Physicians Professional Immunity in the COVID-19 Pandemic. Problems and Solutions

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Abstract: In this article, by professional immunity we refer to limitation of liability to the specific pandemic context, respectively to the concrete possibilities of diagnosis, treatment, care and too few degrees of professional freedom still available. Our thesis is that, regardless of the form of transposition into practice, a form of health professionals protection, such as professional immunity is necessary. The need for specific measures for professional immunity is not identical in each state, depending on the specifics of the legal system, social values, measures characteristics taken to combat the pandemic, the degree of transparency of each healthcare system. However, this need doesn't start from "no measure", the appropriate minimum level of protection seemingly to constitute a patient compensation no-fault model, plus the characteristics of the professional immunity, designed to adapt liability to specific conditions. In the absence of professional immunity there is a risk of transferring the cost of ignorance, visible, in the inadequate expectations of medical science, on healthcare professionals, the limits of scientific knowledge risking to be reinterpreted as medical fault. The COVID-19 pandemic has somehow forced an additional step towards broadening discussions on universal human rights, being forced to consider ways of putting them into practice in the context of limited resources. Assuming that the increase in social complexity increases the risks of such events, we approach these problems from the perspective of creating rapid mechanisms to adapt to such changes, the lessons learned now being applied in the future to other similar cases.

Keywords: *doctors; professional immunity; malpractice; COVID-19; limitation of liability.*

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1. Introduction

The COVID-19 pandemic brought with it a series of new challenges for health professionals, the new conditions for carrying out the activity having associated a series of unique problems which aim at professional liability. For example, Bilotta, Zerbo, Perrone, Malta, & Argo (2020) presents an analytical approach of the factors that have a negative impact on the safety and quality of medical services, indicating: (a) structural problems caused by the need to reconfigure medical services in a short period of time (derogation from the accredited circuit form, dependence of resources allocation to the possibility of procurement, derogation from the staff recruitment based on competence criteria), (b) continuous change of case definition and suspicious cases, (c) absence/ PPE deficit, and (d) decrease of average level of staff experience: some experienced staff end up being infected and isolated, while the new employee faces the lack of experience (Bilotta et al., 2020). Along with a new danger addressed to all citizens, we are witnessing an increase in the risks faced by health professionals during the pandemic (Al-Azri, 2020), some of them aiming the inadequacy of professional responsibility to the concrete conditions of their activity. This asymmetry leads to the situation where the fear of malpractice is a concern for professionals involved in health services, important being both the risk and the distraction that brings with itself (Teo et al., 2020).

The problem of professional liability is already visible in the name used by society for health workers during the pandemic: heroes. Heroism occurs against the background of a self-unity quite close to imprudence, it involves both taking risks against oneself and non-compliance with prudential procedures. In this context, there's the question of who protects the heroes from what could be consequences of their heroism. Some authors have indicated other problems generated by the use of the name 'hero', respectively the attempt of society to burden them with an unusual high responsibility in terms of possibilities, responsibilities and level of protection (Robert et al., 2020).

The rules specific to the liability of healthcare professionals have a great variability, being intensely dependent on the legal systems specific to each state. Basically, a correct understanding of the situation requires a comparative analysis of the legal rules specific to the responsibility of health professionals in different states. However, there are some variables that could change some of the professional responsibility dimensions, in the sense of increasing their uniformity. The strongest push in the direction of increasing similarities is given by the characteristics of the COVID-19

pandemic and the reactions to it. Overall, we believe that a common solution is needed for all states, adapted to the legal system of each one of them, to protect health professionals, it should guarantee a good balance between patients' rights and employees justified protection (Tozzo et al., 2020).

Types of social change brought by COVID-19 pandemic adaptation could become much more common. In this article we also try to think from the perspective of creating rapid mechanisms for adapting to such changes. The lessons learned now can be applied in the future to other similar cases, they becoming rules of disaster medicine (Fisher et al., 2020).

2. Professional immunity

The debates on professional immunity are based on the possibility of an asymmetry between the assumed risks by health professionals in the professional activity during the COVID-19 pandemic and the level of protection they benefit. With regard to professional liability, the following ones are, for example, sources of risk for COVID-19 patients: (a) lack of informed consent, which is amplified by the large number of intubated patients, poor connections with family members who should decide instead and radical interventions such as the refusal or withdrawal of life support, determined by specific procedures or the "first come, first served" rule; (b) deviations from standard treatments and medical practice protocols rigors; (c) the absence of evidence-based therapies for a very large number of patients, which amplifies the uncertainty. The risks are not limited to COVID-19 patients, the specific procedures for these patients having effects on non-COVID-19 patients, which can be questioned from the perspective of injury, respectively of liability. The need for interventions, in the sense of immunity introduction, is supported both by the estimate that at the end of the pandemic the pain of losing loved ones throughout this period and greed sometimes, will lead to a large number of lawsuits against health professionals (Oliva et al., 2020), as the fact that professional immunity (civil and criminal) has been introduced in many US states (Klitzman, 2020).

