University of Miami Business Law Review

Volume 30 | Issue 2 Article 3

Rationing Healthcare During a Pandemic: Shielding Healthcare Providers from Tort Liability in Uncharted Legal Territory

Frederick V. Perry
Florida International University

Miriam Weismann
Florida International University

Follow this and additional works at: https://repository.law.miami.edu/umblr

Part of the Health Law and Policy Commons, and the Torts Commons

Recommended Citation
Frederick V. Perry and Miriam Weismann, *Rationing Healthcare During a Pandemic: Shielding Healthcare Providers from Tort Liability in Uncharted Legal Territory*, 30 U. MIA Bus. L. Rev. 142 ()
Available at: https://repository.law.miami.edu/umblr/vol30/iss2/3

This Article is brought to you for free and open access by the Journals at University of Miami School of Law Institutional Repository. It has been accepted for inclusion in University of Miami Business Law Review by an authorized editor of University of Miami School of Law Institutional Repository. For more information, please contact library@law.miami.edu.

Rationing Healthcare During a Pandemic: Shielding Healthcare Providers from Tort Liability in Uncharted Legal Territory

Frederick V. Perry*

Miriam Weismann*

Abstract

As the coronavirus pandemic intensified, many communities in the U.S. experienced shortages of ventilators, ICU beds, and other medical supplies and treatment. There was no single national response providing guidance on the allocation of scarce healthcare resources. There has been no consistent state response either. Instead, various governmental and nongovernmental state actors in several but not all states formulated "triage protocols," known as Crisis Standards of Care, to prioritize patient access to care where population demand exceeded supply. One intended purpose of the protocols was to immunize or shield healthcare providers from tort liability based on injuries resulting from a medical decision rationing access to care. Research shows that various state protocols have been implemented to this end by either executive order issued by the governor; state legislation; or action by individual hospital ethics boards. This paper examines a legal question of first impression: Whether the right to institute suit for pandemic related healthcare injuries can be constitutionally eliminated using state triage protocol immunity provisions passed by executive order or state statute during the pandemic. The paper concludes that healthcare providers may still be subject to some legal liability depending upon each state's unique constitutional grant of powers to the executive and legislative branches and the dictates of the Fourteenth Amendment.

I. INTRODUCTION…………………..……………………………143
II. FEDERAL LEGAL REQUIREMENTS TO PROVIDE MEDICAL
TREATMENT………………………………………………145
A. EMTALA………………………………………………145
B. The Federal Declaration of Limited COVID-19 Liability Immunity………………………………………………148
C. The PREP Pre-Emption Exclusion…………..………….151
D. The Failed Federal Attempt to Legislate Provider Immunity: Safe to Work Act……………………………………..…153
E. State Medical Treatment Waivers and EMTALA………...155
III. STATE LEGAL REQUIREMENTS TO PROVIDE MEDICAL
TREATMENT………………………………………..…..156
A. State Law: Executive Orders and Legislation Used to Allocate Scarce Healthcare Resources During the Pandemic……………………………………………..157
1. Pushback by State Activists Opposed to CSC SOFA Scoring Metrics……………………….…………………..161
B. Can the States Immunize Healthcare Providers from Tort Liability Using Executive Orders and/or Legislation?....163
C. Common Law and State Constitutional Prohibitions……164
D. The Fourteenth Amendment Right to Due Process and Equal Protection……………………………………………….166
E. State Legislation and the Attempt to Provide a Pandemic Liability Shield………………………………………..167
F. Gubernatorial Executive Orders Providing Immunity Shields Raise Enforceability Issues…………………………..…..173
IV. CONCLUSION……………………………………...……….178
APPENDIX A…………………………………………….……..181
APPENDIX B……………………………………….…………..184

I. INTRODUCTION

As COVID–19,[1] also referred to as the coronavirus pandemic, [hereinafter "the pandemic"] intensified, many communities in the U.S.

---

*Frederick V. Perry is a Professor of Business Law at Florida International University. Miriam Weismann is a Professor of Business Law and Tax at Florida International University.

[1] COVID–19 is an acute respiratory disease that can be spread from person to person for which there is no known cure at the time of the submission of this article. *See How COVID–19 Spreads*, CENTERS FOR DISEASE CONTROL AND PREVENTION (last updated July 14, 2021), https://www.cdc.gov/coronavirus/2019–ncov/prevent–getting–sick/how–covid–spreads.html.

experienced shortages of ventilators and intensive care (ICU) beds.[2] The pandemic placed unprecedented demand on the nation's healthcare systems.[3] Conservative estimates[4] show that the health needs created by COVID–19 far exceeded the capacity of U.S. hospitals.[5] Such demand created the need to ration or plan for rationing medical equipment and care interventions.

As discussed below, some states responded with triage protocols referred to as Crisis Standards of Care (CSC), Appendix A,[6] some did not respond at all. This paper focuses on those states that did formulate CSC guidelines and excludes consideration of non–governmental actors such as provider hospitals or healthcare associations formulating guidelines on an informal and legally nonbinding basis.[7] It also excludes consideration of

---

[2] Fred Schulte, et.al, *Millions of Older Americans Live in Counties with No ICU Beds as the Pandemic Intensifies*, KAISER HEALTH NEWS, Mar. 20, 2020, https://khn.org/news/as–coronavirus–spreads–widely–millions–of–older–americans–live–in–counties–with–no–icu–beds/ ("More than half the counties in America have no intensive care beds, posing a particular danger for more than 7 million people who are age 60 and up — older patients who face the highest risk of serious illness or death from the rapid spread of COVID–19 . . . .").

[3] *See* U.S. DEP'T OF HEALTH AND HUM. SERV., PANDEMIC INFLUENCE PLAN 2017 UPDATE 1, 3 (2017), https://www.cdc.gov/flu/pandemic–resources/pdf/pan–flu–report–2017v2.pdf.

[4] Ezekiel Emanuel, et al., *Fair Allocation of Scarce Medical Resources in the Time of Covid–19,* 382 NEW ENG. J. MED. 2049, 2050 (2020). According to the American Hospital Association, there were 5198 community hospitals and 209 federal hospitals in the United States in 2018. In the community hospitals, there were 792,417 beds, with 3532 emergency departments and 96,500 ICU beds, of which 23,000 were neonatal and 5100 pediatric, leaving just under 68,400 ICU beds of all types for the adult population. *Id.*

[5] Neil M. Ferguson, et al., *Impact of Non–pharmaceutical Interventions (NPIs) to Reduce COVID–19 Mortality and Healthcare Demand*, at 7 (Mar. 16, 2020), https://www.imperial.ac.uk/media/imperial–college/medicine/sph/ide/gida–fellowships/Imperial–College–COVID19–NPI–modelling–16–03–2020.pdf.

[6] Emily C. Cleveland Machanda, et al., *Crisis Standards of Care in the USA: A Systematic Review and Implications for Equity Amidst COVID–19*, J. OF RACIAL AND ETHNIC HEALTH DISPARITIES, 4–5 (2020), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7425256/pdf/40615_2020_Article_840.pdf. Replicated in **Appendix A** (Crisis standards of care are generally frameworks for catastrophic disaster response. For a discussion of such frameworks, *see* NAT'L INSTITUTE OF HEALTH, National Library of Medicine, https://pubmed.ncbi.nlm.nih.gov/24830057/; DEP'T OF HEALTH AND HUMAN SERV., *Topic Collection: Crisis Standards of Care*, https://asprtracie.hhs.gov/technical–resources/63/crisis–standards–of–care/0; and for Covid specific, *See* Crisis Standard of Care Covid–19 Pandemic, from the American Nurses Association 2008 https://www.nursingworld.org/~4ade15/globalassets/docs/ana/ascec_whitepaper031008final.pdf.

[7] In March 2018, the Florida Department of Public Health issued a Preparedness and Response Multi–Year Training and Exercise Plan (MYTEP). Fla. Dep't of Health, Public Health and Health Care Preparedness (PHHP): MYTEP, at 5 (2017), https://www.ncfhcc.org/wp–content/uploads/2017/08/2018–2020–mytep.pdf. This plan does not

those states not responding with any triage protocols and/or emergency plans.

Generally, triage protocols are guided in design by general concepts of "fairness" under accepted medical ethics rules which provide that limited medical resources should be allocated "to do the greatest good for the greatest number of individuals." [8] There has been to date no single national response providing for allocation of scare healthcare resources. Instead, for those states that have fashioned a rationing protocol design, each state guideline differs in language, implementation, and content. Various triage protocols are examined below to illustrate this point.

One intended purpose of the various CSC protocols in some states was to immunize or provide safe harbors to hospitals or healthcare providers from tort liability based on actions arising from pandemic related injuries including the consequences from an unavoidable medical decision limiting access to care. One legal implication of a provider immunity shield from tort liability is the loss of a patient's right to exercise otherwise guaranteed common law rights and remedies and, in some instances, state constitutional rights that guarantee access to the courts to redress legal

---

include any discussion of CSC triage protocols. In fact, Florida does not have a state sponsored plan for healthcare rationing in the event demand exceeds supply. Steve Contorno & Allison Ross, *If hospitals get overwhelmed, Florida is silent on who survives*, TAMPA BAY TIMES (Apr. 19, 2020), https://www.tampabay.com/news/health/2020/04/18/if–hospitals–get–overwhelmed–florida–is–silent–on–who–survives/. Recognizing the problem, the Florida Bioethics Network (FBN) filled the gap. *See* FLA. BIOETHICS NETWORK, ETHICS GUIDELINES FOR CRISIS STANDARDS OF CARE IN PUBLIC HEALTH EMERGENCIES, at 10 (2020) https://fha.informz.net/FHA/data/images/CSC–FBN–3.pdf. The FBN plan has been endorsed by the Florida Hospital Association which is made up of 200 hospitals. However, the FBN plan is not authorized as an appropriate triage protocol by the state. *Id.* at 1 ("No FBN members are authorized to speak on behalf of any institution they might work or volunteer for, and any listing of members' institutions is for identification purposes only. This document does not provide, and should not be inferred to provide, legal advice of any kind.").

[8] Am. Nurses Ass'n, Adapting Standards of Care Under Extreme Conditions, at 1 (2008), https://www.nursingworld.org/~496044/globalassets/practiceandpolicy/work–environment/health—safety/coronavirus/crisis–standards–of–care.pdf (for the proposition that "in a pandemic, nurses can find themselves operating in crisis standards of care environments. In such situations, a utilitarian framework usually guides practice decisions and actions with special emphasis on transparency, protection of the public, proportional restriction of individual liberty, and fair stewardship of resources); *see infra* note 96 (noting that healthcare rationing policies are designed to direct limited resources toward patients most likely to benefit from them). This notion derives from the Classical Utilitarians, Jeremy Bentham and John Stuart Mill posited that we ought to "maximize the good, that is, bring about 'the greatest amount of good for the greatest number.'" Julia Driver, *The History of Utilitarianism*, STANFORD ENCYC. OF PHILOSOPHY, https://plato.stanford.edu/entries/utilitarianism–history/ (Sept. 22, 2014).

grievances.[9] This paper examines a legal question of first impression: Whether the right to institute suit for pandemic related injuries can be constitutionally eliminated using triage protocols whether implemented by executive order or state statute during the pandemic. The paper concludes that healthcare providers may still be subject to some legal liability depending upon each state's unique constitutional grant of powers to the executive and legislative branches and the dictates of due process and equal protection of law as provided in the Fourteenth Amendment.[10]

II. FEDERAL LEGAL REQUIREMENTS TO PROVIDE MEDICAL TREATMENT

A. EMTALA

The federal Emergency Medical Treatment and Active Labor Act,[11] commonly referred to as "EMTALA," was enacted by Congress in response to a concern over "patient dumping" by hospitals refusing treatment of individuals who could not afford to pay for medical services.[12] EMTALA imposes a legal duty on the hospital and its physicians to provide medical screening examinations, medical stabilization[13] and treatment of all individuals seeking emergency care,[14] regardless of the

---

[9] See discussion of the common law tradition of rights in tort and of state constitutions *infra* Section III. C.

[10] Section One of the Fourteenth Amendment to the U.S. Constitution provides: "All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the state wherein they reside. No state shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws." U.S. CONST. amend. XIV, § 1.

[11] *See* Emergency Medical Treatment and Active Labor Act of 1986 (EMTALA), 42 U.S.C. § 1395dd. "In the case of a hospital that has a hospital emergency department, if any individual . . . comes to the emergency department and a request is made . . . for examination or treatment for a medical condition, the hospital must provide an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department to determine if an emergency medical condition . . . exists." 42 U.S.C. § 1395dd(a).

[12] June M. McKoy, Obligation to Provide Services: A Physician–Public Defender Comparison, AMA Journal of Ethics (May, 2006).
https://journalofethics.ama–assn.org/article/obligation–provide–services–physician–public–defender–comparison/2006–05

[13] "'To stabilize' means . . . [that] within reasonable medical probability . . . no material deterioration" should occur from or during the transfer. 42 U.S.C. § 1395dd(e)(3)(A).

[14] The term "emergency medical condition" means "[A] medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—(i) placing the

individual's ability to pay.[15] Notably, it does not matter if the patient was denied EMTALA treatment for non–monetary reasons as the Supreme Court has held that no "improper motive," financial or otherwise, must be proved to find a hospital in violation of EMTALA.[16]

By definition, EMTALA applies to a medical condition like COVID–19 manifesting itself by "acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the health of the individual in serious jeopardy, cause serious impairment to bodily functions, or cause serious dysfunction of any bodily organ or part."[17] Almost immediately, CMS made clear that "it is a violation of EMTALA for hospitals and critical access hospitals [hereinafter "CAHs"] with emergency departments [hereinafter "ED"] to use signage that presents barriers to individuals, including those who are suspected of having COVID–19, from coming to the ED, or to otherwise refuse to provide an appropriate medical screening examination [hereinafter "MSE"] to anyone who has come to the ED for examination or treatment of a medical condition."[18]

Additionally, the Secretary of Health and Human Services (HHS) observed that EMTALA likewise applies if a community has exhausted its supply of beds and/or ventilators and a patient presents with an emergent condition that requires these resources for stabilization. "In situations where facilities may not have the necessary services or equipment, they should provide stabilizing interventions within their capability until the individual can be transferred. For example, in cases where the hospital does not have available ventilators, establishing an advanced airway and providing manual ventilation can assist in stabilizing the individual until

---

health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part." 42 U.S.C. § 1395dd(e)(1).

