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# BUSINESS LAW NEWS

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BUSINESS LAW NEWS

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# Ignorance Is Not Bliss: The Consequences of How Little We Know About COVID-19

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Craig B. Garner

*"Those who can make you believe absurdities can make you commit atrocities."* – François-Marie Arouet (Voltaire)

## Lessons From the Past (X37.41XA)[1]

Following the 1994 Northridge earthquake, California passed legislation requiring hospitals to upgrade their physical infrastructure to survive future seismic events. Twenty-six years and multiple extensions later, California hospitals face a 2030 deadline with an eleven-figure price tag.[2] Spending money on what may occur is not uncommon in health care. A 2017 study commissioned by the American Hospital Association estimated that hospitals and health systems spent as much as $2.7 billion the year before to prepare for, and respond to, the threat of violence at work.[3] California law requires hospitals to rehearse disaster plans at least twice each year.[4]

## A Novel Threat (A98.4)[5]

An expensive endeavor, hospital disaster preparedness focuses on a rapid response to an unexpected event, designed to protect, stabilize, and bring calm to shaken communities following a disaster's aftermath. The 2019 novel coronavirus disease (COVID-19) has presented a different type of disaster, necessitating just as novel a response. In the pandemic's early days, it moved in slow-motion as the health care community initiated disaster protocol over a period of weeks, not hours. While mobilizing any hospital to battle a pandemic is not easy, legally at least, hospitals benefitted from unprecedented support by practically every federal and state agency. The assistance from these dual agencies eliminated most barriers overnight so hospitals could establish and maintain momentum in the face of an epic disaster that, over several months, has moved forward, backward, and forward again.[6]

Charged with protecting a health care system from a new disease while treating millions of patients without much in the way of established protocol is a formidable task for even the most seasoned health care practitioner. These practitioners also faced, and continue to face as of the date of this article, challenges in maintaining stockpiles of the personal protective equipment ("PPE") for treating a new virus against which the human body has no known internal protections,[7] not to mention a government order for all residents to remain at home,[8] which has since gone back and forth.[9] Restaurants, small businesses, and most larger counties in California remain stuck on a viral string looped around two disks, not to mention school children around the nation who may not enter an actual classroom until at least 2021.[10] What remains unchanged, however, is the six feet between most people.[11]

This is the environment in which health care practitioners must work, and in some ways over a painfully extended period of time, for tactical planning and re-planning. While news outlets, statements from state and federal officials, and the trusted information disseminated on social media portrayed COVID-19's siege on New York City as apocalyptic,[12] Governor Newsom's projection regarding the later May surge[13] has been replaced by fear from the pandemic's forthcoming "second wave."[14] Monitoring of this fear and of similar,

predictions tests the ability of any hospital to maintain the necessary vigilance during an unprecedented time with mortal employees.

### Leading by Leadership (X99.9)[15]

Hospital leadership can only be as effective as the workforce over which they serve, and preventing employees from abandoning posts[16] may ultimately depend upon not just how well California survives COVID-19, but how long the pandemic lasts. With no end in sight, hospital leaders may consider a crash course in psychology, although there are plenty of studies on how people respond in a crisis.[17] Fortunately, hospitals have relied upon the Hospital Incident Command System ("HICS") since the pandemic began.[18]

HICS is a system based on principles of the Incident Command System ("ICS") that assists hospitals and health care organizations to improve their emergency management planning, response, and recovery capabilities for both unplanned and planned events. ICS is a management system designed to enable effective and efficient domestic incident management by integrating a combination of facilities, equipment, personnel, procedures, and communications operating within a common organizational structure.[19] However, the effectiveness of HICS in response to COVID-19 remains largely unknown.

### Not So Armed With Statistics (R41.82)[20]

With trusted resources upon which hospital leaders can rely, coupled with the unprecedented waivers in what many once considered a heavily regulated industry, these institutions have remained on the front lines as California battles COVID-19, one hospital at a time, month after month. As medical science learns more about this virus, recent studies indicate that the overall case fatality ratio may be somewhere between 0.3% and 1.5% (including unreported cases),[21] far below the original estimates in the pandemic's early days.[22]

As a practical matter, what if the statistical information upon which the world leaders relied was wrong? More specifically, what is the significance of 650,000 COVID-19-related deaths by the end of July 2020?[23] Before the global economy plunges even deeper into depression, entire industries disappear overnight, and every boy and girl born in the past decade miss out on that rite of passage commonly known as childhood, those responsible for connecting the statistical information with the effect of the pandemic should double check their calculations.