2.1 What we mean by professional immunity

In the meaning that we propose, professional immunity means limiting professional liability to the conditions created by the "new normal". In other words, by professional immunity against malpractice allegations we mean the adequacy of the professional responsibility of health professionals to the reality of combating this pandemic. Immunity doesn't mean the

absence of any liability, but the limitation of professional liability to the concrete possibilities of diagnosis, treatment, care and to the few degrees of professional freedom still in force. Understood within these limits, professional immunity is a form of protection against civil litigation and criminal charges intended for the conditions of normal social existence, but which do not correspond to the context created by the COVID-19 pandemic.

Professional immunity risks to be interpreted as a permission for negligence, both by the public and professionals. The problem lies in the meaning given to this term. Clearly, can't be brought up a negligence immunity, which has led to avoidable harm, identified on the basis of the common standards applicable during the pandemic. One might ask what the difference is then from the current situation? The answer is provided both by the difficulty of identifying common standards and by the special meaning given to them during the pandemic. We specify that the purpose of such an approach cannot be an increase of tolerance to negligence, but the adaptation to the specific context of the pandemic.

Actions for the establishment of professional immunity have two meanings: the *active meaning*, as a form of protection created through normative acts and the *passive meaning*, as protection generated on the interpretation's basis. The protection mechanisms based on the extension of the insurance coverage, respectively the compensation of the patients is part of the active sense of immunity.

In a first attempt to clarify the situation, compared to the two types of approaches, we can consider that the following intervention mechanisms are possible:

a) Introduction of normative acts or existing one's modification:

- Professional immunity compared to the previous regulatory framework, by introducing some ***legal provisions for protection against the application of liability standards governing the normal conditions for carrying out the activity***. It involves stipulating exceptions to the standards of responsibility specific to normality. It's the way we consider the most appropriate, respecting the condition of the least legal intervention, meant to reduce the disturbances of the normative framework applicable to the civil society. However, it raises a problem that needs to be solved: the preservation of evidence on the factual situation of each healthcare unit is problematic, the crisis situations implying a reduction of standard documents.
- Adapting the regulatory framework to the current context: adapting legal responsibility to this pandemic conditions. It's based on the

development of specific treatment standards and legal provisions on liability appropriate to the new standards. However, because the standards of care have as reference point the level of scientific knowledge and it's evolving very rapidly, we can see the impossibility of establishing adequate standards, in the strong legal sense of the term. Given that the reduction of liability must be proportionate to the intervention of the situations that call it into question, this solution lacks the necessary dynamics to adapt to the conditions applicable to every moment.

b) Modification of the applicable legal situation:

- ***Battlefield medicine.*** Such rules are very difficult to apply in civil society because the transposition of military regulations into everyday life on the scale of entire societies would generate a complex of chain interventions that would seriously disrupt their functioning.
- ***Major force.*** The duration and dynamics specific to the pandemic suggest that many of the situations fall outside the definition of major force. The adaptation of intervention measures to the evolution of scientific knowledge generates graduality that makes it difficult to use this legal institution.

The relevance of one or other of the action directions may depend on the specific legal context of each community. Our thesis is that, regardless of the form of transposition into practice, a form of protection of health professionals, such as professional immunity is necessary. An account of the main issues justifying the discussion on professional immunity can support the identification of appropriate solutions.

The COVID-19 pandemic brought with it a series of new challenges for health professionals, the new conditions for carrying out the activity having associated a series of unique problems regarding professional responsibility.

3. Case study: the situation from Romania

In order to analyze the relevance of discussions on professional immunity, the example of a state that hasn't introduced any measures to protect health professionals, from the category of those considered in discussions on professional immunity is relevant. This case study is based on the situation of professionals from Romania. We mention that, as same as the case of all European Union Member States, an additional specific note is

provided for the coexistence of the two legal spaces, national and EU, which also generates a level of overlap of two different legal systems.

From the national specific category, with impact on analyzed problems from this article, are also the axiological indecisions caused by the interferences of traditional religious values with the axiological framework generated by forced modernization (sometimes only partial). The neo-feudalism of the health system is a revealer of the reduced permeability to the axiological structure, it also contributing to some limitations of the impact of evidence-based medicine. The lack of ethicists in hospitals could be an indication of the weak influence of ethical values on the medical decision, the priests in hospitals not being able to generate the necessary ethical impulse: most belong to the Orthodox Christian cult, its bioethical concerns rather being related on appearance. The refusal of the dialogue about professional immunity and, especially, on the need for ethical criteria for selecting patients in conditions of insufficient resources, generates an additional degree of complexity. The COVID-19 pandemic brought a series of new challenges for health professionals, the new conditions for carrying out the activity having associated a series of unique problems regarding professional responsibility.

In its current form, malpractice insurance doesn't cover the gestures of health professionals in an increasing number of situations. Practicing medicine in a specialty other than the one held, limiting the access of other categories of patients than COVID-19 to medical services, decisions on the priority allocation of life support, consideration of SARS-CoV-2 as a nosocomial infection, diagnostic errors regarding identification of SARS-CoV-2 infected patients are just a few examples of this type.