15 Brenda Goodman & Andy Miller, *Lives Lost Amid ER Violations, Investigation Finds*, GA. HEALTH NEWS, (Nov. 29, 2018), https://www.georgiahealthnews.com/2018/11/investigation–finds–lives–lost–er–violations/. 4,341 EMTALA violations occurred at 1,682 hospitals nationwide between 2008–18. EMTALA violations occurred more often at hospitals with fewer than 100 beds, with these hospitals accounting for 34 percent of violations. *Id.*

16 Roberts v. Galen of Virginia, Inc., 525 U.S. 249, 249 (1999) (explaining that a plaintiff does not need to prove that the hospital acted with improper motive in failing to stabilize her in order to recover in a suit alleging a violation of § 1395dd(b)).

17 AM. COLL. OF EMERGENCY PHYSICIANS, EMTALA Fact Sheet (2021), https://www.acep.org/life–as–a–physician/ethics—legal/emtala/emtala–fact–sheet/.

18 CENTERS FOR MEDICARE AND MEDICAID SERVICES, FREQUENTLY ASKED QUESTIONS FOR HOSPITALS AND CRITICAL ACCESS HOSPITALS REGARDING EMTALA (Apr. 30, 2020), https://www.cms.gov/files/document/frequently–asked–questions–and–answers–emtala–part–ii.pdf.

an appropriate transfer can be arranged."[19] There is nothing in the statute, regulations or CMS guidelines that allow some patients to be denied treatment under state triage protocols as an alternative to mandated treatment under EMTALA. Thus, rationing healthcare by hospitals and CAHs has the potential to violate the federal statutory legal obligation to screen and stabilize patients presenting to hospital EDs for treatment and is legally impermissible under federal legislation mandating access to care.[20] This is true even though the full application of EMTALA was later circumscribed by a federal declaration of COVID–19 immunity and section 1135 waivers.[21] However, the section 1135 immunity waivers were not a stabilization mandate substitute.

In fact, Section 1135 waivers are expressly limited to situations arising out of the need by a hospital to "transfer" covid patients not yet stabilized due to an emergency or "redirect" patients under recognized state emergency pandemic treatment plans.[22] However, these waivers to provide Medical Screening Examinations (MSE) at an offsite alternate screening location not owned or operated by the hospital are subject to review on a case–by–case basis.[23] In interpreting the section 1135 waiver provision, CMS underscores that ". . . **there is no waiver authority available for any other EMTALA requirement."** [Emphasis added].[24] Thus, the waiver only authorizes non–stabilized patient transfers in an emergency or under a recognized state emergency pandemic plan, which

---

19 "[U]nder section 1135 of the Social Security Act, the Secretary [of HHS] may temporarily waive or modify certain Medicare, Medicaid, and Children's Health Insurance Program (CHIP) requirements to ensure [that] [s]ufficient health care items and services are available to meet the needs of individuals enrolled in Social Security Act programs in the emergency area and time periods[, and that] [p]roviders who provide such services in good faith can be reimbursed and exempted from sanctions (absent any determination of fraud or abuse)." CENTERS FOR MEDICARE AND MEDICAID SERVICES, 1135 WAIVER AT A GLANCE, https://www.cms.gov/Medicare/Provider–Enrollment–and–Certification/SurveyCertEmergPrep/Downloads/1135–Waivers–At–A–Glance.pdf.

20 *See* CENTERS FOR MEDICARE AND MEDICAID SERVICES, COVID–19 EMERGENCY DECLARATION BLANKET WAIVERS FOR HEALTH CARE PROVIDERS (Mar. 30, 2020), https://www.cms.gov/files/document/covid19–emergency–declaration–health–care–providers–fact–sheet.pdf.

21 *See id.*

22 The waiver provides as follows, in pertinent part: "Only two aspects of the EMTALA requirements can be waived under 1135 Waiver Authority: 1) Transfer of an individual who has not been stabilized, if the transfer arises out of an emergency or, 2) Redirection to another location (offsite alternate screening location) to receive a medical screening exam under a state emergency preparedness or pandemic plan. A waiver of EMTALA sanctions is effective only if actions under the waiver do not discriminate as to source of payment or ability to pay. Hospitals are generally able to manage the separation and flow of potentially infectious patients through alternate screening locations on the hospital campus. *Id.*

23 *See id.*

24 *Id.*

parenthetically was not implemented in all states as indicated in Appendix A.

Additionally, under EMTALA, physicians are subject to federal civil monetary penalties and may be subject to exclusion from participation in the Medicare and Medicaid programs for gross and flagrant or repeated violations of EMTALA.[25] Although a patient cannot directly sue a physician for noncompliance with EMTALA's requirements,[26] physicians may still be subject to a patient tort claim for medical malpractice arising out of the failure to properly administer the federal EMTALA requirements.[27]

B. The Federal Declaration of Limited COVID–19 Liability Immunity

On March 17, 2020, HHS declared COVID–19 a public health emergency[28] under the Public Readiness and Emergency Preparedness Act[29] [hereinafter "PREP"]. PREP was intended to directly impact states, providing a source of potential liability protection for governmental and private sector persons developing and administering "approved countermeasures"[30] during a public health emergency. The Declaration states that its purpose is to provide "liability immunity for activities related to medical countermeasures[31] against COVID–19."[32] The immunity provisions were specifically directed to "covered persons" defined as

---

25 *See* 42 U.S.C. §1395(dd)(d)(2)(A); *See* Coleman v. Deno, 813 So. 2d 303, 313–14 (La. 2002) (for the proposition that the court upheld a malpractice claim against a physician for "patient dumping" and the improper transfer of a patient under EMTALA while hospitalized and under the physician's treatment). Negligence is not the standard here. It is the violation of the statute that exposes the physician and hospital to liability.

26 *See* 42 U.S.C. § 1395dd(d)(2)(a).

27 *See id.*

28 *See* DEP'T OF HEALTH AND HUM. SERV., DECLARATION UNDER THE PUBLIC READINESS AND EMERGENCY PREPAREDNESS ACT FOR COUNTERMEASURES AGAINST COVID–19, 85 FED REG. 15198 (2020). [hereinafter "Declaration"].

29 *See* 42 U.S.C. § 243 (2005) (PREP amended the Public Health Service (PHS) Act, adding § 319F–3 (liability immunity) and § 319F–4 (compensation program). These sections are codified at 42 U.S.C. §§ 247d–6d and 247d–6e, respectively.).

30 42 U.S.C. § 247d–6d.

31 *See* Declaration, *supra* note 28, at 15199–200. A covered countermeasure must be a "qualified pandemic or epidemic product"; a "security countermeasure"; a drug, biological product, or device authorized for emergency use in accordance with various sections of the Federal Food, Drug, and Cosmetic Act; or certain approved respiratory protective devices. Qualified pandemic and epidemic products may also include products that "limit the harm such a pandemic or epidemic might otherwise cause." *Id.*

32 *Id.* at 15198.

manufacturers, distributors, and others including hospitals, physicians and other healthcare professionals engaged in COVID–19–related efforts.[33]

However, after the Declaration was issued, there were numerous questions regarding the scope and applicability of the immunity provisions under the Declaration. No one was really sure what PREP meant in terms of a provider immunity shield. In an attempt to clarify, on April 14, 2020, HHS issued an Omnibus Advisory Opinion[34] [hereinafter "Opinion"] that provided additional non–binding guidance, not having the force of law,[35] on this question. If all requirements of PREP and the Declaration are met, the Opinion provides that PREP immunity covers both tort and contract claims, including claims for loss relating to compliance with local, state, or federal laws, regulations, or other legal requirements.[36] However, immunity is expressly limited to claims for personal injury or damage to property.[37]

The Opinion clarified that immunity only "applies when a covered person engages in activities related to an agreement or arrangement with the federal government, or when a covered person acts according to an [a]uthority [h]aving [j]urisdiction to respond to a declared emergency."[38] The Opinion interprets these two conditions broadly to include: (1) any arrangement with the federal government, or (2) any activity that is part of an authorized emergency response at the federal, regional, state, or local level. "Such activities can be authorized through, among other things, guidance, requests for assistance, agreements, or other arrangements."[39]

However, "PREP immunity is not absolute."[40] It does not provide immunity against federal civil, criminal, or administrative actions. "Nor does it provide immunity against suit and liability for claims under federal law for equitable relief."[41] Also, a covered person is not immune from

---

[33] *Id*. at 15199. The Declaration defines "covered persons" for purposes of its immunity provisions to include "a qualified person" defined as a licensed health professional or other individual authorized to prescribe, administer, or dispense Covered Countermeasures under the law of the state in which the Covered Countermeasure was prescribed, administered or dispensed. *Id.* The term "person" includes an individual, partnership, corporation, association, entity, or public or private corporation, including a federal, state, or local government agency or department. 42 U.S.C. § 247d–6d(i)(5).

[34] DEP'T OF HEALTH AND HUM. SERV., ADVISORY OPINION ON THE PUBLIC READINESS AND EMERGENCY PREPAREDNESS ACT FOR COUNTERMEASURES AGAINST COVID–19, at 1 (2020), https://www.hhs.gov/sites/default/files/prep–act–advisory–opinion–hhs–ogc.pdf .

[35] *See id.* ("It is not a final agency action or a final order. Nor does it bind HHS or the federal courts. It does not have the force or effect of law.").

[36] *See id.* at 2.

[37] *See id.*

[38] *Id.*

[39] *Id.*

[40] *Id.*

[41] *Id.*

liability for willful misconduct that proximately causes death or serious injury.[42] Thus, there is no immunity for intentional tort liability. Finally, in states where no protocol exists, there is no "authorized emergency response" at the state level that would qualify for provider immunity under the second prong of the Opinion.[43]

A month later on May 19, 2020, HHS issued an Advisory Opinion signed by General Counsel, Robert Charrow, further clarifying the scope and application of the PREP immunity waiver provision [hereinafter "Advisory Opinion].[44] According to the Advisory Opinion: "The PREP Act authorizes the Secretary to issue a declaration to provide liability immunity to certain individuals and entities (covered persons) against any claim of loss caused by, arising out of, relating to, or resulting from the manufacture, distribution, administration, or use of medical countermeasures (covered countermeasures)."[45] The Advisory Opinion again emphasizes that the PREP Act applies only to covered persons engaged in covered countermeasures. The Advisory Opinion concludes by stating that "HHS encourages all covered persons using or administering covered countermeasures to document the reasonable precautions they have taken to safely use the covered countermeasures."[46] This language seemingly adds a duty of care requiring reasonable safety precautions when implementing countermeasures under the immunity provision.

Parenthetically, there is nothing in the Advisory Opinion or in PREP shielding healthcare providers from liability for personal injury claims arising out of healthcare rationing protocols that limit or deny access to state healthcare resources. The specific question of permissible rationing is not specifically listed as an authorized countermeasure, and it remains unclear if rationing fits under the language "any activity." As noted in the following discussion of the PREP pre–emption exclusion, it would not appear that "any activity" is intended to immunize healthcare rationing or denial of healthcare access resulting in a claim for resulting injuries.

In terms of legal guidance, it is also significant that in any case, neither the Opinion nor the Advisory Opinion have the force of law, potentially leaving several legal questions unresolved as well. For example, does PREP immunize healthcare providers at the state level for other tort

---

42 *See* 42 U.S.C. § 247d–6d(c)(3). "Any action [alleging an exception to immunity for covered persons] shall be assigned initially to a panel of three judges [the United States District Court for the District of Columbia]." 42 U.S.C. § 247d–6d(e)(1), (5). And to prevail, a plaintiff must establish, by clear and convincing evidence, that the willful misconduct proximately caused death or serious injury. *See* 42 U.S.C. § 247d–6d(c)(3).

43 *See* DEP'T OF HEALTH AND HUM. SERV., *supra* note 34, at 2.

44 *See id.*

45 *Id.* at 3

46 *Id.* at 8.

actions such as gross negligence or medical malpractice for claims arising out a refusal treat where medical resources are otherwise unavailable? These ambiguities in the PREP legislation are further complicated by an accompanying "pre–emption exclusion" contained in the PREP legislation (discussed in the next section) and the subsequent issuance by CMS of the Section 1135 waiver addressed above that expressly forbids any waiver authority for any other EMTALA requirement outside of the parameters of the section 1135 transfer waiver.[47]

C. The PREP Pre–Emption Exclusion

PREP includes a pre–emption exclusion.[48] This exclusion provides that "no State or political subdivision of a State may establish, enforce, or continue in effect with respect to a covered countermeasure any provision of law or legal requirement that is different from, or is in conflict with, any requirement applicable under this section."[49] In forceful language, the statutory pre–emption exclusion makes clear that patients' legal rights were not intended to be suspended or otherwise pre–empted by state or local laws in conflict with PREP during the crisis.[50] This last part of the pre–emption exclusion seemingly contradicts the language of the non–legally binding Opinion which interprets with approval **any activity** that is part of an authorized emergency response at the federal, regional, state, or local level.[51] Alternatively, reading the Opinion, the Advisory Opinion, and the pre–emption exclusion together, could support the conclusion that PREP immunity applies only to a covered person engaged in covered countermeasures and not to the suspension of a patient's right to equal access to care, even by CSC guidelines issued by executive order or pursuant to state statute.[52] This interpretation might smooth any discord between the Opinion and the exclusion.[53] However, that statutory construction would require a judicial determination.

