are doing this even as many in our country deny the efficacy of masks, continue to gather in ways that spread the virus, and display vaccine hesitancy. HCW are taking on increased risk in many ways: they are at risk of contracting the virus and spreading it to their loved ones. They risk burnout as their working conditions deteriorate and they see their fellow HCW come down sick. They are shouldering moral burdens when they practice under conditions of shifting standards of care, especially in places like Los Angeles County where the crisis situation on the ground was not recognized by local or state government as being in crisis. The legal protections for which we argue are owed to HCW because of their willingness to shoulder burdens above and beyond their normal work.

The final purpose of the proposed laws is to help offer "moral buffering" to HCW, which might help reduce their incidence of traumatization and retraumatization. Laws are needed that acknowledge conventional standards of care are not expected during a crisis. Traditional standards of care during conventional capacity are consistent with high standards of patient-centered care, but they are not the primary focus during CSC in a pandemic. Thus, in such a setting, high standards of patient-centered care are not only impractical, but also potentially impossible. Laws acknowledging that what we expect of HCW in normal times is not what we expect during a crisis may help to mitigate some of the psychological and emotional burdens on HCW as well as prevent future retraumatization that would occur because of lawsuits.

Burdens to HCW related to an inability to provide high standards of patient-centered care during a pandemic are, to a certain extent, unavoidable; however, laws should help protect them from unnecessary secondary trauma. There are two significant ways

laws might protect from further trauma to HCW. First, these laws provide a level of protection against moral suffering during the crisis or at least a way to frame experiences when reflecting on them after the crisis subsides. These laws also will prevent reigniting the trauma post-incident that is sure to occur if complaints are brought against HCW, especially if they are sued. What follows is a brief overview of the psychological impacts of crisis medicine and how the new norms established by law might help providers navigate the moral suffering endured during this crisis, followed by an exploration of how avoiding lawsuits can help prevent the retraumatization of HCW.

Trauma and Crisis Medicine

The toll on the mental health of workers and first responders involved in emergency and crisis response is well-established. Stellman and colleagues found that the frequency of psychological distress and psychopathology among first responders was greatly above that of the general population even years after the incident and was comparable to rates seen in veterans returning from the war in Afghanistan (Stellman et al., 2008). Similar issues were seen in first responders to the Uttarakhand flood in India (Jain 2013) and in search and rescue workers after the Bingol earthquake in Turkey in 2003 (Ozen & Sir, 2004). In fact, dozens of studies have been conducted which outline the potential mental health risk to those who responded to the September 11th attacks (Bills et al. 2008) and to Hurricane Katrina (Osofsky et al., 2011).

Although the nature of the crises mentioned above differ from what HCW face during the COVID-19 pandemic, research currently being produced on the toll the COVID-19 pandemic is having highlights the potential for similar impacts despite the differing nature of the crises. A rise in anxiety in the general population has been documented (Lima et al., 2020), as has a rise in depressive symptoms and sleep issues (Huang and Zhao, 2020). Very recent studies out of China indicated adverse mental health outcomes for HCW, including symptoms of depression, anxiety, insomnia and distress (Lai et al., 2020; Li et al., 2020; Huang et al., 2020). The distress caused by seeing widespread suffering alone should inspire us to protect HCW in whatever ways possible, but there is an additional type of psychological wounding—moral suffering[18]—that makes protecting this population in the ways described above even more important.

Moral suffering occurs in many forms, but two are especially important here: moral distress and moral injury. Moral distress is a type of moral suffering first identified in the nursing literature and refers to negative feelings caused by the inability to translate one's moral choices into action (Volbrecht, 2002). There are many possible reasons for the inability to act on one's sense of morality, from time pressures, institutional protocols, etc., but ultimately the frustration of one's ability to act on one's moral intuitions and reasoning is central to this phenomenon. McCarthy and Deady (2008) extend moral distress to the experience of needing to make difficult moral judgments in complex

[18] We are adopting the term used by Papzoglou and Chopko (2017) here. We recognize that there are important differences between moral injury and moral distress, but for the purposes of this paper, we are considering these phenomena related.

situations without appropriate support. Moral distress is obviously of great concern during the COVID-19 crisis. During this crisis, there are decisions being made every day because of the lack of PPE and the desire to conserve resources that likely go against many HCW' moral intuitions. More than this, given the uncertainty noted above, and that it is rare that healthcare systems find themselves clearly in crisis capacity (with obvious exceptions), shifting from making treatment decisions based on the best interest of the patient to considerations of public welfare might cause increased moral distress.