### Why U.S. Results Matter (Y31.XXXA)[24]

Like it or not, the United States still remains a powerful nation, a true democracy capable of leading other nations around the globe deep into the abyss. Today our health care system, a product of partisan politics fifty-five years in the making, faces its greatest challenge in an order of magnitude above the constitutionality of the individual mandate[25] or safe harbor expansion under the fraud and abuse laws.[26] The story changes considerably, however, if COVID-19 data deviates in accuracy by its own order of magnitude, such that the number of those infected increases exponentially, thereby pushing the overall mortality rate down. If it turns out the overall mortality rate is below 1%, it may still never answer whether the global response should be any different. To be sure, no one likes to suffer from ordinary influenza, but at a certain point the numbers may fail to justify the wreckage caused each day to the global economy or the mental stress caused by isolation and social distancing, much less the possibility that children may someday vaguely remember when teachers existed beyond a computer screen.

Hospital leaders may prefer to focus on their own four walls rather than the nation-wide system. The speed with which federal and state regulations disappeared underscores the foundation of the health care system today, a microcosm of democracy in the United States. Like the nation's leaders, those at the hospital helm can yield strength in targeting tyranny as easily as they can chase windmills.

The nation's history portrays somewhat of a wild ride. With the support of France, the original Thirteen Colonies defeated the British Empire in 1783, and just under 200 years later, in its attempt to support France, the United States was defeated by a former French colony in southeast Asia. Somewhere in between, the nation waged a civil war against itself and banned alcohol (only to change its mind a few years later and bring back the drink), and still appears unable to come to terms on when life begins or what the Second Amendment actually means. Be it in failure or in success, the United States

has almost perfected its ability to constantly redefine the term "epic."

For better or worse, the history of health care in the United States runs along parallel tracks. Only the poor and destitute frequented the nation's first hospitals in the eighteenth century, while those with financial means waited at home for the doctor to arrive. Throughout the twentieth century, the hospital's place in society dramatically changed, a natural result once medical science recognized, in part, the importance of running water and infection control. How the nation's health care system responds to COVID-19 may once again change the role of the hospital in the United States, especially if it joins cruise ships and outdoor festivals as top places to avoid when the next pandemic arrives.

## A Story Still to Be Told (J12.89,[27] J20.8,[28] Z03.818,[29] Z20.828[30])

In the pandemic's first few months, attention focused on the nation's hospitals and the ways in which they responded to COVID-19, and in return hospital leaders worked tirelessly day and night to protect health care's sacrosanct institution. Most health care practitioners swore an oath to stand firm in the face of any novel pandemic, while the non-clinical leadership exercises equal vigilance to ensure that the lights stay on while they track down PPE and whatever else may be necessary to protect their health care family. To be sure, no run on toilet paper or ill-advised social gathering will break the resolve of the collective leadership.

At the same time, the tale of COVID-19 may not end with ventilator or vaccine, but instead prove to be a seminal reminder of a particular tragic shortcoming in modern medicine. Somewhere in the wake of COVID-19's body count is mental health, still just as hard to identify as it is to treat.[31] COVID-19 survivors, as well as those who manage to avoid the pandemic altogether, may ultimately end up with Rorschach and Prozac,[32] just like the other 264 million individuals worldwide who suffered from depression in 2017.[33]

In Plato's *Republic,* democracy failed when it chose money over humanity, leaving the door wide open for tyranny.[34] Fearing COVID-19, parts of the United States appear to be acting the same way, each day moving closer toward total chaos and the end of the democratic state.[35] The struggling version of today's United States health care may be the last obstacle preventing it from making a tyrannical plunge. Whether health care can succeed may depend in large part upon the number of hospital beds made available to those patients with advanced complications or the necessary medical equipment and staff available to keep these patients alive.

Currently, health care must maintain myopic focus on these immediate tasks at hand, which places the burden on hospital leadership as it meets the challenge not only through medical science, but also through discipline, resilience, and creativity. In an almost ironic sense, for health care to survive, and to a lesser extent democracy, the nation must not impede hospitals from doing their job. If the nation's hospital system can somehow contain COVID-19 until long-term solutions appear, panic ceases and global healing begins. And perhaps most importantly, children can return to school.