Likewise, this proposed statutory interpretation finds some support in the position of the HHS Office of Civil Rights [hereinafter "OCR"]. On

---

[47] *See* CENTERS FOR MEDICARE & MEDICAID SERVICES, *supra* note 20.
[48] *See* 42 U.S.C. § 247d–6d(b)(8)(A), (b)(1).
[49] § 247d–6d(b)(8).
[50] *See* Kathleen Liddell et al., *Who Gets the Ventilator? Important Legal Rights in the COVID–19 Pandemic*, 46 (7) J. MED. ETHICS, 421–426 (2020).
[51] *Supra* note 34.
[52] *Id.*
[53] *See See Kathleen Liddell et al., Who Gets the Ventilator? Important Legal Rights in the COVID–19 Pandemic, 46 (7) J. MED. ETHICS, 421–426 (2020)..*; *cf.* A. E. Nettleton Co. v. Diamond, 27 N.Y.2d 182,193 (1970) (When a statute is challenged on nonprocedural grounds as violative of due process of law, the court considers whether there is "'some fair, just and reasonable connection' between the language of the statute and the promotion of the health, comfort, safety and welfare of society").

March 28, 2020, shortly before the issuance of the Opinion, OCR issued a Bulletin to ensure that healthcare entities "keep in mind their obligations under laws and regulations that prohibit discrimination on the basis of race, color, national origin, disability, age, sex, and exercise of conscience and religion in HHS–funded programs."[54] The Bulletin cautioned that the "laudable goal of providing care quickly and efficiently must be guided by the fundamental principles of fairness, equality, and compassion that animate our civil rights laws."[55] Likewise, OCR's director emphasized that, "HHS is committed to leaving no one behind during an emergency, and this guidance is designed to help health care providers meet that goal . . . Our civil rights laws protect the equal dignity of every human life from ruthless utilitarianism."[56]

Thus, while PREP provides some immunity to providers, the scope of the immunity remains at least subject to the requirements of civil rights laws which are not suspended during a declared state of emergency arising out of the pandemic. Given that several legal scholars have suggested that various state triage CSC guidelines allocating scarce resources may have a discriminatory impact in application on the disabled and minorities, such an emergency response may subject providers to a claimed violation of patient civil rights.[57]

The state triage protocol system and the use of CSC, endorsed by HHS,[58] is designed in part to provide some legal relief to hospitals and physicians, although the extent of that protection is not clear given the EMTALA and PREP legislative mandates just examined above. As we will see, some states, but not all, did include a grant of immunity to providers in their respective CSC guidelines to protect those providers implementing state triage protocols otherwise approved by HHS.[59] However, the research does not reveal any formal approval process by HHS of the state triage protocols issued during the pandemic. Nor is there

---

54 *Civil Rights, HIPAA, and the Coronavirus Disease 2019*, DEP'T OF HEALTH AND HUM. SERV. OFF. FOR CIV. RTS. (Mar. 28, 2020), at 1.

55 *Id.*

56 *Id.*; *See* AM. NURSES ASS'N, *supra* note 8.

57 *See* Miriam Weismann & Cheryl Holder, *Ruthless Utilitarianism? COVID 19 State Triage Protocols May Subject Patients to Racial Discrimination and Providers to Legal Liability,* 47 AM. J.L. & MED. 264 (2021); *see also* Liddell et al., *supra* note 53.

58 *See* Benjamin J. McMichael et al., *COVID–19 And State Medical Liability Immunity,* HEALTH AFFAIRS BLOG (May 14, 2020), https://www.healthaffairs.org/do/10.1377/hblog20200508.885890/full/.

59 *See* Appendix A.

any formal statement by HHS which approves any particular state triage protocol, including healthcare rationing, issued during the pandemic.[60]

D. The Failed Federal Attempt to Legislate Provider Immunity: Safe to Work Act

In an effort to provide some relief from medical malpractice exposure during the pandemic, Congress did propose draft legislation, The Safe to Work Act,[61] [hereinafter "SWA"] to provide a "liability shield" protecting businesses and healthcare providers against workers, customers and patients suing over pandemic–related injuries. SWA was first introduced on July 27, 2020, in a previous session of Congress, but it did not receive a vote.[62] In summary, the proposed legislation would have enacted a five–year period of limited immunity for certain defendants in coronavirus–related personal injury and medical malpractice suits.[63] These cases, normally filed in state civil courts, would fall under federal court jurisdiction with a one–year statute of limitations within which to file the lawsuit.[64] Under the proposed legislation, plaintiff patients must satisfy a two–pronged requirement to establish that a healthcare provider or business was grossly negligent or engaged in willful misconduct and that the provider failed to make "reasonable efforts" to comply with applicable federal or state public health guidance.[65] In short, a claim of gross negligence would fail if a defendant provider could establish it made a reasonable effort, but failed, to comply with pandemic safety measures.[66]

---

[60] There are at least two circumstances where HHS rejected state protocols of Washington and Alabama as violative of civil rights. *See* Sheri Fink, *U.S. Civil Rights Office Rejects Rationing Medical Care Based on Disability, Age*,
N.Y. TIMES (Mar. 30, 2020), https://www.nytimes.com/2020/03/28/us/coronavirus–disabilities–rationing–ventilators–triage.html.

[61] *See* Safe to Work Act, S. 4317, 116th Cong. (2020). https://www.congress.gov/bill/116th–congress/senate–bill/4317/text.

[62] *See S. 4317 (116th): SAFE TO WORK Act*, GOVTRACK, https://www.govtrack.us/congress/bills/116/s4317 (last visited Oct. 26, 2021).

[63] *See* Safe to Work Act, S. 4317, 116th Cong. (2020).

[64] *See id.*

[65] *See id.*

[66] *See id.* Other salient features of the proposed legislation include: The bill states that the liability shield is retroactive to Dec. 1 and will remain in effect until either Oct. 1, 2024, or the end of the national public health crisis as declared by the U.S. Department of Health and Human Services, whichever is later. If a coronavirus–related suit is filed in or removed to federal court, a plaintiff must provide an opinion from a medical expert essentially vouching for an injured party's claim. Plaintiffs are required to provide a list of the places they went and people they met in the 14–day period prior to experiencing symptoms, as well as any persons who visited their residence during that period. Overall awards can be reduced to account for payments made by so–called collateral sources such as insurance companies and government reimbursements. In cases where there are multiple defendants,

Again, the legal standard still required a duty of care to engage in a reasonable effort to comply with safety guidelines. However, the proposed statute makes no specific reference to healthcare rationing or the denial of access to healthcare.

The Act's Senate sponsors, argued that passage of the Act was legally required to limit or eliminate the risk of expensive litigation that might deter businesses and other entities, such as healthcare providers, and jeopardize the nation's recovery from the pandemic, and put at risk the investment of taxpayer dollars under the CARES Act.[67] Critics argue that the "preponderance of provisions contained in the bill is nothing more than a business liability shield."[68] Opponents also argued that the Act would eliminate an important incentive for individuals and entities to comply with government standards and guidelines intended to protect workers and the public. Opponents concluded that "the Act would leave vulnerable individuals who are exposed to the coronavirus without recourse if they suffer harm because of lax compliance."[69]

SWA was never passed signaling that healthcare providers remain exposed to the threat of legal liability. The liability shield question was in any case not resolved at the federal level. Nor have the requirements of due process and equal protection under the Fourteenth Amendment, guaranteeing litigants access to the courts to redress legal grievances, been diminished by the pandemic. The question of due process and equal

---

defendants will only be responsible for a proportionate share of damages, and it will be up to juries to determine the percentage of fault for each defendant. The bill includes a "loser pays" provision that allows prevailing defendants to seek compensatory and punitive damages if a claim outlined in a demand letter turns out to be meritless.

[67] The CARES Act was designed to stimulate the economy by putting money into the hands of small, medium sized and large businesses, but tort lawsuits would extract the same money from intended business recipients, thereby having an adverse effect on economic recovery. U.S. DEP'T OF TREASURY. *About the CARES Act and the Consolidated Appropriations Act*, https://home.treasury.gov/policy–issues/coronavirus/about–the–cares–act#:~:text=The%20Coronavirus%20Aid%2C%20Relief%2C%20and,%2C%20 small%20businesses%2C%20and%20industries. (last visited Jan. 5, 2021).

[68] Julia Musto, *Senate GOP's SAFE TO WORK Act may be crucial point in stimulus talks*, FOX NEWS (Sept. 8, 2020), https://www.foxnews.com/politics/senate–republicans–safe–to–work–act–could–be–difference–between–stimulus–deal–or–not; *See generally* Tami S. Smason et al., *Proposed SAFE TO WORK Act Offers Protections to Businesses Impacted by COVID–19*, 293 THE NAT'L LAW REVIEW 197 (Aug. 21, 2020), https://www.natlawreview.com/article/proposed–safe–to–work–act–offers–protections–to–businesses–impacted–covid–19; *See also* Gary Anderson, *Democrats allow abuse of legal system by not supporting 'Safe to Work'*, WASH. TIMES (Aug. 11, 2020), https://www.washingtontimes.com/news/2020/aug/11/democrats–allow–abuse–of–legal–system–by–not–suppo/.

[69] *The SAFE TO WORK Act: An In–Depth Guide for Employers to the Senate's Proposed Coronavirus Liability Shield*, MORRISON & FOERSTER (Aug. 11, 2020), https://www.mofo.com/resources/insights/200811–safe–to–work–act.html.

protection is addressed below in the context of the state response to the threat of provider legal liability given the absence of a cogent federal response.

E. State Medical Treatment Waivers and EMTALA

CMS did not deny the states the continued use of a medical treatment waiver during the pandemic but did expressly circumscribe its use in conformity with HHS pronouncements.[70] Specifically, state medical treatment waivers[71] may not include waiver of protections granted under other laws such as the federal civil rights laws. Hospitals receiving federal financial assistance likewise remain obligated to comply with federal civil rights laws, including Section 504 of the Rehabilitation Act, Title VI of the Civil Rights Act of 1964, Section 1557 of the Affordable Care Act and the Hill–Burton Act.[72] As discussed below, these federal laws require equal medical treatment especially for the disabled and other vulnerable populations.[73] In this regard, there is some legal concern that state CSC guidelines may have the impact of discriminating against the disabled and minorities in prioritizing access to limited treatment resources.[74] There appears to be no liability shield in this case.

Thus, the federal EMTALA obligations to treat patients until stabilized and provide all necessary treatment that does not deviate from accepted norms of practice, may create a legal quandary for medical providers where demand for healthcare treatment exceeds the supply. This is confounded by the complete absence of national CSC guidelines for allocating ICU beds, ventilators and other necessary medical treatment

---

[70] "In general, a liability waiver (sometimes called a 'release of liability') is a legal agreement where the signer does two things: 1) 'waives' (or gives up) the right to sue in the event of misfortune or 'simple negligence,' and 2) releases a person or organization from 'liability.'" Stephen Porritt, *"What's a Medical Liability Waiver?" and Other Important Questions Answered*, WAIVERSIGN (Oct. 21, 2020), https://www.waiversign.com/blog/medical–liability–waiver. For such waivers to constitute binding legal consent, "the waiver needs to explain the risks involved in the given activity, and the signer needs to be given time to read it." *See id.*

[71] *See* CENTERS FOR MEDICARE AND MEDICAID SERVICES, s*upra* note 20 at 4.

[72] *See id.* at 11; *see* Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. 794 (disability), under any health program or activity, any part of which is receiving federal financial assistance; any program or activity administered by the Department under Title I of the Act; or any program or activity administered by any entity established under such Title (Emphasis added). HHS. Gov, *Section 1557 of the Patient Protection and Affordable Care Act*, https://www.hhs.gov/civil–rights/for–individuals/section–1557/index.html.

[73] *See generally* Weismann & Holder, *supra* note 57 at 272–73.

[74] *See, e.g., id.*

during a declared emergency like a pandemic[75] and the failure to legislate a provider liability shield under the SWA.

Nonetheless, states are still faced with the practical legal quandary of satisfying federal laws while at the same time dealing with the impact of medical resource shortages. Accordingly, several states formulated and adopted their own CSC guidelines to deal with the pandemic. A consideration of the state legal landscape and the varied attempts to offer medical providers a liability shield may raise more legal hurdles than it can resolve.

III. STATE LEGAL REQUIREMENTS TO PROVIDE MEDICAL TREATMENT

While federal law does not provide a direct cause of action for malpractice against physicians for failure to treat, state law does.[76] Under state law, physicians have no duty to accept a patient, regardless of the severity of the illness.[77] A physician's relationship with a patient is voluntary, a contracted one. However, once a treatment relationship exists, the physician has legal duty to treat and must provide all necessary treatment to a patient unless the relationship is ended by the patient or by the physician, provided that the physician gives the patient sufficient notice to seek another source of medical care.[78] In failing to meet these requirements, "medical malpractice is defined as any act or omission by a physician during treatment of a patient that deviates from accepted norms of practice in the medical community and causes an injury to the patient."[79]

A. State Law: Executive Orders and Legislation Used to Allocate Scarce Healthcare Resources During the Pandemic

Rationing of medical resources became a critical issue in several states as the number of patients contracting the coronavirus increased in the U.S.

[75] Alice Park & Jeffrey Kluger, *The Coronavirus Pandemic Is Forcing U.S. Doctors to Ration Care for All Patients,* TIME (Apr. 22, 2020, 8:00 AM), https://time.com/5825145/coronavirus–rationing–health–care/.

[76] *See* B. Sony Bal, *An Introduction to Medical Malpractice in the United States,* 467 CLINICAL ORTHOPEDICS RELATED RSCH., 339–347 (2009).

[77] Bernard Lo, *Resolving Ethical Dilemmas*, at 183, Wolters Kluwer, 4th Edition (2009)

[78] *See* Valarie Blake, *When Is a Physician–Patient Relationship Established?* 14 AMA J. OF ETHICS (2012) (citing Ricks v. Budge, 64 P.2d 208, 211–212 (Utah 1937)).

[79] Bal, *supra* note 76.