Moral injury is a slightly different, though related, concept developed from work with soldiers and veterans (Shay, 1994). Moral injury occurs when a person is confronted with a catastrophic situation in which that person perpetrates, fails to prevent, or witnesses' actions that run counter to deeply held moral beliefs (Litz et al., 2009). While moral distress might occur at any point, moral injury is a phenomenon experienced during moments of catastrophe. Again, it is clear that moral injury is a concern during this crisis, especially in areas where conventional and contingency capacity have been surpassed and genuine triage decisions are being made.

Scholars are already raising concerns about moral distress and moral injury impacting HCW during COVID-19. Mazanec (2020) explains that nurses witnessing the triaging of equipment to patients, dealing with limited medical supplies, and watching patients die without visitors to comfort them might experience moral distress. Angelos (2020) writes that surgeons will likely experience moral distress when asked to shift from doing what is in the best interest of individual patients to acting in the interest of public health. This is clearly seen with surgeons canceling elective surgeries and being mandated to stay at home unless they are called in to offer care. Also, similar concerns have been raised in palliative care (Domenico et al., 2020; Wallace et al., 2020) and oncology (Shuman and Campbell, 2020). Greenberg and colleagues believe that for some working on the front lines, recognizing that they did what they could for their patients with the limited resources they had, rather than their customary ability to do everything possible for patients, is the potential "seed" of moral injury (Greenberg et al. 2020).

One important function of the laws we propose is to provide "moral buffering" from this psychological wounding by offering formal and public recognition of the fact that in certain situations, there are no good choices. Like the doctrine of double effect, these laws give credence to reduced moral responsibility in times when the moral landscape means our best moral efforts will still have bad effects. As applied in situations of war, the doctrine of double effect allows for the fact that sometimes the pursuit of some greater moral good leads to bad consequences. We offer legal protections to those who do things in situations of war that would otherwise be considered illegal or at least morally intolerable. More to the point, the Feres Doctrine protects military doctors from being sued for medical malpractice in a triage zone. The laws we are proposing might offer HCW the same sort of mitigation, not only legally, but in terms of the way in which healthcare providers reason through their own moral culpability. The doctrine of double effect does not leave the moral actor perfectly comfortable, but it does give her space to reframe her actions as morally necessary, even if not morally good. We may

not be able to save HCW from the emotional guilt that they carry, but we can give them socially recognized absolution in the form of these laws, and thus impact HCW's moral reasoning about their own culpability in the situations they face.

The Perfect Storm: Medical Malpractice Stress Syndrome and Second Victim Syndrome

Even if the hope that the laws we propose might offer "moral buffering" is simply that— a hope—there are other ways in which the passage of these laws will prevent further harm befalling HCW. While some have argued that the common law legal standard is adaptable enough to provide legal protections if HCW are acting in good faith, these authors fail to address the potential harm that complaints against HCW, whether civil or criminal, cause to HCW, even when HCW are ultimately cleared of wrongdoing (*c.f.*, Annas, 2010; Koch et al., 2020). In addition to the well-documented emotional and moral burdens experienced by HCW during crises, there are two other forms of distress faced by HCW that bear exploring here: Second Victim Syndrome (SVS) and Medical Malpractice Stress Syndrome (MMSS).