3.1. Exceeding the limits of competence

One of the solutions used by the Romanian Government to solve the problems generated by the pandemic, is a measure that has significant consequences on both the quality of medical services and professional life of health professionals: the transformation of entire departments or hospitals into COVID-19 (which treats patients COVID-19). As we will see, the negative impact of these measures occurs at least in terms of risks related to the exercise of the profession (malpractice), occupational risks (related to working conditions), professional stress (determined by the need to carry out professional activity in a specialty other than the one held), professional success satisfaction. These hospitals have been transformed into infectious disease hospitals, all staff, regardless of the specialization of each of the workers, being forced to deal with the treatment of patients who have

COVID-19 as main condition. In other words, doctors in these hospitals are forced to treat patients who don't belong to their specialization, to establish diagnoses, medications and therapeutic procedures for which they don't have specialized training. Basically, we can consider that they are among those many professionals working outside their specialization and professional experience (Tomkins et al., 2020) existing at this moment in many states. These doctors, together with the rest of the specialists, end up being responsible for the consequences of professional actions /inactions without being covered by malpractice insurance or legal provisions. Professional immunity aims the introducing of legal provisions for their protection or, as a specific option, the partial suspension of legal provisions specific to medical malpractice.

The existence of volunteers among them can be considered as a proof that these workers carry out such activities from their sense of duty. However, in the vast majority of cases, it's legally relevant that healthcare professionals are prohibited from resigning. The prohibition of resignation (introduced by prohibiting the obligatory gesture prior to resignation: the notice) is the *de facto* introduction of forced labor. As a result, in Romania health professionals are, during the establishment of the state of emergency/alert in response to the pandemic, in the situation of forced labor, executing in many cases provisions they can't oppose the right to profession free exercise. The lack of this professional freedom essential component should be accompanied by an appropriate limitation of responsibilities, which is part of the content of professional immunity.

In the case of forcing doctors from other specialties to treat COVID-19 patients, the problem is amplified by the fact that most patients have comorbidities, those also ending up being treated by doctors who aren't specialized in that area. The change of the clinical picture from one moment to another generates the impossibility of performing clinical examinations in many cases, the decision reaching entirely the task of the attending physician (of another specialty). In addition, the professional activity of a doctor who treats patients in another medical specialty isn't covered by malpractice insurance. Although these doctors perform an extremely important public service in the context of the COVID-19 pandemic, they illogically end up bearing the risks of professional gestures that they didn't choose to make. In order to be able to use this solution, we need doctors who are obliged to practice medicine in another specialty they hold, not to be held responsible for the effects of this situation: practicing medicine in another specialty and its legal effects. In other words, doctors obliged (or forced by the situation) to practice the profession in a specialty

other than the one they hold, have the right to professional immunity in this situation. Professional immunity refers to liability for excess of competence and insufficient medical knowledge (reported to the specialty they were forced to work), not to civil or criminal liability arising from negligence or malicious intent. This dimension of professional immunity should be part of an international standard of professional liability limitation in the COVID-19 pandemic.

3.2. Professional immunity/limitation of professional liability regarding therapeutic protocols use

Doctors obliged to practice the profession in a specialty other than the one they have in the treatment of COVID-19 patients, shall be reported to the therapeutic protocols recommended by the Ministry of Health specialized commission. There are situations where the protocols contain questionable therapeutic recommendations from the perspective of international practice (the most obvious being the use of hydroxychloroquine in the treatment of COVID-19 patients), specialists having at hand the principles of free exercise in deciding treatment.

Because the forced doctors to practice the profession in a specialty other than their own, aren't accessible the principle of profession free exercise (they can't invoke the freedom of professional conscience in a field in which they don't specialize) in the treatment of COVID-19 patients, having to refer strictly to therapeutic protocols, they must be protected by some form of professional liability limitation from the professional immunity.

The COVID-19 pandemic brought with it a series of new challenges for health professionals, the new conditions for carrying out the activity having associated a series of unique problems regarding professional responsibility.

3.3. The possibility of exceeding the competence is an insufficient solution

The maximum level of "debate" about the problem of professional immunity reached in the case of Romania, is the proposal of the doctors' professional body (Romanian College of Physicians [CMR]) to introduce the possibility of exceeding competencies/"extending competencies" of doctors during the COVID-19 pandemic (Romanian College of Physicians, 2020). Beyond the fact that the proposal hasn't (yet) been put into practice, it's far from being enough, compared to the doctor's protection required to practice their profession in another specialty, its initiators missing both the set of

provisions applicable in the new context and the framework as a whole, as well as the concrete legal situation of these doctors. Interpreted correctly, the CMR proposal aims to suspend the obligation to exercise the profession only within the limits of the competence, respectively it intends to create the professional (partial) immunity related to the provisions of art. 653 par. 4 of the Law no.95/2006 (Parliament of Romania, 2006). CMR's desire to avoid the term 'professional immunity' doesn't change the legal classification of the approach: since competences don't actually exist, the intention to revoke professional liability in the case of exceeding the competence is an intention to create professional immunity to before the competences exceed. In principle, this proposal is correct, but far from providing sufficient protection. This approach doesn't provide sufficient protection because not only the 'limit of competence' is the problem, but also the responsibility for the effects of practicing medicine in the absence of the necessary competencies. Professional competence can't be extended by decree, because we can't change a state of affairs by law (except in situations where we try to force a 'status quo' change in accordance with the intentions of the law; which isn't the case for this proposal). Professional competence can only be extended through specialized training (a short training cycle, adapted to the characteristics of the situation, could be an acceptable breakdown solution).

