COVID-19 and its Impact on Medical Professional Liability: First Impressions

By: Paul Greve JD RPLU, Richard Henderson and Lori Semlies

The first confirmed case of coronavirus disease 2019 (COVID-19), a global pandemic, occurred in the United States in January 2020.[1] The disease has caused deaths in every state.[2] By April, the United States had more active cases and deaths than any other country.[3]

Just as the disease has affected, and will continue to affect, American society in unimaginable ways, so has it affected, and will affect, the medical professional liability (MPL) insurance industry. It is far too early to know what changes are occurring that will have even short term, much less long term, impact on MPL as we have not even reached the height of the pandemic as of early April.

We know from watching the nightly news that COVID-19 is already impacting and will continue to profoundly impact the health care industry, even though as of this writing, few areas of the country are over surges of coronavirus cases nor have many "flattened the curve".[4] Accordingly, the pandemic will potentially be a major influence on MPL claims and litigation, underwriting strategy, rates and carrier finances.

We will explore, in a preliminary way of necessity, the issues raised for the MPL insurance industry by COVID-19. It will be many years until the final chapter is written about what could be profound changes for the MPL insurance industry as a result of this disease. The goal of this article is to help those in the MPL insurance industry to begin to consider the multiple changes wrought by the pandemic. Many of them are potentially favorable.

COVID-19: Theories of Medical Professional Liability

The exigent circumstances created by the pandemic could give rise to lawsuits. These might include allegations of negligence based on a healthcare organization's:

- Lack of preparedness for the pandemic
- Lack of personal protective equipment for staff thereby injuring/infecting patients
- Lack of adequate equipment such as lab tests and ventilators
- Lack of adequate staffing and appropriately trained staff
- Lack of beds (especially intensive care) and other capacities for care
- Inadequately training staff in infection control practices resulting in injury
- Delaying care, like elective surgeries and procedures, that would have been rendered under normal circumstances, especially due to state and federal directives

But these same exigent circumstances may well provide a defense in MPL litigation. An Office of the Inspector General (OIG) report issued April 6th provided an overview of the most difficult needs and challenges faced by hospitals in addressing the COVID-19 pandemic. The report enumerated all of the circumstances that could give rise to the potential allegations listed above. The problems are so widespread that few hospitals have not been affected.[5] Their staffs have heroically responded despite these daunting challenges.

It is difficult to imagine plaintiff's attorneys taking cases on the allegations above, particularly against hospitals and physicians, absent cases of gross negligence. In the ordinary circumstances of the last few decades, attorneys have been far less likely to take MPL cases of questionable liability. Malpractice cases arising out of the pandemic will be especially difficult to litigate.[6] Aside from the exigent circumstances, there will be difficult issues with proving causation since transmission of the virus is poorly understood and finding credible expert witnesses may be problematic.

COVID-19: The Pandemic Standard of Care

The lack of foreseeability of all the specific health care emergency circumstances in urban and regional settings that have been created by the pandemic creates strong arguments favoring institutional as well as individual provider defendants. The question about the applicable standard of care is the same as it always is: what was reasonable under the circumstances? And what is

reasonable can vary by individual patient.

The highly altered circumstances of the pandemic will have a major influence on the standard of care. The limitations of available staff and supplies, and their redirection to prepare and care for COVID-19 patients limits services available. Policies and procedures and protocols have had to be altered. The inability to perform in-person examinations in all circumstances and the need to retrain physicians and nurse for critical care settings are just some of the examples of influences on the standard of care.[7]

The standard of care also can be greatly affected by state and federal laws, staff shortages (especially doctors, nurses, and respiratory therapists), and shortages of personal protective equipment, COVID-19 lab tests, and ventilators. At least one plaintiff's lawyer has stated that the bar in proving negligence will of necessity be set at a higher level. Attorney Jeffrey R. Davis, who practices in Miami, stated:

"I think the standard of care is going to be flexible. The standard of care on a battlefield is different than the standard of care in an emergency ward and is different from a routine examination."[8]

COVID-19: The Effect on the MPL Litigation Environment in 2020

For most of the past decade, there has been a shift in societal attitudes toward medical professional liability litigation and other civil litigation. Social inflation has caused juries to give large awards to plaintiffs.[9] This trend has been especially true with MPL verdicts exceeding $5M against hospital defendants. An article published in *Medical Liability Monitor* in January noted that "the average cost of a medical malpractice claim has increased by 50 percent since 2009 with a sharp rise in the number of claims of more than $5 million during the last four years…" The data came from the latest annual Aon/ASHRM Hospital & Physician Professional Liability Benchmark Study.[10]