## Endnotes

1 X37.41XA is a billable code used to specify a medical diagnosis of tidal wave due to earthquake or volcanic eruption, initial encounter. ICD-10 is a medical classification list by the World Health Organization. It contains codes for diseases, signs, and symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or diseases). *See* World Health Org. Int'l Classification of Diseases (ICD) Info. Sheet, https://www.who.int/classifications/icd/factsheet/en/ (

2 Preston, Benjamin Lee, et al., *Updating the Costs of Compliance for California's Hospital Seismic Safety Standards*, RAND Corporation (2019), https://www.rand.org/pubs/research_reports/RR3059.html.

3 Jill Van Den Bos, et al., *Cost of Community Violence to Hospitals and Health Systems*, Rep. for the Am. Hosp. Ass'n 3 (July 26, 2017), https://www.aha.org/system/files/2018-01/community-violence-report.pdf.

4 California Code of Regulation, title 22, section 70741(b) states:

> The program shall cover disasters occurring in the community and widespread disasters. It shall provide for at least the following:
>
> (1) Availability of adequate basic utilities and supplies, including gas, water, food and essential medical and supportive materials.
>
> (2) An efficient system of notifying and assigning personnel.
>
> (3) Unified medical command.
>
> (4) Conversion of all usable space into clearly defined areas for efficient triage, for patient observation and for immediate care.
>
> (5) Prompt transfer of casualties, when necessary and after preliminary medical or surgical services have been rendered, to the facility most appropriate for administering definite care.
>
> (6) A special disaster medical record, such as an appropriately designed tag, that accompanies the casualty as he is moved.

(7) Procedures for the prompt discharge or transfer of patients already in the hospital at the time of the disaster who can be moved without jeopardy.

(8) Maintaining security in order to keep relatives and curious persons out of the triage area.

(9) Establishment of a public information center and assignment of public relations liaison duties to a qualified individual. Advance arrangements with communications media will be made to provide organized dissemination of information.

*See also* Cal. Code Regs. tit. 22, § 70743(c) (requiring hospitals to conduct fire and internal disaster drills at least quarterly).

5 *Ebola virus disease* (ICD-10).

6 In the first few weeks of the pandemic, the United States redefined "regulatory flexibility" to assist health care providers contain the spread of COVID-19. Federal law theoretically contemplates disasters such as COVID-19, *see* 42 U.S.C. § 5195 ("The Federal Government shall provide necessary direction, coordination, and guidance, and shall provide necessary assistance, as authorized in this subchapter so that a comprehensive emergency preparedness system exists for all hazards."), and the 2003 SARS coronavirus (SARS-CoV) epidemic combined with the 2009 H1N1 influenza virus pandemic provided sufficient examples of the possible damage caused by a global flu pandemic. As theory transitioned into practice, COVID-19 delivered an epic "knock-out" punch on most of the world, the effects of which remain hotly contested, and actual containment is still a challenge. COVID-19 has been so damaging thus far that, pursuant to the emergency declaration by President Trump under the Robert T. Stafford Disaster Relief and Emergency Assistance Act to declare a national health emergency, 42 U.S.C. §§ 5121-5207; the Centers for Medicare & Medicaid Services ("CMS"): (1) waived enforcement of key provisions within the Emergency Medical Treatment and Labor Act ("EMTALA"), 42 U.S.C. § 1395dd; (2) waived certain requirements of verbal orders where readback verification is required, 42 C.F.R. §§ 482.23, 482.24, 485.635(d)(3); (3) waived reporting requirements for intensive care unit patients who died while in restraints, 42 C.F.R. § 482.13(g)(1)(i)-(ii); (4) waived patient rights with respect to obtaining a copy of a medical record, patient visitations and seclusion, 42 C.F.R. § 482.13; (5) waived requirements for sterile compounding to ensure an adequate supply of face masks, 42 C.F.R. §§ 482.25(b)(1), 485.635(a)(3); (6) waived detailed information requirements for discharge planning, 42 C.F.R. § 482.43; (7) waived regulations governing the medical staff, including credentialing, privileging, and the effect of expirations, 42 C.F.R. § 482.22(a); (8) waived the organization and staffing of medical records departments, 42 C.F.R. § 482.24; (9) waived advance directive requirements, 42 C.F.R. § 489.102; (10) waived certain requirements for the physical environment as conditions of participation, affording hospitals flexibility in using non-hospital buildings/space for patient care and quarantine sites, including ambulatory surgery centers, hotels, and dormitories, 42 C.F.R. §§ 482.41, 485.623; (11) waived provisions related to telemedicine, making it easier for hospitals to deploy telemedicine services, 42 C.F.R. § 482.12(a); (12) waived requirements that Medicare patients be under the care of a physician, 42 C.F.R. § 482.12; (13) waived physician oversight for a certified registered nurse anesthetist, 42 C.F.R. §§ 482.52(a)(5), 485.639(c)(2), 416.42(b)(2); (14) waived certain requirements for utilization review planning, 42 C.F.R. §§ 482.1(a)(3), 482.30; (15) waived written policies and procedures for staffing surge facilities, 42 C.F.R. § 482.12(f)(3); (16) waived emergency preparedness policies and procedures, 42 C.F.R. § 482.15(b); (17) waived quality assessment and performance improvement programs, 42 C.F.R. §§ 482.21, 485.641; (18) waived requirements for the nursing staff to develop and keep current a nursing care plan for each patient, 42 C.F.R. § 482.23(b)(4); (19) waived food and dietetic services, 42 C.F.R. § 482.28(b); (20) waived certain requirements for respiratory care services, 42 C.F.R. §57(b)(1); (21) waived requirements that secluded acute care psychiatric patients from acute care patients; (22) waived the bed limitations for critical access hospitals ("CAHs") as well as the length of stay limitations; (23) extended deadlines for reporting under the inpatient prospective payment system; (24) waived patient stay limitations for long-term acute hospitals; (25) waived requirements that out-of-state practitioners be licensed in the state where they are providing services; (26) established a hotline for physicians and non-physician practitioners to enroll and receive temporary Medicare billing privileges, including the elimination of application fees, criminal background checks, and site visits; (27) granted extensions for Medicare appeals in fees for service, Medicare Advantage, and Part D; (28) waived sanctions under the physician self-referral law (Stark Laws); (29) generally abandoned the requirements under the 1996 Health Insurance Portability and Accountability Act ("HIPAA"); and (30) significantly expanded Medicare's Accelerated and Advance Payment program, issuing approved payments within seven days from the request, as well as other requirements for hospitals.