In its approach, CMR misses the fact that in the case of doctors obliged to practice their profession in a specialty other than their have, there are two aspects that aggravate their situation: (a) liability is accentuated by the actual lack of skills (indicated by the formula „insufficient medical knowledge”) and (b) the malpractice insurance doesn't cover their professional gestures performed in a specialty other than the one held.

As we indicated before, the factual situation is as follows: in the Romanian health system, in a large part of COVID-19 hospitals, currently there are whole categories of doctors (surgeons, orthopedists, ophthalmologists, gynecologists, etc.) who are required to practice medicine in another specialty (most often Infectious Diseases) than the one they have. Their responsibility is derived from the effects that diagnosis and treatment have on patients, effects that are closely related to the real skills of the doctor. An argument in this sense is provided by art. 653 par. 2 of the Law no. 95/2006, which indicates that the medical staff is civilly liable for 'insufficient medical knowledge in the exercise of the profession', a situation fully applicable in case of being obliged to exercise the profession in another specialty than the one held. The legislator intentionally differentiated the liability regarding the exceeding of the competence limit (art. 653 par. 2)

from the liability for insufficient medical knowledge, in the latter case the professional immunity against the exceeding of competences being insufficient. In addition, it's easy to understand that we can't legally transform insufficient medical knowledge into sufficient medical knowledge, the only solution remaining professional immunity. An additional argument is provided by art. 30 par. 1 of the Law no. 46/2003 (Parliament of Romania, 2003), which indicates the patient's right to benefit of medical interventions performed by accredited staff. One of the forms of accreditation is the certificate of free practice. Exceeding the competencies doesn't say anything about the extension of the certificate of free practice in the field of new competences (the suspension of the rules on the certificate of free practice in such cases is one of the options that should be considered in such cases), its correlative obligations remain in effect.

There is one aspect that could actually worsen the doctor's situation: the intervention aimed only on rules cancelation about exceeding the competence can also be interpreted as a legal extension of the competence. In such a situation, the doctor's responsibility remains, being even amplified: by "extending the skills" the doctor who's forced to work in a specialty other than the one held will be judged as a specialist in the new field.

3.4. Absence of patient selection criteria

In Romania, the criteria for vital support allocating resources in crisis conditions aren't officially implemented, in a public way, the only point of reference for professionals being *The criteria for hospitalization/admission and triage of patients in intensive care* (ICU) (Ministry of Health, 2009, Annex no. 2). Beyond the fact that the 4 priority criteria in this document don't offer solutions for a good part of the current situations, because they are too general, they don't explicitly include the option of interrupting vital life support. In the absence of ethical criteria for detailed prioritization, if the existing criteria don't allow a practical decision, the most common practice is to apply the "first come, first served" rule on the allocation of vital support resources. It is known in practice as "There are no more places at ICU!". The "first come, first served" rule is accompanied by the increased risk of mortality for patients following alternative routes (transfer, waiting, admission to a less specialized unit), respectively for those which admission to therapy is delayed due to lack of resources (Robert et al., 2020). This approach is morally problematic and, consequently, from the point of view of professional responsibility. One form of illustration the problems generated by such decisions, is the ***tram dilemma***, unlike the rule "*No more free beds at ICU!*", which is treated as an abstention from the decision,

generating the feeling of lack of responsibility, the existence of priority criteria implies the action of disconnecting a patient from life support and allocating these resources to another patient with a higher chance of survival.

As an explanatory hypothesis: the paternalistic model of society organizing could be an impediment to the implementation of life cycle theory. This form of patients age selection tends to be accepted in societies where there are both significant differences in wealth and private health systems that can offer privileges for a fee, thus bypassing this type of selection. Given that rescue opportunities are dependent on the resources of the public health system and informal mechanisms for accessing health services don't provide sufficient guarantees of privileged access, significant resistance to such criteria development for selecting patients in crisis can be estimated. Regardless of the correctness of the hypothesis, it's certain that the absence of clear rules increases the burden of professionals' decision and, with it, professional responsibility.

4. The general problems created by the COVID-19 pandemic with an impact on professional responsibility

4.1. Insufficient resources

The shortage of medical resources in the COVID-19 pandemic is notorious, as it's global. The main cause is the unpredictable dose that this pandemic has brought in the area of type and, especially, the number of sanitary materials and equipment needed. The effects of globalization on local production capacity have amplified the problem. One of the causes for the hospitals lack of preparation in the face of this pandemic seems to be their organization on *just-in-time* model (Solomon et al., 2020). Organizing *on demand* - supplying as needed, without building up reserves - is a robust model for pandemic events. The objectively limited effectiveness of treatments amplifies the problem. Because there's no specific treatment against COVID-19, with proven efficacy, therapeutic interventions have on their own an extremely low effectiveness, while generating very long periods of occupancy of hospital beds. Severe cases have a very high mortality rate. Given the long duration of these patient's hospitalization, the speed of available resources immobilization is also very high.

The differences between normal and crisis situations, in resources allocation are known, being already known that in crisis some patients will receive treatment and others won't, going to situations where for some patient's vital life support ends up being withdrawn (Kirkpatrick et al., 2020).

In the case of the activity carried out during the COVID-19 pandemic, the deficits amplify the stress of the professionals: the medical errors can be determined by the stressful work environment and by existing deficits (Teo et al., 2020). Stress is also amplified by public misunderstanding of limitations and ethical issues raised by lack of resources (Martin-Fumadó et al., 2020).

