

VIEWPOINT

Potential Legal Liability for Withdrawing or Withholding Ventilators During COVID-19

Assessing the Risks and Identifying Needed Reforms

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With an anticipated shortage of ventilators for patients with coronavirus disease 2019 (COVID-19), hospitals, physicians, and nurses may have to make an unprecedented decision: should they withdraw or withhold ventilators from some patients and use them for other patients who have a better chance of survival? It is not uncommon for care teams to decide against initiating or continuing mechanical ventilation when such treatment would not achieve a patient's goals or directives. COVID-19 presents a different case: patients who do not receive a ventilator could benefit, perhaps living for many additional years, if they receive short-term mechanical ventilation. Denying patients such treatment, against their wishes, most likely will result in their death, but it will also make this scarce resource available to other patients who are more likely to survive if they receive ventilator support.

Recently developed protocols expressly call for the rationing and reallocation of ventilators, in a manner that aims to save the greatest number of lives.¹ These protocols are broadly accepted by medical ethicists.^{1,2} But ethics aside, there are potential legal ramifications of either withholding or withdrawing a ventilator from a patient who would ordinarily receive such aid in the absence of a public health emergency.

In this Viewpoint, we assess the legal risks that physicians, other health care workers, and hospital systems confront in such scenarios and recommend that states explicitly and immediately adopt legal protections for health care workers, modeled on provisions in place in Maryland.

The Risk of Criminal and Civil Liability

In theory, clinicians who withhold or withdraw ventilators without patients' consent become exposed to risks of criminal and civil liability. The odds that such liability will materialize in any given instance are likely low, especially if clinicians follow recommended guidelines and strategies when allocating ventilators. But the risk of liability is not zero, especially in the case of withdrawal of a ventilator, a scenario that may occur during the COVID-19 pandemic under existing triage protocols. Importantly, clinicians' concerns about liability must be addressed because even a small chance of a serious lawsuit could push physicians toward a less ethical and less efficacious first-come, first-serve allocation system for ventilators, leading to a major loss of lives.

Medical Malpractice and Other Civil Liability

Clinicians who withhold or withdraw ventilators could be sued for negligence, especially medical malpractice.³ Unlike criminal charges, which can only be filed by prosecutors, civil suits could be filed by the survivors of any

of the potentially thousands of people who could die as a result of ventilator triage decisions. Such lawsuits could be brought against anyone who participated in the triage decision and against the hospital.

To prevail on such a claim, the suing plaintiffs would need to persuade a jury, among other things, that the health care clinicians and hospital violated the applicable standard of care and, in so doing, caused the patient harm. Plaintiffs may struggle to satisfy these elements. Adherence to well-recognized triage guidelines, for example, will likely constitute strong evidence that the standard of care was satisfied. Moreover, the standard of care against which clinicians and health care entities will be judged in a pandemic is not the same as the standard of care under ordinary circumstances.

Plaintiffs also will be challenged to show causation (or to show significant damages) if a patient who was denied care likely would have died with ventilator assistance.⁴ But importantly, these are all trial questions, which means clinicians making triage decisions do so at the judgment of future juries. Even if those juries are sympathetic to health care workers given the circumstances, physicians, other clinicians, and hospitals may still have to defend themselves against these lawsuits, which will impose additional stresses and burdens during or in the immediate aftermath of an already traumatic pandemic.

Criminal Law

A clinician is unlikely to incur criminal liability for failing to provide a scarce ventilator to a patient who requires ventilator support, so long as the decision is made pursuant to triage protocols. The criminal law generally penalizes actions, not refusals to act. Moreover, a physician cannot be punished for failing to provide a ventilator that does not exist, as will be true if the supply of ventilators is insufficient.⁵

By contrast, a clinician who intentionally withdraws a ventilator from a nonconsenting patient could conceivably be charged with criminal homicide. If the clinician knows that removing the ventilator will result in the death of the patient, the applicable charge would be murder. If the clinician knows there is a substantial risk the patient will die, and the patient does die, the applicable charge would be manslaughter. It does not matter whether the patient would have died soon regardless. Action that shortens a life, even if just by hours, can be prosecuted as a homicide, with charges potentially filed against any individual who participated in or directed the ventilator removal and against the hospital.