California tried to keep up with CMS, and Governor Newsom issued an executive order intended to expand California's health care workforce and recruit health care professionals with an active license, public health professionals, medical retirees, medical and nursing students, or members of medical disaster response teams. Cal. Exec. Order No. N-39-20, Exec. Dep't, State of Cal. (Mar. 30, 2020). At the same time, California also reminded hospitals that rationing care based upon a patient's disability status is impermissible and unlawful.

7 *See* Andrew Jacobs, *Grave Shortages of Protective Gear Flare Again as Covid Cases Surge*, N.Y. Times (July 8, 2020), https://www.nytimes.com/2020/07/08/health/coronavirus-masks-ppe-doc.html.

8 Cal. Exec. Order No. N-33-20, Exec. Dep't, State of Cal. (Mar. 19, 2020).

9 *See* Taryn Luna, *Newsom Reopened California Without Meeting His Own Coronavirus Testing Tracing Benchmarks,* L.A. Times (July 17, 2020), https://www.latimes.com/california/story/2020-07-17/gavin-newsom-contact-tracing-testing-coronavirus-covid-19-reopening-california.

10 Cal. Dep't of Pub. Health, COVID-19 Industry Guidance: Schools and School-Based Programs (July 17, 2020), https://files.covid19.ca.gov/pdf/guidance-schools.pdf.

11 *See, e.g.,* Ctrs. for Disease Control and Prevention, How to Protect Yourself, https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/prevention.html.

12 Michael Rothfield, et al., *13 Deaths in a Day: An 'Apocalyptic' Coronavirus Surge at an N.Y.C. Hospital*, N.Y. Times (Mar. 25, 2020), https://www.nytimes.com/2020/03/25/nyregion/nyc-coronavirus-hospitals.html (content access may require an account).

13 *Newsom: Coronavirus Set to Peak in California By Late May*, MSN News (Mar. 31, 2020), https://www.msn.com/en-us/news/us/newsom-coronavirus-set-to-peak-in-california-by-late-may/ar-BB11YM1L.

14 Jared S. Hopkins, *Hospitals Stock Up on Covid-19 Drugs to Prepare for Second Wave in Fall*, Wall St. J. (July 14, 2020), https://www.wsj.com/articles/hospitals-stock-up-on-covid-19-drugs-to-prepare-for-second-wave-in-fall-11594719000.