In March 2020, the governors of Arizona,[80] Florida,[81] California,[82] Georgia[83] and New York[84] declared a state of emergency based on the coronavirus. By March 17, 2020, forty–eight states had followed suit.[85] The emergency declarations were followed by some states implementing new or preexisting Crisis Standards of Care (CSC) guidelines which provide in part a method to ration healthcare services when patient demand exceeds medical services supply. These protocols are formulated and issued by the states in the form of triage protocols. The National Academy of Science (NAS) has also issued voluntary advisory guidelines for state guidance in implementing CSC protocols.[86]

The NAS guidelines provide that CSC protocols should only be activated when a pervasive or catastrophic disaster make it "impossible" to meet usual health care standards.[87] The NAS guidelines acknowledge that while CSC protocols "strive to save the most lives possible, . . . some individual patients will die, who would otherwise survive under usual care."[88] "Implementation of CSC will require facility–specific decisions regarding the allocation of limited resources, including how patients will be triaged to receive life–saving care."[89] Notably, the guidelines do not define the term "impossible" or the specific criteria to be applied by facilities in reaching a care rationing decision.

Further, without providing any legal basis for its conclusion, NAS observes that "[u]nder disaster conditions, adherence to core constitutional

---

80 Elizabeth Whitman, *Arizona Governor Declares State of Emergency on Coronavirus, with Nine Cases So Far*, PHX. NEW TIMES (Mar. 11, 2020, 3:45 PM) https://www.phoenixnewtimes.com/news/arizona–governor–declares–state–of–emergency–over–coronavirus–11456074.

81 Fla. Exec. Order No. 20–52 (Mar. 1, 2020), https://www.flgov.com/wp–content/uploads/2020/03/EO–20–52.pdf.

82 Cal. Proclamation of a State of Emergency (Mar. 4, 2020), https://www.gov. ca. gov/wp–content/uploads/2020/03/3.4.20–Coronavirus–SOE–Proclamation.pdf.

83 Ga. Declaration of Public Health State of Emergency (Mar. 14, 2020), https://gov.georgia.gov/executive–action/executive–orders/2020–executive–orders.

84 N.Y. Exec. Order No. 202, (Mar. 7, 2020), https://www.governor.ny.gov/news/no–202–declaring–disaster–emergency–state–new–york.

85 Rosie Pepper, *Almost all US states have declared states of emergency to fight coronavirus — here's what it means for them,* BUSINESS INSIDER (Mar. 17, 2020, 1:34 AM) https://www.businessinsider.com/california–washington–state–of–emergency–coronavirus–what–it–means–2020–3.

86 *See* NAT'L ACADS. OF SCIS., ENG'G, AND MED., RAPID EXPERT CONSULTATION ON CRISIS STANDARDS OF CARE FOR THE COVID–19 PANDEMIC (2020), https://files.asprtracie.hhs.gov/documents/nap–rapid–expert–consultation–on–csc–for–covid–19–pandemic.pdf.

87 *Id.* at 82.

88 *Id.* at 2.

89 *Id.*

principles remains a constant, but other statutory or regulatory provisions can be altered as necessary in real time."[90] NAS continues:

> The law must inform CSC and create incentives for protecting the public's health and respecting individual rights. Extreme scarcity can necessitate difficult life–and–death decisions. Health care workers who will have to make them must have adequate guidance and legal protections. They must be able to follow the rule of law, even under disaster conditions.[91]

Thus, at least two things are required according to the NAS when life and death decisions are being made by providers during the pandemic: adequate guidance and legal protections allowing providers the ability to follow the law.

A comparison of several state CSC protocols demonstrates that the most common metric used by states or healthcare organizations to justify rationing healthcare,[92] is the Sequential Organ Failure Assessment [hereinafter "SOFA"] score.[93] The SOFA triage protocol is based on a priority point system formula.[94] The formula specifies the order in which

---

[90] *Id.* at 3.

[91] *Id.* at 5.

[92] For example, in a medical study conducted using 26 state guidelines used to determine ventilator rationing, 24 of the 26 states recommended objective scoring systems for the allocation of ventilators. Gina M. Piscitello et al., *Variation in Ventilator Allocation Guidelines by US State During the Coronavirus Disease 2019 Pandemic*, JAMA NETWORK OPEN (June 19, 2020), at 1, 3, https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2767360. Furthermore, Sequential Organ Failure Assessment ("SOFA") scoring was recommended in 15 of the 26 state guidelines. *Id.* at 1.

[93] Other models, such as the Pitt Model, integrate SOFA scoring models to eliminate exclusion criteria that are not adjusted for the potential of discriminatory impact. However, even under the Pitt Model, higher SOFA scores may still result in lower priority for receiving care, a subtle distinction within exclusion metrics. *See* Douglas B. White ET AL., *Allocation of Scarce Critical Care Resources During a Public Health Emergency Executive Summary*, UNIV. OF PITT. SCHOOL OF MEDICINE, 1, 2 (Apr. 15, 2020), https://ccm.pitt.edu/sites/default/files/UnivPittsburgh_ModelHospitalResourcePolicy_2020_04_15.pdf for the proposition that: "There are compelling reasons to not use exclusion criteria. Categorically excluding patients will make many feel that their lives are not worth saving, leading to justified perceptions of discrimination. Moreover, categorical exclusions are too rigid to be used in a dynamic crisis, when ventilator shortages will likely surge and decline episodically during the pandemic. In addition, such exclusions violate a fundamental principle of public health ethics: use the means that are least restrictive to individual liberty to accomplish the public health goal. Categorical exclusions are not necessary because less restrictive approaches are feasible, such as allowing all patients to be eligible and giving priority to those most likely to benefit."

[94] *See* Gina M. Piscitello et al., *Variation in Ventilator Allocation by US States During the Coronavirus Disease 2019 Pandemic: A Systematic Review*, JAMA NETWORK OPEN 1,

a needed resource, like a ventilator, is to be rationed for patients.[95] The priority order is determined by patient mortality risk. Using mortality risk, a patient's priority assignment is re–evaluated every 48 hours to determine if there is any change in health status.[96] Mortality risk is also measured by the Sequential Organ Failure Assessment (SOFA) score.[97] Simply, each of six organ systems, lungs, liver, brain, kidneys, blood clotting, and blood pressure, is independently assigned a score of 1 to 4.[98] The SOFA score totals these six scores, with sicker patients generally being assigned higher scores.[99] Those with higher scores are placed behind those with lower scores who are more likely to survive a medical intervention. The idea is that wasting scarce healthcare resources on those less likely to survive is an inefficient use of limited resources.[100]

In July 2020, a panel of experts from the American College of Chest Physicians (CHEST) published principles of critical care triage to "direct limited resources toward patients most likely to benefit from them" during the COVID–19 crisis.[101] These triage protocol guidelines are similarly

---

1–7 (June 19, 2020), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2767360.

[95] *Id.*

[96] HOWARD A. ZUCKER ET AL., N.Y. STATE TASK FORCE ON LIFE AND THE LAW, *Ventilator Allocation Guidelines* 1, 15 (2015), https://www.health.ny.gov/regulations/task_force/reports_publications/docs/ventilator_guidelines.pdf.

[97] The European Society of Intensive Care Medicine designed the SOFA score metric in October 1994 in Paris, France. J.L. Vincent et.al, *The SOFA (Sepsis–related Organ Failure Assessment) score to describe organ dysfunction/failure*, 22 INTENSIVE CARE MEDICINE 707–710 (1996).

[98] "SOFA [is] based on six different scores, one for each of the respiratory, cardiovascular, hepatic, coagulation, renal and neurological systems each scored from 0 to 4 with an increasing score reflecting worsening organ dysfunction." Simon Lambden et al., *The SOFA score—development, utility and challenges of accurate assessment in clinical trials*, 23 CRITICAL CARE 1, 2 (2019), https://ccforum.biomedcentral.com/track/pdf/10.1186/s13054–019–2663–7.pdf.

[99] While not initially designed as a prognostic score, subsequent research supports its use for that end. A.E. Jones et. al, *The Sequential Organ Failure Assessment score for predicting outcome in patients with severe sepsis and evidence of hypoperfusion at the time of emergency department presentation*, 37 CRITICAL CARE MED., 1649, 1652 (2009).

[100] *See generally Health Care System Surge Capacity Recognition, Preparedness, and Response*, AM. COLL. OF EMERGENCY PHYSICIANS (Oct. 2017), https://www.acep.org/patient–care/policy–statements/health–care–system–surge–capacity–recognition–preparedness–and–response/.

[101] Ryan C. Maves et. al., *Triage of Scarce Critical Care Resources in COVID–19 An Implementation Guide for Regional Allocation,* 158 CHEST 212, 212 (2020).

designed to be implemented when "surge capacity"[102] is exceeded and there is a need to allocate scare medical resources.[103]

CHEST recommends the "use of tertiary triage, which takes place at an acute care hospital when deciding whether or not to admit for critical care services."[104] Generally, coronavirus patients will fit into one of three tertiary triage categories: "(1) too well to benefit from critical care, (2) too sick to benefit from critical care because of severe underlying illness or a poor likelihood of surviving their hospitalization, or (3) sick enough to benefit from critical care."[105] "The goal is not to exclude categories of patients based on age or underlying co–morbidities and disease. Rather, the goal of a triage protocol is to maximize the use of critical care resources for patients in the third category."[106] "These categories apply to all patients presenting with critical illness under crisis standards of care, not just those infected with COVID 19."[107] CHEST concludes that it is necessary to "recognize that patients less likely to benefit from critical care may not be provided those services and interventions under a triage system."[108]

However, referring to the practice of singular reliance on SOFA scores, CHEST expressly recognizes that "protocols that explicitly exclude patients based on a single criterion alone may run afoul of antidiscrimination laws in many jurisdictions."[109] CHEST further recommends against the use of SOFA scoring alone because "a growing body of evidence suggests such scoring systems are unlikely to predict critical care outcomes with sufficient accuracy, in particular patients suffering from COVID 19, or be a useful basis for triage decisions based on the current protocol cut points."[110]

Medical ethicists likewise criticize the use of priority point systems like SOFA for ignoring ethical values.[111] Some argue that at "[a]ny patient

---

102 *Compare* AM. COLL. EMERGENCY PHYSICIANS, *supra* note 100, at 1 ("Surge capacity is a measurable representation of ability to manage a sudden influx of patients") *with* NAT'L ACAD. OF SCI., ENG'G, AND MED. *supra* note 86, at 2 (finding states should implement protocols when it is "impossible" to meet healthcare standards).

103 AM. COLL. OF EMERGENCY PHYSICIANS, *supra* note 100, at 1.

104 *Id*. at 217.

105 *Id.* at 217.

106 *Id.*

107 *Id.*

108 *Id.*

109 *Id.*

110 *Id.*

111 *See* Harald Schmidt, *The Way We Ration Ventilators is Biased*, N.Y. TIMES (Apr. 15, 2020), https://www.nytimes.com/2020/04/15/opinion/covid–ventilator–rationing–blacks.html (noting that "[f]or example, creatinine levels, which reflect kidney function, vary across income and racial groups. African–Americans, who have higher creatinine levels on average, would be assigned a higher risk."); Parag A. Pathak ET AL., *Leaving No Ethical*

priority level, there is a potential that one priority group could completely exhaust the remaining available resources leaving remaining patients without access."[112]

Still, Arizona, Florida, California, Georgia, Pennsylvania, and New York rely on SOFA scoring as the single metric to justify rationing healthcare during a healthcare emergency. Arizona is currently the only state as of June 30, 2020, to actually initiate its rationing triage protocol in response to the pandemic.[113] A summary of Arizona' CSC protocol and those of other state national pandemic hotspots, including Florida, California, Georgia, New York and Texas is provided in Appendix A. A few of these states such as Pennsylvania have incorporated the CHEST guidelines which provide operational steps to implement a triage system within a state, county or jurisdiction.[114]

1. Pushback by State Activists Opposed to CSC SOFA Scoring Metrics

Almost immediately after issuing triage protocols under CSC, several states' protocols were questioned by state disability activists. This resulted in the Director of the HHS OCR declaring that the CSC protocols adopted by two states, Washington and Alabama, discriminated against the disabled.[115] HHS expressly rejected any protocols that had the potential to place "[p]ersons with disabilities, with limited English skills and older persons . . . at the end of the line for health care during emergencies,"[116] noting that new investigations would be conducted to ensure compliance with civil right laws during the pandemic. The conclusion was not predicated on any actual finding of intentional discrimination but rather upon a determination that the guidelines subjected the disabled to unfair

---

Value Behind: Triage Protocol Design for Pandemic Rationing, 3 Nat'l Bureau of Econ. Rsch., Working Paper No. 26951, 2020), https://www.nber.org/papers/w26951.

[112] Parag A. Pathak ET AL., *supra* note 111.

[113] Michael Hiltzik, *Arizona's rules for rationing healthcare in the COVID–19 pandemic should terrify you*, L.A. TIMES (June 30, 2020), https://www.latimes.com/business/story/2020–06–30/hiltzik–arizona–rationing–healthcare–coronavirus–covid–19.

[114] Maves et al., *supra* note 101, at 213–215; Pennsylvania Dept. of Public Health, and the Hospital and Health System Ass'n of Pennsylvania, *Interim Pennsylvania Crisis Standards of Care for Pandemic Guidelines Version 2* (April 10, 2020) at 7. https://www.health.pa.gov/topics/Documents/Diseases%20and%20Conditions/COVID–19%20Interim%20Crisis%20Standards%20of%20Care.pdf

[115] Sheri Fink, *U.S. Civil Rights Office Rejects Rationing Medical Care Based on Disability, Age* N.Y. TIMES, (Mar. 28, 2020), https://www.nytimes.com/2020/03/28/us/coronavirus–disabilities–rationing–ventilators–triage.html.