A clinician facing such charges could attempt to invoke the so-called necessity defense, arguing that

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removing the ventilator avoided a greater harm—namely, the death of a healthier patient who was more likely to survive if ventilated. This defense, however, may not be available if removing the ventilator saves only one other patient (as opposed to multiple others), because criminal law generally considers each life “to be of equal value.”⁶ Moreover, some states do not recognize the necessity defense in homicide prosecutions, reserving it instead for lesser crimes.⁷

To be sure, the likelihood that a prosecutor would bring charges against a physician trying to minimize deaths during a pandemic is extremely low. But there are more than 2300 independently elected local prosecuting offices in the US, any one of which could decide to pursue such charges, particularly if local communities urge such intervention. In times of emergency, frontline health care workers should not have to rely on, or try to anticipate, the future decisions of such officials.

Existing Immunities

Existing federal and state statutes provide limited immunity to physicians and nurses in times of emergency.⁸ But importantly, these laws do not clearly immunize decisions to withhold or withdraw ventilators, which might be seen as willful, reckless, or wanton conduct and thus beyond the scope of existing shields.³ Moreover, only a small number of states extend immunity to criminal charges.

The Need for Urgent Action by State Governments

With potentially thousands of triage decisions on the horizon, clinicians should not be expected to move ahead with implementing triage protocols based on the hope that prosecutorial discretion or sympathetic juries will protect them in the future.

There will be time after the COVID-19 pandemic ends to debate long-term or systematic solutions to this liability problem. But with a likely impending significant ventilator shortage, physicians, other health care professionals, and medical centers need a clear-cut solution now.

Some states have provided partial answers, but one state offers a clear model: a Maryland statute in place since 2004 indicates 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,” with health care provider defined to include most health care facilities.⁹ According to the

operative Maryland Attorney General opinion interpreting this statute, it immunizes a “provider who acts in accordance” with mandatory ventilator allocation protocols established by the state and “likely” immunizes clinicians who comply with voluntary state-approved protocols as well, “regardless of the negative consequences arising from the withdrawal of a patient’s ventilator.”¹⁰

Other state legislatures must take action. They should adopt a version of Maryland’s statute, immediately, accompanied by an emergency proclamation. Such a statute should expressly immunize all health care clinicians and health care entities from civil and criminal liability for ventilator triage decisions made in good faith compliance with mandatory or voluntary state-approved protocols, which could simply adopt the well-recognized University of Pittsburgh model.¹

To ensure prompt passage of such a law, the statute should include an automatic expiration date of 120 days; this will assure legislators that they can act quickly, without being concerned about or debating every possible ramification of the law. In the meantime, while such laws are debated, every state attorney general and every local district attorney in the country can take additional helpful steps. They should send a letter to every hospital in their jurisdiction, informing the hospitals and their employees that triage decisions that comply with well-recognized triage protocols will not be considered crimes, and they will not be prosecuted as such. Clinicians and health care organizations that receive and rely on such letters can be assured (under the “entrapment by estoppel doctrine”) that they will be protected from future criminal liability.

As recent examples show, governments can enact sweeping new laws quickly in times of crisis. The proposal for state legislators to take action related to liability for decisions involving ventilator use in the time of ventilator shortages is comparatively narrow, but it is essential. Hopefully, physicians and nurses, other health care professionals, and medical centers will be spared the tragic decisions that triaging and rationing ventilators would entail. But the need to prepare for that eventuality must be recognized. If such events come to pass, compliance with effective triage protocols will be essential and will depend on state governments’ ability to assure physicians, nurses, and hospitals that they will not be taking on even low risks of civil or criminal liability if they act in good faith compliance with rules governing the withdrawal and withholding of ventilators.

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