The pandemic may limit the cases taken to trial and resolved in 2020, including those with high valuations. The attitudes of the general public, and therefore of jurors, may be favorably influenced, at least in the near term, by favorable media focus as to certain health care defendants, especially hospitals, physicians, and nurses. The plaintiff's bar may need to settle cases for the benefit of certain clients, some of whom may be unemployed and need the money more immediately.[11] Plaintiff's firms may need the income during the pandemic.

Claim Resolution During the COVID-19 Pandemic

One result of the COVID-19 pandemic has been the closure of some courts for jury trials, although claims are still being filed and processed through certain discovery phases via telephonic and virtual conferences. This is noteworthy because although bench trials can theoretically be held, the overwhelming majority of medical malpractice trials are conducted before a jury. Since the media attention paid to plaintiff verdicts, particularly in recent years, can arguably influence the negotiations in future claims, the lack of jury trials may dampen the amount paid for both indemnity and ALAE, at least in the short term. In those jurisdictions particularly hard hit, including some of the largest cities, courts may not be fully operational with in-person hearings for several months. The result is that claims that were on the verge of trial (or that would be in the near future) may now be further delayed, potentially creating a backlog which could extend claim resolution for several months, if not longer. Further, medical malpractice losses are hardly the only matters on the court dockets, and other matters, including criminal trials, are likely to take precedence.

Absent the ability to try these claims, what recourse is there for claim resolution for matters that are trial-ready? One option is to engage in video mediations or settlement conferences. Given that on-site mediation is far costlier and more inconvenient than video due to travel costs, additional travel time/time out of office, and weather-related impediments in certain areas of the country, use of video mediations may increase in the future and may be embraced as a longer-term viable

alternative to on-site mediation. Another option would be to return to the "old fashioned" method of picking up the phone and directly negotiating without the use of a mediator. Particularly amongst some of the more senior attorneys and claims professionals, this might be a welcome return to a time when engaging a third party to facilitate settlement was not deemed necessary with anywhere near the frequency with which it has developed over the past 20 years or so.

For claims that are trial-ready but where the gap cannot be bridged via mediation or other negotiation, it was initially presumed that the defense would find themselves in a much stronger negotiation position because plaintiffs would be motivated to settle for less now versus waiting an indeterminate time to attempt to recover more at trial or via settlement. Note it is a given that a thorough analysis of liability and damages should always be undertaken. Furthermore, it was thought that many plaintiff attorneys might find themselves in a cash-sensitive position that would benefit the defense. Lastly, the heroic efforts of the front-line medical professionals have been placed the defense in an advantageous position to stand firm with offers arguably well below forecasted levels on existing claims. Therefore, is it reasonable to assume that the defense is in an enviable position when it comes to negotiation leverage?

The answer, perhaps surprisingly, may be "no," or at least not as much as anticipated. While there is little doubt that some claims have been resolved for less than anticipated, we have not seen frequent reports of great bargains being achieved, at least not at the time of this writing. First, a thorough analysis of liability and damages should always be undertaken in order to evaluate claim values. Second, many of the highest value claims reside in the hands of extremely capable plaintiff firms which have the ability and financial resources to not only wait out the current pandemic on the medical malpractice side, but also leverage alternative sources of funding. Indeed, the presence of third-party funding options can help plaintiff firms avoid compromising claims at less than desirable levels.[i] In short, if the defense is expecting a windfall in the way of settlement discounts on the higher-value claims, they may be quite mistaken.