[116] U.S. DEP'T OF HEALTH AND HUM. SERV. OFF. FOR CIV. RTS. IN ACTION, BULLETIN: CIVIL RIGHTS, HIPAA, AND THE CORONAVIRUS DISEASE 2019 (COVID–19) (2020).

and unequal treatment in the administration of the state respective protocols.[117] While not issuing a legal opinion, the language of the HHS decision clearly implicated the right to equal protection under the Fourteenth Amendment.

Notably, not all states went even so far as to create CSC resource allocation or rationing standards. On April 9, 2020, HHS published a state–by–state listing of CSC guidelines.[118] (Appendix A). HHS determined that 17 states had no published guidelines or allocation standards as of that date including, Alaska, Delaware, Georgia, Hawaii, Idaho, Indiana, Montana, New Hampshire, North Carolina, North Dakota, Rhode Island, South Carolina, South Dakota, Virginia, West Virginia, Wisconsin, and Wyoming.

Only 13 states had devised standards in 2020 in direct response to COVID–19 including, Alabama, California, Colorado, Florida, Kentucky, Maryland, Massachusetts, Minnesota, Nevada, Pennsylvania, Tennessee, Utah, and Washington.[119] In several of these states, however, the

---

[117] Laws that have a disparate impact are prohibited under the Civil Rights Act. OFF. CIV. RTS., *Civil Rights Requirements– A. Title VI of the Civil Rights Act of 1964, 42 U.S.C. 2000d et seq. ("Title VI")*, U.S. DEPT. OF HEALTH AND HUM. SERV. (last reviewed July 26, 2013), https://www.hhs.gov/civil–rights/for–individuals/special–topics/needy–families/civil–rights–requirements/index.html ("This prohibition applies to intentional discrimination as well as to procedures, criteria or methods of administration that appear neutral but have a discriminatory effect on individuals because of their race, color, or national origin. Policies and practices that have such an effect must be eliminated unless a recipient can show that they were necessary to achieve a legitimate nondiscriminatory objective."). The Supreme Court originated the theory of disparate–impact in the case Griggs v. Duke Power Co., 401 U.S. 424 (1971). In *Griggs,* employees hired into service jobs by the power company had to have a high school diploma and satisfy a minimum IQ test score. *Id.* at 425–26. The plaintiffs argued that these two requirements disproportionately disqualified blacks in the application process and thus violated Title VII of the Civil Rights Act of 1964, which prohibits employment discrimination based on race, color, religion, sex, or national origin. *Id.* The Supreme Court agreed, ruling that "job criteria with an adverse or exclusionary effect on minorities — even if those criteria were 'neutral on their face, and even neutral in terms of intent' — could violate the Title VII ban on race discrimination in hiring." *Id.* at 430. The Court further stipulated that employers could avoid liability for "disparate impact" only if they "demonstrated that their adverse selection practices had a manifest relationship to the employment in question" or that they were justified by "business necessity." *Id.* at 431, 432. The Supreme Court agreed, ruling that "job criteria with an adverse or exclusionary effect on minorities — even if those criteria were 'neutral on their face, and even neutral in terms of intent' — could violate the Title VII ban on race discrimination in hiring." Amy L.Wax, *The Dead End of "Disparate Impact*,*"* NAT'L AFFAIRS (Summer 2012), https://www.nationalaffairs.com/publications/detail/the–dead–end–of–disparate–impact. The Court further stipulated that employers could avoid liability for "disparate impact" only if they "demonstrated that their adverse selection practices had a manifest relationship to the employment in question" or that they were justified by "business necessity." *Id.*

[118] State Level Crisis Standards of Care, *supra* note 6.

[119] *Id.*

government did not devise any CSC protocols. Instead, as in the case of Florida, a private nongovernmental organization stepped in to create an informal voluntary plan endorsed by the Florida Hospital Association when the state government failed to act.[120]

Other states merely adopted pre–COVID plans drafted between 2008 and 2019 which had not been updated to consider many of the novel health issues raised by the pandemic including, Arizona, Connecticut, Washington D.C., Illinois, Maine, Michigan, Minnesota, Mississippi, New Jersey, New York, Ohio, Oregon, and Vermont.[121] Texas was not mentioned in the HHS publication.

It is worth noting that in those states that have no CSC guidelines at all, the decision regarding allocation of limited resources to presenting COVID–19 patients remains based on individual, arbitrary healthcare provider guidelines and are not afforded the limited liability protections discussed above.[122] These states have no emergency guidelines for rationing care or otherwise limiting liability for pandemic related injuries.

In addition to many states choosing not to formally design and/or implement CSC protocols, only few have immunity shield provisions included as part of the CSC protocol. As noted previously, several of these immunity shield provisions are implemented by statute and others are facilitated using the issuance of an executive order. The next section considers if there is legal authority to substitute a patient's legal right to sue with a provider immunity shield whether by executive order or by state statute.

B. Can the States Immunize Healthcare Providers from Tort Liability Using Executive Orders and/or Legislation?

For those states that have not acted to provide a CSC protocol, leaving scarce resource allocation to the absolute discretion of the providers, there is seemingly no immunity shield to protect providers during the pandemic for claims arising out of rationing and/or limiting access to healthcare. Indeed, the research discloses no legal authority allowing providers to arbitrarily remove and reallocate a lifesaving ventilator from one patient to give it to another.[123]

Conceivably, rationing care or limiting access to care could give rise to claims of intentional tort and/or gross negligence liability as well as

---

[120] Christine Sexton, *Hospital Group Backs Guidelines For Use Of Ventilators During Coronavirus Peak*, WUSF PUBLIC MEDIA (Apr. 14, 2020, 12:01 AM), https://health.wusf.usf.edu/health–news–florida/2020–04–14/hospital–group–backs–guidelines–for–use–of–ventilators–during–coronavirus–peak.

[121] State Level Crisis Standards of Care, *supra* note 6.

[122] *See* DEP'T OF HEALTH AND HUM. SERV., *supra* note 33; CMS, s*upra* note 19.

[123] Liddell et al., *supra* note 49.

medical malpractice.[124] The history of the development of tort common law and more recent cases where states have attempted to substitute liability waivers for common law tort remedies are instructive here.

C. Common Law and State Constitutional Prohibitions

There is little at the Common Law to support restricting a citizen's right to redress grievances in a court of law. Indeed, Chief Justice Marshal[125] stated in 1803 that: "The government of the United States has been emphatically termed a government of laws, and not of men. It will certainly cease to deserve this high appellation, if the laws furnish no remedy for the violation of a vested legal right."[126] Quoting Blackstone[127] he continued: "it is a general and indisputable rule, that where there is a legal right, there is also a legal remedy by suit or action at law, whenever that right is invaded."[128] It appears that one of the major reasons for the existence of such civil law remedies is to make injured parties whole and to deter corporate and private misbehavior.

Marshal illuminated a deeply embedded principle in the Common Law tradition dating back to at least the Magna Carta. In England, the monarch had very broad powers including the power of dispensation and the power of pardon. Using the power of dispensation, the monarch could, with some limitation, relieve a person's obligation to comply with a statute.[129] However, the monarch could not suspend a law related to whole classes of people, nor could he/she excuse persons from Common Law obligations.[130] The monarch likewise had no power to dispense if in doing so it would deprive another of recourse to a private suit or action.[131] For example, the monarch could pardon a person accused or found guilty of

---

[124] DEP'T OF HEALTH AND HUM. SERV. OFFICE FOR CIV. RTS. IN ACTION, *supra* note 11.

[125] John Marshall was the fourth Chief Justice of the U.S. Supreme Court, serving from 1801 to 1835. Marshall made the Supreme Court an important institution of government, deciding many important cases during his tenure, among them *Marbury v. Madison*, which stood for and provide the country with judicial review. Marbury v. Madison, 5 U.S. 137 (1803).

[126] *Id.* at 163.

[127] *Id.* (citing THE COMMENTARIES ON THE LAWS OF ENGLAND, an influential 18th–century treatise on the common law of England by Sir William Blackstone).

[128] *Id.* at 121.

[129] The Magna Carta is a charter of rights signed by King John of England on June 15, 1215. *See* Sir Edward Coke, *The Reports of Sir Edward Coke* (1602), in THE SELECTED WRITINGS AND SPEECHES OF SIR EDWARD COKE 37, 40 (Steve Sheppard ed., 2003).

[130] Paul Birdsall, *"Non Obstante" A Study of the Dispending Power of English Kings*, *in* ESSAYS IN HISTORY AND POLITICAL THEORY IN HONOR OF CHARLES HOWARD MCILWAIN (Carl Wittke ed., 1967).

[131] John C. P. Goldberg, *The Constitutional Status of Tort Law: Due Process and the Right to a Law for the Redress of Wrongs*, 115 YALE L.J. 524, 540 (2005).

murder but could not stop interested parties from suing for compensation for the legal wrong.[132]

In the *Commentaries,* Blackstone [133]

> . . . defines a private wrong as a breach of a duty owed by the wrongdoer to the victim and, hence, a mistreatment of ("injury to") the victim by the wrongdoer. For this class of wrong, Blackstone explained, the law confers on the victim (or his or her survivors) a special privilege to respond to the wrongdoing, consisting typically of a power to invoke the writ of trespass or case to obtain damages from the wrongdoer. This power, Blackstone insisted, is not "merely" a common law entitlement, but rather a right guaranteed by England's unwritten constitution.[134]

The Enlightenment thinker, John Locke, whose writing influenced both the design of the U.S. Constitution and its Declaration of Independence, in his *Second Treatise on Government,* likewise "insisted that the sovereign has no authority to extinguish a victim's claim to recourse against an injurer."[135]

The early American Colonies inherited the Common Law tradition of redressing legal wrongs by suing in tort. Most of the original states like Delaware, New Hampshire, Maryland, Massachusetts, and Vermont, included such rights in their early constitutions, respectively.[136]

Yet, in the nineteenth century during a national crisis, some state legislatures attempted to eliminate the state constitutional rights of citizens to redress legal grievances in the courts. For example, during the Civil War, the Minnesota legislature passed a law that foreclosed "all persons aiding the rebellion against the United States" the right to file a lawsuit in state courts.[137] The state supreme court struck it down, saying:

> We would never for one moment suppose that the Legislature has the power under the constitution, to

---

[132] *Id.* at 540–541.

[133] Sir William Blackstone (10 July 1723 – 14 February 1780) was an English legal scholar, or jurist, judge and politician of the eighteenth century. He is most well–known for writing the Commentaries on the Laws of England.

[134] Goldberg, *supra* note 133, at 549.

[135] *Id.* at 541; *see also id.* n.80.

[136] *See* DEL. CONST. of 1792, art. I, § 9; MD. DECLARATION OF RIGHTS AND CONST. of 1776, art. XVII; MASS. CONST. of 1780, art. XI; N.H. CONST. of 1784, art. 14; VT. CONST. of 1786, art. IV.

[137] Davis v. Pierse, 7 Minn. 13, 15 (1862).

> deprive a person or class of persons, of the right of trial by jury, or to subject them to imprisonment for debt, or their persons, houses, papers and effects, to unreasonable searches; or their property to be taken for public use without just compensation; and yet neither of these is more sacred to the citizen, or more carefully guarded by the constitution, than the right to have a certain and prompt remedy in the laws for all injuries or wrongs to person, property or character.[138]

The Fourteenth Amendment to the U.S. Constitution operates hand in hand with state constitutional due process mandates prohibiting states from enacting statutes negating the right of the citizenry to redress grievances in the courts.

D. The Fourteenth Amendment Right to Due Process and Equal Protection

The Fourteenth Amendment to the Constitution was "meant to guarantee that states would attend to basic obligations, including the duty to provide law for the redress of wrongs, and that federal courts were meant to enforce that guarantee."[139] The right to the equal protection of the law includes the right to use the law; namely, the courts, to protect those rights, to redress wrongs suffered by the citizenry. The Supreme Court of the United States, in describing the rights afforded by the Fourteenth Amendment, observed: "all the privileges of the English Magna Charta in favor of freemen are collected upon him and overshadow him as derived from this amendment. The States must not weaken nor destroy them."[140]

Thus, any citizen of any state is protected against what any state might do which is inconsistent with the guarantees of the U.S. Constitution, including the deprivation of the right to redress a grievance. Indeed, in providing the litany of citizen protected rights under the Fourteenth Amendment, Justice Story, in a case arising under a New Jersey Statute, included, "those privileges and immunities which are, in their nature, fundamental; which belong, of right, to the citizens of all free governments; and which have, at all times, been enjoyed by the citizens of the several states which compose this Union . . . to institute and maintain

---

[138] *Id.* at 18.

[139] Goldberg, *supra* note 126, at 564; *see also id.* at 564 n.198 (citing an argument made in William E. Nelson, THE FOURTEENTH AMENDMENT: FROM POLITICAL PRINCIPLE TO JUDICIAL DOCTRINE (1988) "that Section 1 identified federal rights against state interference while placing significant responsibility for enforcement of those rights on the states."

[140] Slaughter–House Cases, 83 U.S. 36, 54 (1872).

actions of any kind in the courts of the state . . . which are clearly embraced by the general description of privileges deemed to be fundamental . . . .[141] Again, in 1885, the Supreme Court emphasized that "[i]t is the duty of every State to provide, in the administration of justice, for the redress of private wrongs . . . ."[142]

Despite the historic roots of the common law right to redress grievances in the courts and the Fourteenth Amendment, a few state courts have found an exception. Generally, these state courts have held that legal access guarantee to redress grievances is not absolute under the constitution and may not necessarily restrain state legislatures from acting to at least limit access under certain circumstances by statute.[143]

E. State Legislation and the Attempt to Provide a Pandemic Liability Shield

Unlike many other states examined for this paper, New York's statutory law is unique in that it invests the governor with broad executive powers to suspend generally all laws if determined to be necessary by the governor in an emergency.[144] Despite this grant of power, New York's governor chose not to exercise executive authority and did not issue an executive order to provide healthcare providers with a pandemic immunity shield. Instead, the governor was accused of "burying" a statutory provision as an addendum attached to a piece of proposed budget legislation, that some lawmakers claimed they failed to see when passing the budget legislation.[145] This legislative addendum granted immunity to all healthcare facilities and health care workers "from any liability, civil or criminal, for any harm or damages alleged to have been sustained as a result of an act or omission in the course of arranging for or providing health care services . . . ."[146]

There is some case law in New York to support the constitutionality of the issuance of such immunity by statute. In the context of constitutional

---

141 Corfield v. Coryell, 6 F.Cas. 546, 551–52 (Cir. Ct. E.D. Pa. 1823).

142 Missouri Pacific Railway Co. v. Humes, 115 U.S. 512, 521 (1885).

143 David Schuman, *The Right to a Remedy*, 65 TEMPLE L. REV. 1197, 1204 (1992); Meech v. Hillhaven West, Inc., 776 P.2d 488, 491–97 (Mont. 1989).