4.2. Insufficient material resources

4.1.1. Resources for treating COVID-19 patients

Insufficient resources are an additional complication in the exercise of the medical professions during the pandemic, as it has an increased visibility in the area of life support resources. The lack of resources determines the need for a decision on their allocation. The most important and most difficult decision is the selection of patients who can benefit of life support, respectively those who don't benefit /no longer benefit.

In order to provide healthcare to an increasing number of COVID-19 patients, in conditions of limited resources, health workers, acting in good faith, are required to use alternative solutions, such as treatment in other areas than those specifically designed for them (the latter being occupied), the use of other therapeutic ways than the standard ones (the latter being unavailable) etc. For all such situations, the discussion on limiting professional liability of health workers is relevant.

4.1.1.1. Resources for treating other categories of patients

Specific measures to combat the pandemic also include implicit or explicit forms of limiting access to medical services, accentuating the general level of morbidity. The healthcare systems are in the situation of limiting the access to medical services of other patient's categories than SARS-CoV-2 ones, delaying their healing. In addition, if they become infected with SARS-CoV-2, these patients are much more likely to develop severe and very severe forms of COVID-19 disease.

The possibilities for diagnosis, treatment and care for pathologies other than COVID-19 have been significantly reduced as a result of public policies implemented as a measure to combat the pandemic. However, the moral duty for patients who don't have COVID-19 still exists (Kirkpatrick et al., 2020). We may wonder whether the measures taken in the context of the COVID-19 pandemic, regarding access to medical services, are timely in relation with the principle of redistributive justice (Fisher et al., 2020). Given that the mortality of COVID-19 patients in the ICU is between 70% and 90%, reserving resources for them and depriving these resources of patients

who'd have better chances, raises a real problem compared to the principle of distributivity (Fisher et al., 2020). In this context, healthcare professionals can't be considered responsible for the consequences of decisions that don't belong to them. Those who decide on public health policies during this period must take full responsibility for the consequences of these decisions or distribute the burden of responsibility appropriately on the shoulders of society. It isn't useful for society to pretend that health professionals work in normal conditions, that the reality is different from how they and patients feel. Discourses that use patients' rights as an argument against limiting the liability of healthcare professionals actually end up making these rights inapplicable because they fail to indicate the real culprits. To a considerable extent, patients' right for free access to medical services has already been suspended, against the will of doctors. As we will see below, the use of ethical criteria for the allocation of resources together with the adequacy of professional responsibility could somehow help to clarify the situation, as they are favorable to patients.

4.1.2. *Insufficient human resources*

The influx of COVID-19 patients, the characteristics of their care and the impact of PPE use on the duration of medical procedures determine, as expected, a considerable shortage of human resources. Because the shortage of human resources arises especially in the area of specialties that directly interfere in the treatment of this patient's category (infectious diseases and ICU), in practice there are often situations where doctors in other specialties end up treating COVID-19 patients, even those who need ICU-type care. This is an inevitable consequence of the equation between limited resources + large number of patients, regardless of whether the *ethical selection criteria* or the "first come, first served" rule apply. Along with the professional responsibilities regarding the patient's selection and the exercise of the profession in the conditions of a deficit of skills and experience, other disturbing elements interfere, such as the reduction of time for each patient, the deficient relations with the relatives (Robert et al., 2020).

4.2. *Pandemic-specific situations*

Professional precautions generated by the lack of PPE should also be taken into consideration, along with the contribution of increasing the risk of patient's infection. Also, the use of specific SARS-CoV-2 PPE makes it difficult to interfere in the patient's diagnosis, treatment and care, in every case where their wearing becomes mandatory.

Relevant is also the situation where professionals who are working and, in the same time, have the patient's status. Such situations have already been encountered in some hospitals, the current evolution of the pandemic significantly increasing the probability of increasing cases of this type.

4.3. De facto change of specialization

The problem of staff having to work without the necessary skills, in specializations other than those for which they were hired (Tozzo et al., 2020) has a significant impact on professional responsibility. In many states, physicians have to work during the crisis beyond the traditional boundaries of discipline and specialization (Tingle, 2020). In a schematic approach, we can consider these cases to be in three types of legal situations: (a) volunteering, (b) the common decision of the unit and professional and (c) the impossibility of professional's decision. In the problem of professional responsibility, there are differences for each type of situation.

4.4. Scientific knowledge is limited

Knowledge about the spread and effects of SARS-CoV-2 is limited, the situation being identical for COVID-19 disease. This knowledge is constantly changing in the light of new evidence, in some cases undergoing radical changes (a good example is the situation of wearing masks, which goes from contraindication to obligation within just a few months). At the same time, however, patients must be treated. The possibilities to treat COVID-19 patients are limited. In terms of evidence-based medicine we can say that (so far) there are no treatments with proven effectiveness. One of the consequences is the compassionate use of insufficiently tested therapies - compassionate treatment - during this period (Sandu, 2020); we think hydroxychloroquine could be a good example. This can lead to an additional set of professional responsibility sources.