Of course, not every claim has catastrophic damage potential, nor is every claim in the hands of large well-funded plaintiffs' firms or firms that may be backed with third-party litigation financing. Within this population of claims, where the defense may have more leverage, it is possible that mutually beneficial settlements can be achieved for values below forecasted amounts, however, claims professionals still need to negotiate in a fair and reasonable manner. If a reasonable demand is provided, including those that are time-sensitive, it is still incumbent on the claims handler to respond appropriately under the circumstances even though the claim handler may feel emboldened to take a hardline stance given current dynamics, as there is no guarantee we will see the same landscape once we are beyond the pandemic and no guarantee the plaintiff will accept the prior demand at a future date. In many jurisdictions, the same plaintiff firms, claims professionals, and defense attorneys have been working with each other for years and can be expected to do so well into the future. While it can be very tempting to go for the jugular when either side feels they have the advantage, and while some on the defense/insurer side may feel they have been at a disadvantage more often than they would have liked in recent years and would very much desire to "return the favor, "the situation is not permanent and fair dealings at this time should ideally bear fruit on into the future at a time when the leverage may have shifted.

COVID-19 Claims: Coverage Challenges

A growing subject of discussion from the insurer perspective has been whether COVID-19 claims are individual claims, each subject to a deductible or retention, which could result in horizontal exposure. Or could these claims be aggregated so that they constitute one event, subject to one deductible or retention and one policy limit resulting in vertical exposure? The result of the foregoing may be a misalignment of positions between insured, insurer, co-insurers, and reinsurers.

In light of certain Executive Orders that have been issued, and other similar efforts should significantly limit the scope of COVID19-related litigation, there

are provisions which allow for recovery, including in situations of alleged gross negligence or similar scenarios where the care rendered was beyond "basic" negligence. In many instances, we can expect such claims to include allegations rising to the level of punitive, if not intentional, conduct. One must also recognize that claims involving alleged elder abuse can be subject to both an accelerated docket as well as multiplied/trebled or even punitive damages. Additionally, other "non-traditional" allegations may appear in COVID claims, including claims of alleged Consumer Protection Act violations or negligent activity, some of which may carry the potential for multiplied or trebling of damages. Allegations of this nature often fall outside of the scope of coverage and will merit, at a minimum, reservation of rights, if not disclaimer or partial disclaimer of coverage, as well as additional counsel in the event this causes a conflict of interest for the primary defense counsel.

In the end, one virtual certainty is that a multitude of coverage issues will present themselves as these claims are filed, and that coverage counsel will be in much demand.

Immunity Laws

Equally important to protecting the health and safety of the health care workers, is to give them peace of mind and to protect them from civil liability. Much like the immunity that municipalities offer to protect their law enforcement staff and first responders against negligence or malpractice suits, both the federal and state governments have extended or created legislation to protect front-line health care staff, and many ancillary staff. However, COVID-specific immunity laws are unprecedented and therefore untested. While their intent may be clear, or in some cases obvious, it remains to be seen how exactly they will operate or how the court will interpret them.

PREP Act

The Public Readiness and Preparedness Act (PREP Act) authorizes the Secretary of the Department of Health and Human Services to issue a Declaration that provides immunity from liability to *covered persons* for any loss *caused, arising out of, relating to, or resulting* from administration or use of *countermeasures to diseases*, threats, and conditions determined in the Declaration to constitute a present or credible risk of a future public health emergency. This immunity applies to entities and individuals involved in the development, manufacture, testing, distribution, administration, and use of medical countermeasures described in a Declaration.[12]

Covered persons includes licensed health care professionals and other individuals authorized to prescribe, administer, or dispense countermeasures including volunteers, agents, and employees of any of these entities or persons. *Countermeasures* are related to the use of: any antiviral, any other drug, any biologic, any diagnostic, any other device, or any vaccine, used to treat, diagnose, cure, prevent, or mitigate COVID-19 as well as any device used in the administration of any such product, and all components and constituent materials of any such product.

Countermeasures must either be already FDA approved drugs/devices or specially approved drugs or devices under an FDA emergency use authorization for COVID 19.

Assuming the federal agreement or public agency requirement is met, the types of products that may be covered by the PREP Act could include off label use of FDA approved ventilators (splitting between two patients) under conditions of a ventilator shortage for COVID-19 patients; medical errors by licensed professionals associated with a covered countermeasure in the diagnosis, treatment, or mitigation or COVID-19; claims against medical professionals relating to the spread of COVID-19 with the use of protective equipment authorized by the FDA through a EUA.