144 2021 N.Y. Exec § 29–A (Consol. 2021).

145 Madison Dibble, *New York Budget Provision Bars Families From Suing Nursing Homes over Coronavirus Response*, THE WASHINGTON EXAMINER (Mar. 14, 2020), https://www.washingtonexaminer.com/news/new–york–budget–provision–bars–families–from–suing–nursing–homes–over–coronavirus–response (The headline and article focuses on nursing homes, but the immunity goes much farther.).

146 S. 7506–B, 2019–2020 Sen. Assemb. (N.Y. 2020), https://www.nysenate.gov/legislation/bills/2019/s7506 (The language appeared on page 347 of a 362–page budget bill submitted to the New York State Assembly by the office of the governor.).

construction, New York's Court of Appeals observed[147] that "[the] police power of the State is the least limitable of all the powers of government."[148] In interpreting whether a statute violates the right of access to courts, the highest court of New York observed that when a statute is challenged on nonprocedural grounds as violative of due process of law, the court considers whether there is "'some fair, just and reasonable connection' between the language of the statute and the promotion of the health, comfort, safety and welfare of society."[149] Thus, a legitimate exercise of state police power does not offend the Fourteenth Amendment right to due process which is not deemed to be absolute. Notably, the New York state immunity provision has still to be tested in the courts to determine if this immunity shield constitutes a legitimate exercise of police power.

Illinois follows suit but in a more restrictive manner. Section 12 of the Bill of Rights of the Illinois Constitution provides that: "Every person shall find a certain remedy in the laws for all injuries and wrongs which he receives to his person, privacy, property or reputation. He shall obtain justice by law, freely, completely, and promptly."[150] In analyzing statutes that limit access to courts, the Illinois Supreme Court warns that "(c)ourts should begin any constitutional analysis with the presumption that the challenged legislation is constitutional and it is the plaintiff's burden to clearly establish that the challenged provisions are unconstitutional."[151] The court, in striking down a law that limited plaintiff tort actions, held that "the Illinois constitution is a limitation, not a grant of legislative power.[152] It is this court's duty to interpret the law and to protect the rights of individuals against acts beyond the scope of the legislative power."[153] So while not an absolute prohibition, statutes limiting access to courts are not favored in Illinois.

Despite this warning, the Illinois legislature enacted The Illinois Emergency Management Agency Act (IEMA).[154] This Act grants the governor wide executive authority to act in the event of a state emergency, such as an epidemic,[155] and shields healthcare workers from liability except in cases of gross negligence or willful misconduct.[156] Thus, under

---

147 The Court of Appeal is the highest court in the court system of the state of New York.

148 A. E. Nettleton Co. v. Diamond, 27 N.Y.2d 182, 192 (1970) (quoting Mater of Engelsher v. Jacobs, 5 N.Y. 2d 370, 373 (1959)).

149 *Id.* at 193 (quoting People v. Bunis, 9 N.Y.2d 1, 4 (1961)).

150 IL. CONST. art. I, § 12.

151 Best v. Taylor Mach. Works, 179 Ill.2d 367, 377 (1997).

152 *Id.* at 377.

153 *Id.*

154 127 ILL. COMP. STAT. 3305/1 (2021).

155 *Id.*

156 *Id.* at § 15.

the powers granted in the IEMA, the Illinois governor issued an executive order safeguarding healthcare worker against liability during the pandemic.[157]

In that order, the governor directs:

> **Section 3** . . . that during the pendency of the Gubernatorial Disaster Proclamation, Health Care Facilities . . . shall be immune from civil liability for any injury or death alleged to have been caused by any act or omission by the Health Care Facility, which injury or death occurred at a time when a Health Care Facility was engaged in the course of rendering assistance to the State by providing health care services in response to the COVID–19 outbreak, unless it is established that such injury or death was caused by gross negligence or willful misconduct of such Health Care Facility . . . or by willful misconduct . . . .
>
> **Section 4**. . . . that during the pendency of the Gubernatorial Disaster Proclamations, Health Care Professionals, as defined in Section 1 of this Executive Order, shall be immune from civil liability for any injury or death alleged to have been caused by any act or omission by the Health Care Professional, which injury or death occurred at a time when a Health Care Professional was engaged in the course of rendering assistance to the State by providing health care services in response to the COVID–19 outbreak, unless it is established that such injury or death was caused by gross negligence or willful misconduct of such Health Care Professional . . . or by willful misconduct . . . .[158]

Additionally, the Maryland state statute, Public Safety Title 14 – Emergency Management Subtitle 3A – Governor's Health Emergency Powers, allows the governor to first proclaim[159] a health emergency, and then subsequently issue orders.[160] Such executive orders, in the event of a

---

[157] Rich Miller, *Gov. Pritzker Shields Health Care Workers from Lawsuits During Coronavirus Pandemic*, CHICAGO SUN TIMES (Apr. 3, 2020), https://chicago.suntimes.com/columnists/2020/4/3/21207614/coronavirus–covid–19–j–b–pritzker–health–care–workers–illinois–emergency–management–agency.

[158] IL. EXEC. ORDER No. 2020–19 § 3–4, (Apr. 1, 2020), https://www2.illinois.gov/Pages/Executive–Orders/ExecutiveOrder2020–19.aspx.

[159] MD. CODE ANN., PUB. SAFETY § 14–3A–03 (West 2021).

[160] *Id.*

health emergency, can include both testing and vaccination mandates. By statute, citizens failing to comply with the executive order can be isolated and quarantined by the governor.[161] Knowing and willful violations of any such orders is a criminal offense.[162]

In another unique twist in state law interpretation, both a Maryland attorney general's opinion[163] and an opinion issued by the Maryland court of appeals have concluded that an executive order issued by the governor has the effect of law in Maryland.[164]

Despite the liberality of powers conferred on the executive branch, Maryland's lawmakers chose to pass legislation including an immunity shield provision providing that: "A health care provider is immune from civil or criminal liability if the health care provider acts in good faith and under a catastrophic health emergency proclamation."[165] Again, what is "good faith" is not well defined and does not refer specifically to healthcare resource rationing.

Finally, Pennsylvania is an interesting example that can be viewed as somewhat legally mystifying. In May 2020, the governor signed an executive order providing civil immunity for "good faith" actions to specified health care providers.[166] The order likewise suspended several regulatory requirements relating to in–state activity for out of state licensed health care workers; along with certain in–home health care activities, and who can be health service supervisors.[167] The immunity provisions provided in pertinent part that designated healthcare workers:

> shall be immune from civil liability and shall not be liable for the death of or any injury to a person or for loss of or damage to property as a result of the emergency services activity or disaster services activity described above,

---

[161] *Id.*; MD. CODE ANN., PUB. SAFETY § 14–3A–05 (West 2021).

[162] MD. CODE ANN., PUB. SAFETY § 14–3A–08 (West 2021).

[163] Robert A. Zarnoch, *Gubernatorial Executive Orders: Legislative or Executive Power?*, 44 MD. B. J. 48, 51 (2011).

[164] Dept. of Pub. Safety & Corr. Serv. v. Beard, 790 A.2d 57, 65 (2002) (Dealing with an order for certain employees to engage in collective bargaining, which does not address the specific issue raised by denial of access to healthcare resources. It is, however, instructive by analogy.).

[165] MD. CODE ANN., PUB. SAFETY § 14–3A–06 (West 2021).

[166] Press Release, Governor Tom Wolf, Gov. Wolf Signs Executive Order to Provide Civil Immunity for Health Care Providers (May 06, 2020), https://www.governor.pa.gov/newsroom/gov–wolf–signs–executive–order–to–provide–civil–immunity–for–health–care–providers/.

[167] Governor Tom Wolf, ORDER OF THE GOVERNOR OF THE COMMONWEALTH OF PENNSYLVANIA TO ENHANCE PROTECTIONS FOR HEALTH CARE PROFESSIONALS, (May 6, 2020), https://www.governor.pa.gov/wp–content/uploads/2020/05/20200506–GOV–health–care–professionals–protection–order–COVID–19.pdf.

> except in the cases of willful misconduct or gross negligence, to the fullest extent permitted by law. This grant of immunity shall not extend to health care professionals rendering non–COVID–19 medical and health treatment or services to individuals.[168]

Thereafter, the Pennsylvania legislature passed a statute replacing this executive order that "would have temporarily extended civil liability protection to hospitals, nursing homes, schools, businesses, manufacturers, and other entities but like the executive order would have offered no protection against claims for gross negligence or willful misconduct."[169] In response to the substitution of his executive order by a state statute, the governor opposed the statutory version of the immunity shield claiming that he believed that the bill went too far and would "invite carelessness and disregard for public safety."[170]

However, based on a brief review of the Pennsylvania state constitution and the case history attendant to the issuance of executive orders, the actions of the Pennsylvania state legislature are not surprising. First, the Pennsylvania Constitution provides: "All courts shall be open; and every man for an injury done him in his lands, goods, person or reputation shall have remedy by due course of law, and right and justice administered without sale, denial or delay. Suits may be brought against the Commonwealth in such manner, in such courts and in such cases as the Legislature may by law direct."[171]

Later in 2003, the Pennsylvania Commonwealth Court[172] declared that people, including prisoners in the prison system "have a fundamental constitutional right of access to the courts."[173] The court argued that to find otherwise would be in violation of the First and the Fourteenth Amendments to the U.S. Constitution.[174] The Pennsylvania Supreme Court stated that it did away with the quid pro quo notion that if the law took away a remedy, it provided one in return. Still, the Court did not find its declaration to be an absolute prohibition and applied a balancing test:

---

168 *Id.*

169 Jolena Jeffrey, *Pennsylvania Governor Vetoes Bill Extending Reach of Business Liability Protections During COVID–19*, NAT'L L. REV. (Feb. 17, 2021), https://www.natlawreview.com/article/pennsylvania–governor–vetoes–bill–extending–reach–business–liability–protections.

170 *Id.*

171 PA. CONST. art. 1, § 11.

172 The Commonwealth Court is one of two intermediate appellate courts in Pennsylvania.

173 Bronson v. Horn, 830 A.2d 1092, 1094 (Pa. Commw. Ct. 2003) (quoting Bounds v. Smith, 430 U.S. 817, 828 (1977)).

174 *See id.*

whether the state had a substantial state interest in foregoing the remedy contrary to the remedies clause of the Pennsylvania Constitution. It thus concluded that the right of access set forth in the remedies clause was no longer a fundamental right, but still an important one. Accordingly, in such cases, the court applies the constitutional intermediate scrutiny test:

> [t]his standard of review requires that the government interest be an 'important' one; that the classification be drawn so as to be closely related to the objectives of the legislation; and that the person excluded from an important right or benefit be permitted to challenge his exclusion on the grounds that in his particular case, denial of the right or benefit would not promote the purpose of the classification.[175]

As early as 1973, the Supreme Court of Pennsylvania referred a separation of powers dispute between the governor and the state legislature observing that, absent a statutory enactment providing for it, the governor did not have the authority to order an action or even sue in court even to enjoin activity contrary to constitutional non–self–executing language.[176]Additionally, the Pennsylvania Supreme Court explained that the state constitution provides for a clear separation of powers, with checks and balances to prevent a concentration of power in any one branch, and to ensure that one branch would not exercise the functions of another.[177] Though the executive authority of the governor is not recognized in the Pennsylvania Constitution, the Court nonetheless held that "the Governor may issue executive orders" but they "must not infringe upon the powers of the other two branches of our government . . . ."[178]

Thus, in Pennsylvania, ". . . executive orders (can) be classified into three permissible types: (1) proclamations for ceremonial purposes; (2) directives to subordinate officials for the execution of executive branch duties; and (3) interpretation of statutory or other law."[179] However, executive orders are not legally enforceable and so the courts have held. The Pennsylvania Supreme Court in approving an executive order found that it was not an enforceable order, so that it did not encroach on the purviews of the other branches, and so ". . . while such an order may not be legally enforceable, it nevertheless is permissible as a gubernatorial

---

175 Smith v. City of Philadelphia, 516 A.2d 306, 311 (1986).
176 Commonwealth by Shapp v. Nat'l Gettysburg Battlefield Tower, 311 A.2d 588, 590–95 (Pa. 1973).
177 Markham v. Wolf, 190 A.3d 1175, 1177 (Pa. 2018).
178 *Id.* at 656.
179 *Id. at 1180.*

act,"[180] and such orders are allowed to stand. This appears to be yet another pyrrhic victory for the governor who can issue executive orders that cannot be enforced.

Accordingly, the foregoing states have attempted by legislation to create a pandemic liability shield limiting the common law and/or state constitutional guarantees of a legal access to the courts in the case of pandemic related injuries. Still, none of these statutory provisions have been challenged in the courts. The next section considers whether this same principle applies with equal force to executive orders issued by respective state governors where not otherwise authorized by the state constitution or state statute.

F. Gubernatorial Executive Orders Providing Immunity Shields Raise Enforceability Issues[181]

There are several questions that need to be answered before reaching a conclusion regarding the legal effect of state executive orders providing an immunity shield. First, is the state governor legally authorized to issue an executive order? If so, what does the state law allow a governor to do in terms of limiting a citizen's right to redress legal grievances? In the case of medical emergencies such as the pandemic, are state executive orders enforceable having the clear legal effect of immunizing or shielding healthcare providers from tort liability?