To some extent, health professionals bear the society inadequate expectations, which go beyond the possibility's limits prescribed by scientific knowledge. The mechanism is characterized by a transfer of the ignorance costs on science, respectively on health professionals, in reconfigured guilt formation. The liability of staff must be limited to the real possibilities at each stage of this development, respectively to the official recommendations, valid at the time of treatment.

4.5. Patient triage

The large influx of COVID-19 patients in conditions of limited resources, inevitably leads to situations of unequal access to

resources/medical treatment. Insufficient resources call into question how to allocate them. In a simplified form through resources, we have to understand, depending on the situation, hospital beds (in a generic sense), specialized hospital beds (infectious diseases) and life support beds (ICU). In the conditions of limited resources, the best solution is the implementation of some form of their rationalization, transposing itself in the need of clear criteria for selecting patients. Limited resources put healthcare professionals in a position to decide whom to allocate life support systems.

Patient triage involves ethical issues, not just medical ones (Joebges & Biller-Andorno, 2020). Emergencies lead to derogations from some bioethical principles (Sandu, 2020). The utilitarian approach states that resources must be allocated to those who have the best chance of survival (Fisher et al., 2020). Distributive justice refers to the proper distribution of benefits, risks and costs in a society. It determines the fair access of patients to finite resources, being one of the four bioethical principles, along with the principle of beneficence, non-malignancy and autonomy (Fisher et al., 2020).

4.6. The effects of ethical criteria absence for resource allocation

In the absence of publicly assumed selection criteria and normative acts established, the “first come, first served” rule applies: the first patients occupy the available treatment and care resources, thus blocking the access of the next patients to these resources. This isn't an ethical selection/priority criterion, as it's determined by the fact that criminal sanctions generally sanction the action, not the refusal to act (Cohen et al., 2020). Equally unethical is the absence of clear priority criteria for access to medical resources, publicly assumed by society, this situation throwing doctors in the area of making decisions for which they have no legal coverage. The problem is that the evolution of reality doesn't take into consideration the existence or absence of appropriate legal framework, doctors being forced to make decisions. If the society doesn't officially assume public priority criteria (as it should), then physicians must enjoy the immunity in such situations (and a set of ethical priority criteria developed by agreement of the professional community/professional body). The reason is simple: under the conditions of „battlefield medicine” (an alternative, appropriate definition of this situation) any decision on access/refusal of access to treatment and care resources has serious consequences. It's relevant that in corruption-permeable systems the lack of criteria can lead to a greater intervention of corruption. The risk of Broken Window theory must also be taken into consideration: forcing professionals to make decisions in unregulated areas can increase the distance from the rules. In the absence of selection criteria,

we have to realize that state institutions prefer not to see/recognize this problem. In such situations, health specialists are deprived of the necessary legal protection, being necessary to limit the professional liability of medical staff, this actually being in a fact impossibility (lack of resources) and legal (lack of legal criteria for patient selection).

The absence of ethical selection criteria further raises the issue of resuscitation for cases that have no chance of survival, respectively of providing vital support for patients in clinical death, especially given that these maneuvers bring along a risk for health professionals. (Klitzman, 2020). The staff situation is complicated by the difficulty of obtaining informed consent, arising in particular from the problem of poor contact with patients' family members. Ethical decision criteria can reduce the negative impact of such situations.

The lack of priority criteria for access to health services violates a fundamental right of patients and harms the work of health professionals, being part of healthcare systems lack of preparation for new ethical challenges (Martin-Fumadó et al., 2020). We show respect for patients by introducing procedures (Joebges & Biller-Andorno, 2020). The lack of priority criteria means a lack of system rationality and a lack of transparency. None of the existing protocols in such situations argues in favor of a “first come, first served” lottery (Joebges & Biller-Andorno, 2020). In many cases we're already in the situation of battlefield medicine, the construction of the appropriate legal framework for this context for health professional's activity being in the interest of both them and the citizens. So, we can note the need for documents/guides based on medical criteria and ethical values, meant to support the critical clinical decisions of health workers (Martin-Fumadó et al., 2020).

4.7. Professional issues raised by ethical selection criteria

The existence of transparent patient selection procedures is part of the measures to protect hospitals (Tozzo et al., 2020) and health workers. Guides reduce the burden on professionals, who have to make life and death decisions anyway (Joebges & Biller-Andorno, 2020). Describing the context of the new ethical dilemmas, Robert points to four measures that have been taken in France: prioritizing therapy beds for patients with the best prognosis, increasing the number of therapy beds, organizing distance transport of therapy patients and accelerating the withdrawal of life support (Robert et al., 2020). These measures indicate that in such situations utilitarian ethics prevails over individualistic ethics (Robert, 2020). We have to find that the decision to institute, continue, suspend or interrupt life

support is different during pandemic emergencies than normal (Valiani et al., 2020).

The existence of ethical criteria doesn't eliminate all issues of professional responsibility. For example, the interruption of mechanical ventilation raises the issue of killing. There is also a risk of prophetic mistakes in selecting patients (they end up with a lower chance of survival because they are given a lower chance) based on protocols (Robert et al., 2020). Despite these limitations, the balance between the risks associated with selection protocols and those determined by the absence of such protocols is favorable for the existence of criteria.