As with any piece of legislation, there is an exception. In the cases where a litigant is able to prove willful or wanton misconduct, there will be no such immunity.[13]

State Immunity

Certainly, New York, having suffered the largest death toll to date, and being a highly litigious state, was motivated to enact laws to protect its first responders and health care workers who sacrificed so much to care for its residents. First, by way of an Executive Order

issued on March 23, 2020, Governor Andrew Cuomo offered the first sense of relief for the workers.[14] The Order provides civil liability immunity to physicians, physician assistants, specialist assistants, nurse practitioners, and licensed registered professional nurses, against claims of injury or death alleged to have *resulted directly from an act and/or omission by the healthcare provider during the course of providing medical services in furtherance of the State's response to the COVID-19 outbreak*, so long as injury or death was not caused by gross negligence.[15]

Less than a week later, on April 2, 2020 New York State enacted legislation expanding this immunity in Article 30-D of the Emergency or Disaster Treatment Protection Act. Here, the scope of liability immunity protects healthcare providers so long as the services are (1) pursuant to a COVID-19 emergency rule or otherwise in accordance with the law; and (2) the treatment is impacted by the facility's or professional's decisions or activities during the care and treatment of COVID-19 and *non-COVID-19* patients, when such act or omissions occurred *in response* to the COVID-19 outbreak.

This Act includes healthcare "facilities" signaling that hospitals, nursing homes, doctor offices, and other "facilities" such as converted emergency trauma and care centers such as the Javitz Convention Center in New York City, may receive liability for COVID-19 related claims as afforded under the Governor's Order and state legislation.[16]

Unlike the Executive Order, the Act is intended to protect healthcare workers whose ability to provide care and treatment to non-COVID-19 patients has been impacted by the facility's response to the COVID-19 outbreak. This means to the extent a healthcare worker is somehow limited in his or her ability to provide ordinary care or services to a non-COVID-19 patient because of the strain on resources as a result of the outbreak they too are immune.

Currently, several states including New York and its neighboring New Jersey and Connecticut have either issued a similar executive order or expanded their so called Good Samaritan statutes and granted immunity.[17]

Similar to the PREP Act, there are exclusions. Conduct which amounts to gross negligence, willful or recklessness or intentional misconduct, is not protected. Some states also limit protection to volunteer services.

COVID-19: The Impact on Key MPL Insureds

Hospitals

Claims against hospitals have been the primary driver of the rise in MPL insurance industry severity over the last decade. However, the pandemic has brought daily media images of brave physician and nurses risking their lives in hospitals across the country that, for the most part, have responded very capably despite shortages of trained staff, tests, ventilators, and PPE. The hospital industry, possibly due to mergers and acquisitions and loss of local control along with rising health care costs, has not been as favorably perceived over the last decade and this has affected jury awards against hospitals. It is very possible that the perception of hospitals, physicians and nurses will improve at least for a short term of indefinite duration, thereby providing a stronger shield against MPL litigation and large awards.

The focus on COVID-19 preparation and care of patients has been all-consuming for hospitals. There still has been admissions to emergency departments and inpatient care for non-COVID-19 conditions of all kinds including births. The distraction of the pandemic as well as staff and equipment shortages could result in future claims.

But the American Society for Health Care Risk Management (ASHRM) maintains an exchange site for members. There were postings by some hospital risk managers that indicated that there were far lower patient safety/loss event events being reported.[18] This would seem to indicate the potential for fewer lawsuits against hospitals arising out of this time frame.

Another major concern for medical professional liability insureds and insurers is the backlog of patients that, of necessity, has been created due to the need to conserve resources like staff and PPE in order to prepare for a

surge of COVID-19 patients.[19] Elective procedures, surgeries, and the resulting hospital admissions will need to be resumed and prioritizing patients will be a challenge. It certainly is foreseeable that there could be litigation resulting from delayed care arising out of the pandemic.

Physicians

Over the last decade or so, this segment of MPL insurance has fared the best for losses in comparison to others such as hospitals and nursing homes. It is difficult to imagine many lawsuits, much less successful lawsuits, against physicians arising out of the circumstances of the pandemic. Many physicians are being required to practice outside their areas of expertise, such as in critical care units, for coronavirus patients to get care.

Withholding or withdrawing a scarce ventilator could result in a claim of negligence. But following guidelines suggested by medical ethicists and consulting other physicians and perhaps an ethics committee before such a decision is made could provide a strong defense.[20]

One concern could be the distraction factor of the pandemic leading to allegations of misdiagnosis or improper/delayed treatment of patients not affected by the virus. A number of states in recent weeks and months have granted immunity to physicians in various ways arising out of the pandemic and there could be more states doing so in the future.