Logic might dictate that if the federal government felt the need to enact legislation in the form of the Safe to Work Act to achieve a measure of provider immunity, then states would have to take a similar path. But as previously noted, many states have instead opted to adopt CSC protocols by means of an executive order issued by the governor. Nearly every

---

[180] *Id.* at 1185.

[181] David Schuman, *The Right to a Remedy*, 65 TEMP. L. REV. 1197, 1201 n. 25 (finding that 39 states provide a guarantee of access to the courts for their citizens, either by means of explicit language in their constitution or by judicial finding); Arguably, if a governor, through executive order or otherwise, denies access to the courts to a state's citizens, such action may give rise to a constitutional objection of unlawful usurpation of power under the separation of powers doctrine. Even though state constitutions may provide such a right, there appears currently no federal counterpart to such guarantees. *See, e.g.*, *id.* at 1199 (The Magna Carta was specific: "every Subject of this Realm, for injury done to him in [goods, land or person] . . . may take his remedy by the course of the Law, and have justice and right for the injury done him, freely without sale, fully without any denial, and speedily without delay." However, despite its central role in Anglo–American Common Law at the time, it did not make it into the Bill of Rights to the U.S. Constitution. However, as pointed out, many states did include the concept in several state constitutions.); The Supreme Court of Alaska has stated "that a 'legal right' exists only so long as one may obtain redress through the court system. Patrick v. Lynden Transport, Inc., 765 P.2d 1375, 1379 (Alaska 1988).

state's law allows for a governor to issue executive orders. However, no one size fits all and states have differing gauges on whether executive orders have the force of law, whether they expire automatically, and/or the role of legislative oversight over such orders. As noted above, Pennsylvania allows the governor to issue executive orders which are legally non–enforceable.

Accordingly, a governor's power to issue executive orders in most states originates by authority embedded in the state's constitution, statutes or case law, or by some combination of them.[182] Sometimes, it is simply implied by the broad powers afforded the governor by the state constitution.[183] Governors use executive orders for a range of reasons,[184] chiefly among them to:

- Activate emergency powers during disasters, energy calamities, and other conditions that require immediate attention;
- Create advisory or investigative commissions; and
- Deal with administrative matters, including regulatory reform, intergovernmental coordination, environmental impact and discrimination.[185]

See Appendix B for a synopsis of the states that provide authority to the governor to issue executive orders and the source of such authority under each state's law.

For example, Connecticut's constitution provides that: "All courts shall be open, and every person, for an injury done to him in his person, property or reputation, shall have remedy by due course of law, and right and justice administered without sale, denial or delay."[186] However, Connecticut's governor recently issued an executive order on April 5, 2020 that provided for broad protection against civil liability for health care providers, individuals and facilities, except for "acts or omissions that constitute a crime, fraud, malice, gross negligence, willful

---

182 *Governors' Powers & Authorities*, NAT'L GOVERNORS ASS'N, https://www.nga.org/governors/powers–and–authority/ (last visited Nov. 4, 2021).
183 *Id.*
184 *Id.*
185 *Id.*
186 CONN. CONST. art. I, § 10.

misconduct . . . ."[187] A few days later he clarified that such immunity extended for both common law claims or statute–based claims.[188]

However, the use of an executive order in Connecticut to accomplish pandemic tort immunity arguably flies in the face of established case law which confines that type of power to the state legislature. The Connecticut Supreme Court held: "it is within the province of the legislature to redefine or abolish existing definitions of injury . . . ."[189]Thus, "the right of redress for injury is constitutional in its nature but the nature of a specific injury is a right derived from the common law or statute."[190] Accordingly, it is questionable whether an executive order emanates from an "authority having jurisdiction" as that term is explained in the Opinion interpreting the PREP Act immunity provisions.[191] and whether it is even enforceable. This also raises the specter of yet another interesting separation of powers dispute between the legislature and the governor.

Likewise, the PREP pre–emption exclusion, discussed above, provides that "no State or political subdivision of a State may establish, enforce, or continue in effect with respect to a covered countermeasure any provision of law or legal requirement that is different from, or is in conflict with, any requirement applicable under this section."[192] The statutory pre–emption exclusion makes clear that patients' legal rights were not intended to be suspended or otherwise pre–empted by state or local laws in conflict with PREP during the crisis.[193] That which is deemed to be consistent with PREP and that which is deemed to be in conflict with PREP remains undefined and untested. Arguably, the opposing legal authority in a state such as Connecticut which brings into question its own endorsement of the enforceability of the governor's executive order, would support an argument that the countermeasure is not sanctioned by the state and is therefore, inconsistent with the PREP pre–emption exclusion.

In another example, Wyoming's constitution assures citizens the right to redress in the courts: "All courts shall be open and every person for an injury done to person, reputation or property shall have justice administered without sale, denial or delay. Suits may be brought against the state in such manner and in such courts as the legislature may by law

---

[187] STATE OF CONN. GOVERNOR NED LAMONT, Exec. Order No. 7U (2020).
[188] STATE OF CONN. GOVERNOR NED LAMONT, Exec. Order No. 7V (2020).
[189] Gentile v. Altermatt, 363 A.2d 1, 11 (Conn. 1975).
[190] *Morris v. Hartford Courant Co.,* 513 A.2d 66, 70 (Conn. 1986) (quoting Gentile v. Altermatt, 263 A.2d 1, 11 (Conn. 1975)).
[191] Opinion on the Public Readiness and Emergency Preparedness Act, *supra* note 33, at 2.
[192] *Id.* at 2 n.4.
[193] *See* Liddell et al., *supra* note 49, at 422.

direct."[194] This constitution does not confer authority on the governor to even issue executive orders. The Supreme Court of Wyoming, in a case respecting a governor's appointment—another type of order—observed that "(h)e [the governor] has only such power in that connection as is granted him by the constitution and the statutes of this state. If the law requires him to act in conjunction with another body, he cannot evade such provision."[195]

Even though the Wyoming constitution does not specifically authorize gubernatorial executive orders, and notwithstanding the foregoing case precedent, the Wyoming governor issued an order declaring a Covid emergency and a subsequent order implementing measures to deal with the emergency. However, that order merely directed other state agencies to "take all appropriate and necessary" actions to deal with the emergency.[196] But the public interpreted the governor's order to provide a far broader immunity shield. For example, according to the Cowboy State News Network, "Governor Gordon's Executive Order ensures the State Health Officer has the authority to address large–scale health challenges the state may face in the future."[197] The breadth and enforceability of the somewhat ambiguous Wyoming governor's order remains to be tested not only at the state level but also in the context of PREP and the Fourteenth Amendment.

On the other hand, Kentucky law is more restrictive than most states examined in this paper. Kentucky's Court of Appeals explained how and to what extent the state's governor was vested with the power of issuing executive orders:

> The office of Governor is unknown to the common law. It is the title universally applied to the head of the executive department of a state, but in every instance the office is created by the State Constitution. Section 69 of our Constitution creates the office of Governor and vests in him the supreme executive powers of the commonwealth. He has only such powers as the Constitution and Statutes, enacted pursuant thereto, vest

---

194 WYO. CONST. art. I, § 7.

195 People ex rel. Warren v. Christian, 123 P.2d 368, 371 (Wyo. 1942).

196 Wyo. Governor Mark Gordon, *Exec. Order 2020–2, Declaration of a State of Emergency and Public Health Emergency*, STATE OF WYO. EXEC. DEP'T (Mar. 13, 2020), https://content.govdelivery.com/attachments/WYGOV/2020/03/13/file_attachments/1400574/Executive%20Order%202020–2.pdf.

197 Angi Beauheim, *Governor Gordon Signs Emergency Declaration*, COWBOY STATE NEWS NETWORK (Mar. 14, 2020), https://cowboystatenews.com/governor–gordon–signs–emergency–declaration/.

> in him, and those powers must be exercised in the manner and within the limitations therein prescribed.[198]

Kentucky's courts have been reluctant to recognize implied powers or expand on those specifically granted to the governor.[199]

Nonetheless, Kentucky's governor recently issued a variety of executive orders for the ostensible purpose of protecting the health and safety of the citizens of the state[200] during the pandemic based upon a claim that such authority was granted to the governor under state statute.[201] However, these executive orders do not expressly create an immunity shield for healthcare providers in the state and thus, do not necessarily implicate the access issue addressed in this paper.

Parenthetically, the Kentucky courts have so far upheld challenges to pre–pandemic executive orders issued by the governor.[202] It remains unclear how the courts would rule if an immunity shield were included in an executive order, however.

From these examples it is apparent that while the early state constitutional drafters, courts and legislators were wary of giving the governors broad and unforeseen powers, there has been considerable backsliding on this view by more recent drafters of state constitutions, by legislators and even by some state courts. One explanation for this loosening of legal constraints on the governor is that states have recognized, particularly during an unanticipated pandemic, that certain societal dangers greatly impact the health, safety and welfare of the state citizenry and that decisive leadership on the part of the executive is necessary in such an emergent situation.

However, the contours of executive authority during a life–threatening emergency such as the pandemic remain untested. Where not previously authorized by state statute and/or contrary to existing state constitutional provisions guaranteeing access to the courts to redress grievances, the likelihood of the enforceability of executive orders granting an immunity

---

[198] Royster v. Brock, 79 S.W.2d 707, 709 (Ky. 1935).

[199] *See id.* at 710–11.

[200] *Kentucky's Response to COVID–19* COMMONWEALTH OF KY., https://governor.ky.gov/Documents/20201020_COVID–19_page–archive.pdf (last visited Oct. 20, 2020).

[201] Kentucky Revised Statutes Chap. 39A 090 and 39A100. (The Governor claimed broadly that he had authority under Chap. 39A, Ky. Governor Andy Beshar, *Executive Order 2020–215, Executive Order, State of Emergency, 9signed by Secretary of State Michael G. Adams)* Mar. 6, 2020, https://governor.ky.gov/covid19. Last visited Jan. 10, 2022.

[202] *See* WLKY DIGITAL TEAM, *KY Supreme Court Rules Governor Has Power to Issue Emergency COVID–19 Orders,* NOWCAST WLKY NEWS (Nov. 12, 2020, 5:18 PM), https://www.wlky.com/article/ky–supreme–court–upholds–governors–ability–to–issue–covid–19–executive–orders–cameron–beshear/34655535#.

shield remains questionable at best. At the very least questions regarding the separation of powers between state legislative and executive branches loom in the dispute. Still, even those rights that the Supreme Court of the United States and state supreme courts have declared to be fundamental rights—including those found in the Bill of Rights—are not absolute.[203] This notion has led the courts to engage in a balancing act observing that "(a) balance must be struck between a government's obligations to protect its citizens and those citizens' exercise of their rights."[204] The question can only be resolved when ultimately balanced by the courts on a case–by–case basis.

IV. CONCLUSION

The pandemic has had a profound global affect in every aspect of human life. Perhaps once the dust settles and the consequences of respective state government action become clearer, litigation may follow to seek clarification of this question of first impression under the law: Whether the right to institute suit for pandemic related healthcare injuries can be constitutionally eliminated using state triage protocol immunity provisions passed by executive order or by state statute during the pandemic.

Little wonder that some health care providers are cautious. The virus has been an unforeseen and complicated challenge, not made easier by the confusion of the federal and state governmental responses, respectively, particularly in the field of tort immunity for health service providers. The federal government has attempted legislation, regulations and pronouncements, some of which interconnect in a confusing manner, and leave puzzling lacunae. Many states have, in turn, dispensed a variety of attempts, many of which—along with the jumbled federal action—have, it can be argued, gone far in the restraint of individual rights and/or created separation of powers issues.

As stated above, the right to a citizen's access to the court to redress grievances is a long–standing Common Law tradition and enshrined in many state constitutions. As a practical matter, nearly all tort actions are filed in state courts. Several state courts have been creative in devising balancing schemes or constitutional tests for interpreting when to craft

---

[203] *See*, for example, Morse v. Frederick, 551 U.S. 393, 408–09 (2007) (for a discussion of schools' right to restrict student expression reasonable regarded as promoting illegal drug use); Commonwealth v. Ona, 883 N.E.2d. 1217, 1222 (2008) (for a discussion of a state legislature's narrow power to restrict lewd and lascivious expression).

[204] FRANK B. CROSS & ROGER LEROY MILLER, THE LEGAL ENVIRONMENT OF BUSINESS 77 (10th ed. 2018).

exceptions to the guarantee of access to courts to redress legal grievances. Numerous state courts follow the lead of the U.S. Supreme Court[205] in finding a way around the constitutional right of access, and many state courts use arrangements based on terminology designed by federal courts, such as "fundamental rights," legitimate exercise of police power, and "intermediate scrutiny."[206]

Other schemes rely on the idea that the legislature cannot eliminate or modify the right without providing a *quid pro quo*.[207] Other courts appear to use a balancing test, which leads a court to renounce statutory restrictions that are deemed unreasonable or arbitrary.[208] In addition, there are courts that say that the access guarantee does not restrain legislation.[209]

Accordingly, despite respective state constitutional bills of rights, despite governors' constitutional powers and despite judicial precedent, it is unclear what a state court might legally do given the Covid–19 pandemic. The ultimate legal resolution will depend on the courts. The paper concludes that healthcare providers may still be subject to some legal liability for pandemic related tort claims depending upon each state's unique constitutional grant of powers to the executive and legislative branches and the guarantees of due process and equal protection under the dictates of the Fourteenth Amendment.

---

[205] In interpreting the application of the Fourteenth Amendment to a statute, the Supreme Court of the United States stated that "Liberty under the Constitution is thus necessarily subject to the restraints of due process, and regulation which is reasonable in relation to its subject and is adopted in **582 the interests of the community is due process." W. Coast Hotel Co. v. Parrish, 300 U.S. 379, 391 (1937).

[206] Schuman, *supra* note 144, at 1204.