One solution to increase the level of patient's protection and professionals in the presence of selection criteria is to separate the therapeutic decision from that of triage (Robert et al., 2020). The solution can be implemented through ethical decision-making committees, taking the decision burden from clinicians and ensuring fair decision-making (Truog et al., 2020). This solution transposes a relevant principle: the responsibility doesn't have to belong to the attending physician, being necessary a decision responsible or a team (White & Lo, 2020). Selection protocols must be transparent and evidence-based (Joebges & Biller-Andorno, 2020). Transparency is part of the need to educate the public about the conditions of triage during the pandemic (Kirkpatrick et al., 2020). The professional immunity offered by some U.S. states and ensuring that insurance professionals are covered for all professional gestures, practiced in the UK, are benchmarks (Kelly, 2020) to complement the protection of professionals against these abnormal decisions.

4.8. Transparency

The problems we face must be approached with honesty and transparency, both health workers and citizens having the right to know the reality. A clear indication of the problem (the risk of not being able to provide effective health care to all patients) and its magnitude (the risk is proportional to the speed of the infection) could be an effective solution to make citizens aware of the need to use selection criteria, respectively the usefulness and necessity of measures to limit the spread of the virus.

4.9. Judgment criteria

One of the problems faced by professional responsibility analysis is the criteria according to the situations encountered are judged. Because investigations take place after the events, the beliefs of investigators and experts are strongly influenced by subsequent knowledge. In other words,

the standards of care at which the surveys shall be related will be built on the level of knowledge specific to a later period. Judges should consider “changing the standards of assessment/analysis for this period and the existence of a change in standards of patient care” (Tozzo et al., 2020). The context is particularly relevant in the liability analysis.

Another level of variability is induced by the differences generated by two globally existing legal systems, being relevant whether the rules are imposed from the *bottom up* or from the *top down*. U.S. states are in an even more delicate situation, most having an overlap of the two systems.

4.9.1. The importance of context

Poole considers that the analysis of the situation of each case must be made according to the context, which is very important in the legal situation classification. The accusations of malpractice will have to face the context created by the pandemic, of notoriety (Poole, 2020). The basis of the argument is the context wise analysis, very possible in legal systems based on common law. Systems based on the existence of express legal provisions could be more effective in adapting to the context. Another appropriate contextual reporting solution is the use of experts to indicate to courts which guidelines were applicable in each of the crisis moments (Oliva et al., 2020).

The analysis of the context should also highlight the limits of the medical knowledge specific to each stage, taking into consideration the need for decisions taken in conditions of limited resources and incomplete provisions (Kelly, 2020). We are obliged to anticipate, that in the end, the world will fall prey to retrospective distortion: it will forget what happened along this route, respectively what were the interval evolutions, with their level of knowledge, with diagnostic and therapeutic possibilities specific to each period, tending to judge the health professionals' actions by referring to either the maximum possible level in each period or the maximum possible level at the end of the pandemic.

4.9.2. Competent practice reference

Relating to what the community of professionals considers *competent practice*, at a given moment, implies, in the conditions of accelerating change, the construction of a conservation form of the rules applicable to each moment. It also brings with it the specific difficulties of setting a benchmark in such a short time.

In the context of professional information increasing flow on therapies against COVID-19, accelerated by the general interest in them, the

expectations of the population tend to be different from the level where acceptable standards of professional activity are set. While professional communities are organized at the state level, the references that are essential clues to the expectations of the population are located globally. Court actions are determined more by *the therapeutic expectations of the population* (what citizens believe) than by what professionals in a particular community know and can. Citizens' therapeutic expectations, especially as states have introduced universal access to COVID-19 treatments, may be at significantly higher levels than the therapeutic possibilities specific to the communities whom they belong.

4.9.3. Pandemic care standards

We may wonder whether care standards are automatically redefined in the current context. At first glance, if we take into consideration force majeure, we could consider that yes. A closer look shows that the applicability of force majeure-specific rules in the context of the pandemic raises a number of issues.

The evaluation of the competent practice is made on the competence standards basis, the results of the competence exercise being visible in care standards. Competency standards refer to the requirements of the position held by professionals (Tingle, 2020).

Addressing the issue of volunteer's immunity during emergencies, Rothstein refers to care altered standards during a state of emergency (Rothstein, 2010). Tingle argues that the definition of care standards is flexible enough that isn't necessary to introduce the altered variant; care standards themselves imply the need for context adaptations (Tingle, 2020). Current practice encourages medical behaviors that are reasonably justified or excusable, guiding court decisions in setting health service standards for each individual case (Teo et al., 2020). Showing the fact in Australia negligence is defined as failure to exercise reasonable care and skills, Kelly indicates that it involves reporting on what the professional community considers a competent practice at a given time (Kelly, 2020).

Agreeing with the authors who show that the care standards are obviously violated during the pandemic (Tozzo et al., 2020), opting for the creation of new care standards, respectively for defining the minimum level of care (Parisi et al., 2020), we consider that a definition so lax of care standards cancel their quality of standards. We believe that the solution of altering/recalibrating the care standards during the pandemic is an option that offers more proper means of setting the activity and analyzing the responsibilities. From the fact that care standards are an imperfect

compromise (Tingle, 2020) we can't deduce the possibility of expanding them in order they can be used invariably for each of the situations, because a different approach would place care standards rather at the level of minimum care possibilities than average.