15 *Assault by unspecified sharp object* (*e.g.,* assassination) (ICD-10).

16 Thomas Kirsch, *What Happens if Health-Care Workers Stop Showing Up?,* The Atlantic (Mar. 24, 2020), https://www.theatlantic.com/ideas/archive/2020/03/were-failing-doctors/608662/.

17 According to a 2019 study published by the CDC, individuals process information during a crisis in four different ways: (1) some simplify messages, whether by not hearing the salient information, not remembering it, or simply by misinterpretation; (2) some hold on to current beliefs, and during a crisis counterintuitive actions may not be welcome; (3) some look for additional information or different opinions, an option readily available to everyone in the modern age of the Internet; and (4) some believe the first message heard, whether it is based in fact or fiction. *See* Ctrs. for Disease Control and Prevention, Psychology of a Crisis 3-4, (2019 Update), https://emergency.cdc.gov/cerc/ppt/CERC_Psychology_of_a_Crisis.pdf.

18 Hospital Incident Command System Guidebook, Cal. Emergency Med. Servs. Auth. (2014).

19 E/L/G 0300 Intermediate Incident Command System for Expanding Incidents, ICS 300 (FEMA Apr. 2019).

20 *Altered mental status, unspecified.* (ICD-10).

21 Brianna Abbott & Jason Douglas, *How Deadly Is Covid-19? Researchers Are Getting Closer to an Answer*, Wall St. J. (July 21, 2020), https://www.wsj.com/articles/how-deadly-is-covid-19-researchers-are-getting-closer-to-an-answer-11595323801.

22 Robert Verity, et al., *Estimates of the Severity of Coronavirus Disease 2019: A Model-based Analysis*, The Lancet, Mar. 30, 2020, at 8.

23 *See* Johns Hopkins Univ. of Med., COVID-19 Dashboard by the Center for Systems and Engineering (July 25, 2020), https://coronavirus.jhu.edu/map.html.

24 *Falling, lying or running before or into moving object, undetermined intent, initial encounter*. (ICD-10)

25 26 U.S.C. § 5000A, *held unconstitutional by* Texas v. United States, 945 F.3d 355 (5th Cir. 2019), *cert. granted*, 2020 WL 981805 (Mar. 2, 2020).

26 *See, e.g.,* 42 C.F.R. § 411.357.

27 *Pneumonia case confirmed as due to COVID-19* (ICD-10).

28 *Acute bronchitis confirmed as due to COVID-19* (ICD-10).

29 *Possible exposure to COVID-19, but the disease is ruled out* (ICD-10).

30 *Actual exposure to someone who is confirmed to have COVID-19* (ICD-10).

31 Treating mental illness relies upon the subjective, while somatic matters approach illness through diagnostic testing, which can often yield a more precise diagnosis. That which is psycho has a seemingly unfair disadvantage to somatic, although general medicine has enjoyed far more decades to advance from the early days of leeches and amputations. By comparison, mental health treatment exists in its infancy. *See, e.g.,* Charles E. Dean, *Social Inequality, Scientific Inequality, and the Future of Mental Illness,* Phil. Ethics Human. in Med. 12, 10 (2017), https://peh-med.biomedcentral.com/articles/10.1186/s13010-017-0052-x.

32 *See, e.g.,* Mark A. Ellul, et al., *Neurological Associations on COVID-19,* 19 Lancet Neurology 2020 767 (July 2, 2020), https://www.thelancet.com/action/showPdf?pii=S1474-4422%2820%2930221-0 ("With so many people infected, the overall number of neurological patients, and their associated health burden and social and economic costs might be large. Health-care planners and policy makers must prepare for this eventuality, while the many ongoing studies investigating neurological associations increase our knowledge base.").

33 *See Global, Regional, and National Incidence, Prevalence, and Years Lived with Disability for 354 Diseases and Injuries for 195 Countries and Territories, 1990–2017: A Systematic Analysis for the Global Burden of Disease Study 2017*, 392 The Lancet 1789-858 (June 20, 2019), https://www.thelancet.com/action/showPdf?pii=S0140-6736%2818%2932279-7.

34 The Republic of Plato, ch. VIII, at 260-61 (Benjamin Jowett trans., Clarendon Press 1881).

35 *See, e.g.,* Kendra Pierre-Louis, *Panic Buying Comes for the Seeds*, N.Y. Times (Mar. 28, 2020), https://www.nytimes.com/2020/03/28/style/seed-panic-buying-coronavirus.html.

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