SVS was a concept originally introduced by Albert Wu (2000). In an article for the *British Medical Journal*, Wu argued that although patients were obviously the primary victims of medical error, "physicians, pharmacists, and other members of the healthcare team," were potential secondary victims. He argues that the hardships faced by HCW, even when they themselves caused the medical error in question, need to be recognized and acknowledged. Significant literature has developed to explore the contours of SVS and medical error (*c.f.*, Denham 2007; Wu 2012; Scott and McCoig 2016). The repercussions of SVS are numerous. Cognitive effects, including inability to concentrate, are common (Seys et al., 2013). Additionally, feelings of depression, shame, guilt, and loss of confidence are possible (White and Gallagher 2011). Further, second victims are at a much higher risk for burn-out (Schwappach & Boluarte, 2009).

Although SVS was originally restricted to medical error, there have been attempts in the literature to include as possible triggers of SVS any adverse patient events that traumatize HCW, even if there is no medical error involved (Scott et al., 2009). Lander and colleagues argue that a healthcare provider can be the secondary victims of:

> anything that has happened anywhere in your practice (office, hospital, operating room, emergency room, etc.) that was not anticipated, should not have happened, and makes you say 'I don't want this to happen again.' It can be small or large, administrative or clinical—anything that you feel could be avoided in the future (Lander et al., 2006).

The nature of the COVID-19 crisis makes it such that there is much happening in hospitals, doctors' offices, public health districts, and ethics committee meetings across the country that would undoubtedly make HCW say, "I don't want this to happen again." More than this, there is likely recognition that if we were better prepared at national,

state, and local levels, some of what is occurring need not have occurred. Although scholars have been warning of a coming pandemic for years, the political will to prepare for this by adequately stocking our Strategic National Stockpile, by the timely invocation and use of the Defense Production Act, and by proactively upgrading electronic medical systems to help with communication between facilities during disasters like these has been lacking (*c.f.*, Miri & O'Neill, 2020; Kulish et al., 2020). HCW who are asked to make decisions that adversely affect patient outcomes that may have been avoided with proper preparedness are at risk of SVS.

If HCW face legal scrutiny for actions that were necessitated by our current crisis, then they will face more than the threat of SVS. Evidence exists that there are significant emotional and cognitive impacts to HCW who have complaints lodged against them and/or are sued for malpractice. Large scale studies have found that doctors with recent or current complaints filed against them had significant risks of moderate or severe depression, anxiety, and suicidal ideation (*e.g.*, Bourne et al., 2014; Balch et al., 2011). The impact of these incidents is so well-documented that a term has been coined—Medical Malpractice Stress Syndrome (MMSS). MMSS has been identified as a "*forme fruste*" of post-traumatic stress disorder (Patel et al. 2017). Those with MMSS experience depression and feelings of hopelessness (Reyes & Reyes, 2017). It is linked to increased anxiety that manifests as restlessness, exhaustion, difficulty concentrating, and/or insomnia (Sanbar & Firestone, 2007). There have even been cardiac events linked to MMSS (Maroon 2019). Many publications are dedicated to identifying ways to help HCW live through this syndrome (*c.f.*, Ryll, 2015; Iacob & Majer, 2012; Fileni et al., 2007). However, in times such as these, where HCW are asked to make choices well outside the traditional standard of care that might result in adverse impacts on those workers, the best way to help HCW is to prevent the conditions that trigger MMSS at all. The legal protections outlined above do just that.

Conclusion

Without adequate protection, HCW are bearing many risks in the COVID-19 healthcare crisis. Given what we know about the profound burdens experienced by those working in crisis situations, it is clear that we should do what is reasonable to mitigate their trauma. Despite arguments to the contrary, current laws do not offer adequate protections to physicians, let alone to those HCW working in non-physician capacities. One relatively simple way to protect HCW is with legislation that stops legal actions from being taken against them for doing what has been forced on them: moving from treatment shaped by what is in the best interest of individual patients to treatment shaped by the desire to do the most good for the greatest number of people. Such a shift is already an emotionally and psychologically difficult undertaking. HCW should not risk being further traumatized by laws that largely fail to recognize the impact of this shift.

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