

Protecting Patients and Providers in Unprecedented Times

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by Nathan J. Ebnet

As the number of COVID-19 cases increases exponentially, healthcare providers in the United States are bracing for an unmanageable number of critically ill patients. While it is impossible to predict to what extent the virus will overwhelm hospitals in the U.S., Italy foretells a realistic and grim scenario. In early March, the Italian College of Anesthesia, Analgesia, Resuscitation and Intensive Care published guidelines educating Italian physicians on how to conduct “disaster medicine” triage—an approach that recognizes the potential need to base triage decisions on which patients are most likely to survive, and prioritizing treatment for those patients. Traditional disaster medicine or “wartime” triage can result in the denial of medical care for patients with preexisting health conditions or patients above a certain age.

The collective hope is that the COVID-19 pandemic never requires hospitals in the U.S. to adopt disaster medicine triage practices. If it does, healthcare providers will be forced to make triage decisions they have never faced before, and certain patients will succumb to the virus after seeking—and being denied—complete medical care.

By its nature, wartime triage (or some variant thereof) will also mean modified rules for a new world. What may normally be considered medical malpractice will become acceptable under the exigent conditions of the pandemic.

The applicable standard of care, which necessarily turns on the unique circumstances of the situation at hand, will shift, and providers’ actions will be analyzed within the prism of an unprecedented state of emergency. *See, e.g., Estate ex rel. Campbell v. Calhoun Health Servs.*, 66 So. 3d 129 (Miss. 2011) (applicable standard of care may take into



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account mass casualty situation in the emergency room).

Stated differently, providers will not be held to the standard of care applicable in a normal emergency room setting, but instead a unique disaster medicine standard that will grant far more latitude to physicians. That standard, however, is not yet clear. Physicians may reasonably disagree on what constitutes the best patient care in wartime or mass casualty triage situations. The issue is extremely complex and there is no obvious “right” approach at this time.

The unique features of COVID-19 itself may also impact potential medical malpractice claims. There is no current cure for COVID-19, so while physicians can treat the symptoms, they cannot yet address the underlying cause. As a result, it will be difficult for any potential plaintiff to establish definitively that admission to a hospital or access to a ventilator would have prevented the patient’s death. Absent evidence that the patient’s death was primarily caused by a provider’s decision, rather than COVID-19 and/or other contributing factors, medical malpractice claims will fail.



That said, extenuating circumstances do not always deter medical malpractice plaintiffs. See, e.g., *LaCoste v. Pendleton Methodist Hosp., LLC*, 966 So. 2d 519 (La. 2007) (plaintiffs pursued medical malpractice claims against a New Orleans hospital for wrongful death arising from facility deficiencies related to Hurricane Katrina); *Husband v. Tenet*

HealthSystems Mem. Med. Ctr., Inc., 16 So. 3d 1220 (La. Ct. App. 2009) (wrongful death class action against hospital and providers involved in care during Hurricane Katrina).

Therefore, in order to protect physicians who may end up in uncharted waters, and to ensure the best patient care possible in difficult circumstances, healthcare providers may want to prepare for the possibility of wartime triage. Some potential steps include:

- Establishing clear policies and guidelines that govern the implementation and application of disaster triage practices. These guidelines could be adaptations of mass casualty incident plans that are more specifically tailored to COVID-19. The goal is to provide guidance appropriate to the facility and the circumstances so that providers do not need to make ad hoc decisions on their own. Once established, hospitals may also need to reassess the guidelines as the situation develops.
- Ensuring that all providers are familiar with evolving guidelines and fully understand the decision-making criteria. Extensive training and simulations may not be feasible, but basic knowledge of the guidelines will help keep care consistent.
- Emphasizing the need for proper documentation of all care decisions. While maintaining medical records will not seem like a priority in the chaos and tumult of an overflowing emergency department, good documentation will be critical to providing quality care and important for the defense of any future medical malpractice claim.

- Remaining attuned to the publication of national guidelines and the adoption of local laws that may provide limited liability protections during crises. Existing triage guidelines may help hospitals establish their own framework for handling disaster triage decisions.

At this moment, healthcare providers should be focused on patient care and their own health and well-being, not potential legal liability. But specific planning for the potential need for disaster medicine triage can provide comfort, consistency and protection for patients and providers on the front line.