[207] (N.H. 1985), also cited The U.S. Supreme Court has upheld the notion of a *quid pro quo,* that is, an exchange of value for giving tort liability. A clear example is in the workers compensation regime, where the Court has said that "the fundamental purpose of the act is to abolish private rights of action for damages to employees in the hazardous industries (and in any other industry, at the option of employer and employees), and to substitute a system of compensation to injured workmen and their dependents out of a public fund established and maintained by contributions required to be made by the employers in proportion to the hazard of each class of occupation . . . .(and) . . . the employer's exemption from liability to private action is an essential part of the legislative scheme and the quid pro quo for the burdens imposed upon him, so that if the act is not valid as against employees, it is not valid as against employers." *See also,* for example, Estabrook v. Am. Hoist & Derrick, Inc., 498 A.2d 741, 747 et seq. Mountain Timber Co. v. Washington, 243 U.S. 219, 234 (1917).

[208] Schuman, *supra* note 144, at 1204–05.

[209] See the discussion about Meech v. Hillhaven West, Inc., 776 P.2d 488, 491–93 (Mont. 1989) in Schuman, *supra* note 144, at 1200–22; *See* Harrison v. Schrader, 569 S.W.2d 822, 826 (Tenn. 1978) (upholding a three–year statute of limitations (for tort liability), in a medical malpractice suit concluding that the legislation did not do away with the right to access or the tort; it did not prevent redress for injury, rather the statute simply defined when the injury arises or expires.).

Appendix A: Comparison of available state–level Crisis Standards of Care (CSC)

Technical Resources, Assistance Center, and Information Exchange (TRACIE). State Level Crisis Standards of Care. US Department of Health and Human Services: Assistant Secretary for Preparedness and Response (ASPR). April 2020. (Accessed April 15, 2020 at https://files .asprtracie.hhs. gov/documents/4–9–20–state–level–csc–plans–guidance–policy.pdf).

State	**Existence of CSC***	**Date of identified document ****	**Explicit ethical frame work**	**Health equity as a guiding principle**	**Explicitly identity-blind allocation of resources**
Alabama	Yes	4/2010; 2/2020	Yes	Yes	Yes
Alaska	Yes	3/2020	No	No	No
Arizona	Yes	2020	Yes	No	Yes
Arkansas	None identified				
California	Yes	4/2020++	Yes	No	Yes
Colorado	Yes	4/2020++	No	No	No
Connecticut	Yes	10/2010	Yes	Yes	Yes
Delaware	None identified				
Florida	None identified				
Georgia	None identified				
Hawaii	None identified				
Idaho	No–in development				
Illinois	Yes	3/2018; 3/2020++	Yes	No	Yes

Indiana	None identified				
Iowa	No–in development				
Kansas	Yes	9/2013	No	No	No
Kentucky	Yes	3/2020	Yes	Yes	Yes
Louisiana	Yes	9/2011	Yes	Yes	No
Maine	Yes	6/2015	No	No	No
Maryland	None identified				
Massachusetts	Yes	4/2020[++]	Yes	Yes	Yes
Michigan	Yes	11/2012	Yes	Yes	Yes
Minnesota	Yes	12/2013; 1/2020	Yes	Yes	Yes
Mississippi	Yes	2/2017	Yes	No	No
Missouri	Yes	4/2020[++]	Yes	No	No
Montana	No–in development				
Nebraska	None identified				
Nevada	Yes	4/2020[++]	Yes	Yes	No
New Hampshire	None identified				
New Jersey	Yes	4/2020[++]	Yes	Yes	Yes
New Mexico	Yes	6/2018	Yes	Yes	Yes
New York	Yes	11/2015	Yes	Yes	Yes
North Carolina	No				
North Dakota	None identified				
Ohio	Yes[+++]	4/2020	Yes	No	No
Oklahoma	Yes	4/2020	Yes	No	Yes
Oregon	Yes	6/2018	Yes	Yes	Yes

Pennsylvania	Yes	4/2020[2]	Yes	Yes	Yes
Rhode Island	No				
South Carolina	No				
South Dakota	No				
Tennessee	Yes	7/2016	Yes	No	Yes
Texas	No				
Utah	Yes	6/2018	Yes	Yes	Yes
Vermont	Yes	5/2019	Yes	Yes	Yes
Virginia	No–in development				
Washington	Yes	3/2020	Yes	Yes	Yes
West Virginia	No–in development				
Wisconsin	No–in development				
Wyoming	Yes	6/2019	No	No	No

**CSC* Crisis Standards of Care

**As of May 3, 2020

+Specific guidance for critical care and ventilator allocation in 2010; 2/2020 document provides broader guidance

++Specific guidance related to the COVID–19 pandemic

+++Guidelines obtained from the Ohio Hospital Association through correspondence with the Ohio Department of Health's Chief of the Bureau of Health Preparedness

Appendix B: Gubernatorial Executive Orders: Authorizations, Provisions, Procedures

Source: The Council of State Governments survey of governors' offices, April 2019

The Book of States 2019 http://knowledgecenter.csg.org/kc/category/content–type/bos–2019

Table 4.5 at 112–113.

Footnotes to chart:
Key:
C—Constitutional
S—Statutory
I—Implied
—Formal provision.
. . . —No formal provision.

(a) Broad interpretation of gubernatorial authority. In Arizona, the governor is authorized to make executive orders in all of these areas and situations so long as there is not a conflicting statute in place.

(b) Executive orders must be filed with secretary of state or other designated officer.

(c) Authorization implied from constitution and statute as recognized by 63 ops. Cal. Atty. Gen. 583.

(d) Implied from Constitution.

(e) Constitution, statute, implied, case law, common law.

(f) Executive clemency.

(g) Only for EROs. When an ERO is submitted the legislature has 30 days to veto the ERO or it becomes law.

(h) To give immediate effect to state regulation in emergencies.

(i) To control administration of state contracts and procedures.

(j) To impound or freeze certain state matching funds.

(k)To reduce state expenditures in revenue shortfall.

(l) Inherent.

(m) To control procedures for dealing with public.

(n) Reorganization plans and agency creation.

(o) Executive reorganizations not effective if rejected by both houses of legislature within 60 calendar days. Executive orders reducing appropriations not effective unless approved by appropriations committees of both houses of legislature.

(p)To assign duties to lieutenant governor, issue writ of special election.

(q) Filing.

(r) Governor is exempt from the Administrative Procedures Act and filing and administrative procedures Miss. Code Ann. § 25–43–102 (1972).

(s) Reorganization plans and agency creation and for meeting federal program requirements. To administer and govern the armed forces of the state.

(t) In addition to filing and publication procedures – Executive Orders are countersigned by and filed with the Secretary of State and published.

(u) To administer and govern the armed forces of the state.

(v) Must submit to the Secretary of State who must compile index and publish Executive Orders. Copies must also be sent to President of the Senate, Speaker of House and Principal Clerk of each chamber.

(w) To suspend certain officials and/or other civil actions.

(x) To designate game and wildlife areas or other public areas.

(y) Appointive powers.

(z) Executive authority implied by constitution except for emergencies which are established by statute.

(aa) General power to issue executive orders to execute the authority of the Governor as provided in the Constitution and state statute.

(bb) The governor has the authority, through state statute, to enact executive orders that: create agencies, boards and commissions; and reassigns agencies, boards and commissions to different cabinet secretaries. However, in order for the continued operation of any agency created by executive order the state legislature must approve legislation that allows the agency to continue to operate, if not, the agency cannot continue operation beyond sine die adjournment of the legislature for the session.

(dd) For fire emergencies.

(ee) To transfer funds in an emergency.

(ff) Subject to legislative approval when inconsistent with statute.

(gg) Only if reorganization order filed with the legislature.

(hh) Some statutes set forward requirements for executive orders, but few established procedures.

(ii) Expansion of governor's existing state of emergency power to now create a state of preparedness. The governor has the authority to issue an executive order for a state of preparedness in advance of an anticipated event affecting public safety (as of March 8, 2014).

During the first special session in 2016 the legislature gave the governor the power, in the event a budget bill has not been enacted by June 30 of any year, to, by executive order, direct scheduled payments of principal and interest due on bonds or notes of the state or its agencies, boards, or commissions.

(jj) The governor has power to direct the Department of Administration to conduct investigations of any executive or administrative agency in order to determine feasibility of consolidating, creating or rearranging agencies for the purpose of affecting the elimination of unnecessary state functions, avoiding duplication, reducing the cost of administration and increasing efficiency. Wis. Stat. 16.004(3)(a). The governor has power to coordinate services of personnel across state agencies. Wis. Stat. 14.03.

(kk) No specific authorization granted, general authority only.

(ll) If executive order fits definition of rule.

(mm) Can reorganize, but not create.
(nn) Executive Orders are filed in the Department of State.

Gubernatorial Executive Orders: Authorization, Provisions, Procedures

		Provisions								Procedures		
State or other jurisdiction	Authorization for executive orders	Civil defense disasters, public emergencies	Energy emergencies and conservation	Other emergencies	Executive branch reorganization plans and agency creation	Create advisory, coordinating, study or investigative committees/commissions	Respond to federal programs and requirements	State personnel administration	Other administration	Filing and publication procedures	Subject to administrative procedure act	Subject to legislative review
Alabama	S, I, Case Law	★	★	★	...	★	...	...	...	★	...	...
Alaska	C	...	...	...	★	...	...	...	...	★	...	★
Arizona	I	★(a)	★(a)	★(a)	★(a)	★(a)	★(a)	★(a)	★(a)	★(b)	...	...
Arkansas	I, Common Law	★	★	★	★	★	...	...	...	...	...	...
California	I (c)	★	★	★	★	★	★	★	★	...	...	...
Colorado	C	★	★	★	★	★	★	★	★	★	★	★
Connecticut	C, S	★	★	★	...	★	...	★	★	(b)	...	...
Delaware	C	★	★	★	★	★	★	★	...	★	...	...
Florida	C, S	★	★	★	★	★	★	★	...	...	★	...
Georgia	S, I (d)	★	★	★	★	★	★	★	...	★	...	...
Hawaii	C, S, Common Practice	★	★	★	★	★	★	★	...	★	★	★
Idaho	S	★	★	★	★	★	...	★	...	★	...	...
Illinois	C, S	★	★	★	★	★	★	★	★	★	★	★
Indiana	C, S, Case Law	★	★	...	★	★	★	★	...	...	...	...
Iowa	(e)	★	★	★	★	★	★	★	(f)	★	★	★
Kansas	C, S	★	★	★	★	★	...	★	★	...	...	(g)
Kentucky	C, S	★	★	★(h)	★	★	★	★	★(i)(j)(k)	★(b)	★	★
Louisiana	C, S (l)	★	★	★	★	★	★	★	...	★	...	...
Maine	I	★	★	★	★	★	★	★	...	...	...	...
Maryland	C, S	★	★	★	★	★	★	★	★(m)	★	★	★(n)
Massachusetts	C, S	★	★	★	★	★	★	★	★	★	...	...
Michigan	C	★	★	★		★	★	...	★	★(o)	...	...
Minnesota	S	★	★	★	★	★	★	...	(p)(q)	★(b)	★	★(n)
Mississippi	C, S	★	★	★	★	★	★	...	...	(r)	(r)	...
Missouri	C, S, Common Law	★	...	★	★	★	★	★	★	★(n)	...	★(n)(s)
Montana	S, I, Common Law	★	★	★	★	★	★	★	★	★	...	...
Nebraska	C, S	★	★	★	...	★	...	...	...	★	...	...
Nevada	S, I	★	★	★	★	★	★	★	★	★ (t)	...	...
New Hampshire	S	★	★(a)	★	...	★	★	...	★(j)	★	...	...
New Jersey	C, S, I	★	★	★	...	★	★	★	★(u)	★	...	...
New Mexico	C, S	★	★	★	★	★	★	★	★	★	...	...
New York	C, S	★	★	★	...	★	...	...	...	★	...	...
North Carolina	C, S	★	★	★	★	★	★	★	★	★	...	★(v)
North Dakota	S, I	★	★	★	...	...	...	...	(k)(p)(u)(w)(x)(y)	...	...	...
Ohio	C, S, I (z)	★	★	★	★	★	★	★	(aa)	★	...	...
Oklahoma	C	★	★	★	(bb)	★	★	★	...	★	...	...
Oregon	I	★	★	★	...	★	★	★	...	...	...	...
Pennsylvania	C, S	★	...	★(m)(cc)(dd)(ee)	...	★	★	...	★(dd)(ee)	★(b)(cc)	...	...
Rhode Island	S, I, Case Law	★	★	★	★	★	★	★	...	★(b)	...	...
South Carolina	S	★	★	★	...	★	★	...	★	★	...	...
South Dakota	C	★	★	★	★	★	★	★	★	★	...	...
Tennessee	C, S	★	★	★	★	★	★	★	★	★(b)	...	...
Texas	C, S, I	★	★	★	...	★	★	★	★	...	...	...
Utah	S, I	★	★	★	★	★	★	★	...	...	...	...
Vermont	S, I	★	★	...	★(ff)	★	★	...	...	...	...	★(gg)
Virginia	C, S	★	★	★	★	★	★	★	...	...	...	★(hh)
Washington	S	★	...	...	...	...	...	...	...	...	...	...
West Virginia	C, S	★	★	...	...	★	★	...	(ii)	...	...	...
Wisconsin	C, S	★	★	★	★	★	★	★	(jj)	★	...	...
Wyoming	(kk)	...	...	...	...	...	...	...	...	...	...	...
American Samoa	C, S	★	★	★	★	★	★	★	★	★(ll)	★(ll)	...
Guam	C	★	★	...	(mm)	★	★	★	★	★	...	...
CNMI*	C	★	...	★	...	...	...	...	★	...	...	...
Puerto Rico	C, S, I, Case Law	★	★	★	★	★	★	★	★	(nn)	...	...
U.S. Virgin Islands	S	★	★	★	★	★	★	★	★	★	...	...