Nursing Homes/Long Term Care

The long term care/nursing home MPL insurance segment will likely be the most affected. The tremendous amount of national attention focused on the nursing home community has likely incited those most likely to sue and plaintiff's lawyers who specialize in such litigation. There are media reports of families' calls for information going unanswered at the nursing stations. There have been multiple media reports about clusters of deaths within senior care facilities.[21] Reports of television and newspaper ads eliciting such coronavirus-related suits have already been seen throughout the country.

A *Wall Street Journal* article noted the vulnerability of nursing home residents, issues with infection control even preceding the pandemic and the lack of available tests for staff and residents.[22] Still, each facility and case must be evaluated on its own unique facts. An article published April 10th on nursing homes in Indiana noted that teams from the Indiana Department of Health visiting facilities determined that in most cases nursing homes are following proper infection control techniques. But the Indiana State Health Commissioner noted that employees go home daily and to necessary businesses like grocery stores and may unknowingly contract the virus and bring it into the facility without symptoms.[23]

Some of the most recent regulations issued by CMS and Governor Cuomo may make it easier to target nursing homes. CMS declared on March 13, 2020 that a nursing home cannot condition admission from a hospital upon a negative COVID-19 test.[24]

On April 17, 2020 Governor Cuomo issued an Executive Order requiring nursing homes to inform family members when any resident tests positive for COVID-19 or dies from a COVID related illness within 24 hours.

Nursing homes are an easy target and in states with limited immunity protection they are no doubt going to be hit hard with litigation. This will have a profound impact on the nursing home industry and could put some facilities out of business thereby leaving a shortage of skilled nursing beds available to those who will need in the not-so-distant future.

Home Health Care

The pandemic has created great strain on this type of health care provider/firm. There were already waiting lists for this type of care. Staff are not highly paid and usually minimally trained with home health aides mandated by federal law to have 75 hours of training while personal care aides have no similar requirements. There is also high turnover within home health agencies. Add in the challenges of obtaining PPE and other tools to do the job which are now lacking due to the pandemic and it could create potential liability.[25]

Telehealth/Telemedicine

Telemedicine has proven to be a critical tool for the management of patients during the pandemic. Its adoption has occurred very rapidly because it promotes patient access to care, maximizes the safety of patients and providers from the virus and enables quality of care at a reasonable cost. Many state and federal laws and regulations have been rapidly enacted to accommodate the explosive growth of telemedicine and will have a significant impact on providing and expanding care safely during the pandemic.

There have been relatively few lawsuits to date arising out of the classic face-to-face video encounter between physicians and patients. The numbers of patient encounters via telemedicine until the beginning of the pandemic has been relatively low. Malpractice cases arise out of patient encounters and as the numbers of telemedicine visits grow rapidly, it is only reasonable to expect that clinical errors will occur and thus more telemedicine-related litigation, especially as clinicians are less experienced in its use early on.

COVID-19: Claim Frequency in the Future

We have discussed claims that are on the verge of trial and also claims that are in the pipeline but perhaps not as advanced in the discovery process. The question then becomes, what impact will COVID-19 have on future medical malpractice frequency relative to claims yet to be brought? Much has been written quoting various plaintiff attorneys saying that efforts to sue medical professionals in the near-term is a daunting task, and not a path they plan to venture down any time soon. Not only do many jurisdictions require an affidavit of merit or similar statement from a physician as a condition to filing suit. Why would a physician, in these times, agree to a plan to pursue litigation against a peer who has been working under catastrophic conditions? The overwhelmingly supportive public opinion of medical professionals has been on display for all to see. Beyond that, since so many elective procedures have been canceled as a result of the pandemic, it is reasonable to foresee that we may have a noticeable drop in claim frequency at least in the short term.

At the outset, the simple fact that so many elective procedures have been canceled should lead to a corresponding reduction in future claims. We previously noted comments by some hospital risk managers that there have been fewer patient safety events. What remains to be seen is whether or not there will be a population of claims where, say, the deferral of allegedly non-emergent/elective procedures comes into question, or where the treatment of non-COVID patients who sustain injury somehow fall outside of the domain of the executive orders. Further, the executive orders do not provide an absolute bar on litigation for COVID patients; there are exceptions which are spelled out, including for gross negligence-type scenarios, which may well generate more litigation than anticipated, including on a multi-patient/class action-type basis.

Conclusion

The COVID-19 pandemic is affecting the medical professional liability insurance industry and will continue to affect it for years to come. Its impact will have both favorable and unfavorable aspects.

- The defense of cases arising out of the pandemic may be greatly aided by favorable media focus on the health care industry, especially hospitals, physicians, and nurses
- Immunity statutes such as the ones in states with a significant number of COVID-19 cases (NY/NJ/CT/IL and others) will also be effective in reducing the number of suits against hospitals and their staff, maybe less so as to nursing homes
- Nursing homes may be the primary target for MPL litigation arising out of the pandemic
- There should be a reduction in future malpractice claims overall due to the significantly decreased frequency in other non-COVID related types of medical care being rendered

- Indemnity and ALAE costs can be expected to be significantly lower this year compared to recent years but whether those changes extend beyond this year is uncertain
- Expect many coverage issues to arise out of COVID-19 related litigation
- While some MPL claims currently in litigation may yield defense-friendly settlements, experienced plaintiffs' counsel may not yield much on the largest claims
- Pandemic circumstances have caused the need for such tools as virtual mediations which may well lead to an expansion of such options even after the pandemic has cleared.

End Notes

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End Notes

[12] Note that the PREP Act authorizes a fund in the United States Treasury to provide compensation to eligible individuals for serious physical injuries or deaths directly caused by administration or use of a countermeasure covered by the Declaration.

[13] Plaintiff will have to meet a clear and convincing standard to prove exclusion rather than the traditional tort standard of preponderance of the evidence which is essentially a "more likely than not" standard.

[14] Executive Order No. 202.10. This also allows healthcare providers such as Physician's Assistants, RNs, LPNs, and Nurse Practitioners, who are licensed and in good standing but not registered in the State, to practice in the State without civil or criminal penalties. NPs may also provide medical services in accordance with their education and experience levels without a written practice agreement or collaborative relationship with a physician, and PAs may also provide care to the same extent without physician oversight

[15] Executive Order No. 202.10 also relaxes healthcare provider medical recordkeeping requirements, providing liability immunity against claims relating to maintaining and preserving medical records provided the workers acting reasonably and in good faith responding to the COVID-19 outbreak

[16] Based on current State legislation and Executive Orders, paramedics, and emergency medical technicians (EMTs) are not expressly provided liability immunity.

[17] ATRA as of 4/23/20 lists KY, MA, NJ, NY, WI providing immunity by statute. AZ, CT, GA, IL, MI, MS, NJ, NY by executive order. Note that each statute and executive order is unique as to their provisions. https://www.atra.org/covid-19-resources/

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ABOUT THE AUTHORS

PAUL GREVE JD RPLU

is the Director of Healthcare Risk Solutions at Markel Specialty. Paul has twenty years' experience as an administrator, risk manager and attorney for major hospitals in Ohio, including Cleveland Clinic, University Hospitals of Cleveland, Columbus Children's Hospital, and St. Luke's Hospital. Paul also has twenty years' experience in the health care professional liability industry as a broker and consultant. He worked as a broker and consultant for Willis for 19 years, primarily in the National Health Care Practice. He has also worked for two health care professional liability insurance companies including Medical Protective and Markel Specialty.

RICHARD HENDERSON

is a Senior Vice President with TransRe. Mr. Henderson has headed TransRe's medical malpractice claims department for the past 20 years and has more than 30 years of medical malpractice claims experience. He is actively involved with TransRe's reinsured's, brokers and Third-Party Administrators in refining their claim handling strategies and in providing meaningful input as to industry trends and claim handling tactics. Mr. Henderson graduated magna cum laude from John Jay College in 1984 and has continued his insurance industry education through completion of the Chartered Property Casualty Underwriter (CPCU), Associate in Claims (AIC), Associate in Underwriting (AU) & Associate in Risk Management (ARM) programs.

LORI SEMLIES

is a partner with Wilson Elser Moskowitz Edelman & Dicker. A co-chair of the firm's Medical Malpractice & Health Care practice, defends medical and nursing home malpractice claims in state and federal courts, including all phases of litigation through trial. She has handled appeals in the New York Appellate Division, First and Second Departments, and before the Second Circuit Court of Appeals.