5. „Battlefield medicine”

„Battlefield medicine” could be an appropriate conceptual framework for a proper understanding of the current situation. The "war against COVID-19 pandemic" could move from metaphor status to contextual status for appropriate constructions and legal interpretations. The society is obliged to recognize that health professionals are mobilized in the war against COVID-19 pandemic, adapting the legal provisions regarding rights and obligations to this situation.

Battlefield medicine requires an adequate legal framework for the work of health professionals. If we are in the situation of battlefield medicine then it's necessary to apply specific rules in the health professional's responsibility area. Since the state has appealed to forced labor and forced doctors (and other categories of workers) to treat patients from specializations other than the ones they have, we have left the normal framework of medical practice in each of these situations. In particular, moving to the area of infectious diseases and ICU specialties ("pre-ICU" seems to be the concept that covers this obligation), but also adds the multitude of adjacent diseases that these doctors have to treat. Professional gestures performed in such conditions must benefit from the necessary legal protection, professional immunity being the already established legal solution. For the area of civil liability there would be an alternative to professional immunity, namely the obligation of insurers and health units to take full civil liability, but this also requires a legal consecration. In the absence of interventions, we are in a situation where we want to apply the rules that can be used in peacetime also in time of war.

6. Some of the problems that professional immunity raises

In this section we try to answer, within the limits of the meaning that we give to professional immunity in this article, some of the questions raised by Duignan and Bradbury (2020) on this topic.

Should immunity be granted only for specific cases (Duignan & Bradbury, 2020)? Immunity is the establishment of a form of protection against specific risks. It shouldn't be interpreted as a general protection of professionals, regardless of the situation, but as a specific form of

protection. At the same time, however, the characteristics of these measures adopted for large groups of people, must be taken into consideration, as they are forms of approximation that always have a remnant; they are imperfect compromises.

For how long should immunity be granted (Duignan & Bradbury, 2020)? The answer is given by the indication of need to apply the graduality and proportionality principles, as they solve a good part of the problems. The specificity of protection measures determines a very high geographical and temporal variability.

What is the extent of immunity (Duignan & Bradbury, 2020)? Only extraordinary situations require extraordinary measures. Because over time certain dimensions of the extraordinary can be absorbed by the standards of normality, immunity must be thought of as a blanket placed above health professionals, its density is only a visual effect created by distance, it has many meshes that allow adjustments to the context and irregular edges, covering only what needs to be protected.

7. Patient protection

The main concern regarding the introduction of professional immunity is the risk that it will reduce the level of patient protection. Ensuring a standard level of patient protection is a legitimate goal even during the COVID-19 pandemic, which can't be affected by the introduction of professional's overprotection. The problem is the difficulty of establishing this standard level of protection during the pandemic. Attempts in this regard involve struggling to identify a level of balance between the need to protect patients, the concrete medical possibilities and the need not to blame health professionals, by setting them responsibilities above the possible level. So, there is a level of balance where we can talk about professional immunity without reducing the level of patients' rights protection, caused by excessive professional's protection. In other words, there's a reduction in patients' rights, but as a result of the changes caused by the pandemic and within the limits determined by its specific context. Moreover, this reduction of entitlements is influenced by the introduction of professional immunity in the sense of moving a part of the pandemic costs to patients, but only those costs that can't be attributed to medical staff because it doesn't fall within its possibilities to prevent or eliminate.

The situation created by COVID-19 pandemic generates multiple types of losses, in social and individual terms, the essential problem being the distribution of these costs. The main issue is to identify the social

categories that must bear the risks and costs associated with the pandemic. Given that the professional immunity of health workers is a protection against risks, consequences and costs, it's perceived as an action that affects the interests of patients. We show that, as far as are concerned risks, consequences and costs that aren't the responsibility of healthcare professionals, but of chance or social inadequacies, through professional immunity we propose a fair balance between the two categories of interests: general social and healthcare professionals. The absence of such a balance plays an inhibitory role on the willingness of health workers to take such risks. The alternative is to move these risks, consequences and costs borne by health professionals without being responsible for them in the area of general occupational risks. Being accused and convicted for something you can't avoid or for the application of fair redistribution, is an unfair approach, being unacceptable for health professionals.

The solutions to the problem of cost-sharing depends to a large extent on how it's formulated, with two possible approaches: (a) identifying those responsible for each cost category and ordering them to bear the consequences; the formula "Chinese virus" is an example for such an attempt; (b) the classification of the situation as unforeseen and the application of damage control procedures. We consider that approaches focused on damage control procedures are the most appropriate, they reduce the risk of having fall guys for a situation that isn't related to a human cause easily identifiable and isolated. For example, the collective responsibility of the whole humanity or large communities for the occurrence of the pandemic could support an approach that moves much of the costs to the area of hazard.

We consider that patients who have suffered an injury caused by negligence have the right to compensation. However, we need to establish what happens when the damage occurred in conditions similar to those of war (Tingle, 2020), respectively when negligence is causally dependent on the specific context of the pandemic. How can we increase the level of justified protection of staff without transferring costs to patients? One solution is to transfer responsibility to insurers, who'll benefit from state support. That actually means mutualisation of costs.

In principle, we agree that we can't anticipate the unintended consequences of immunity (Duignan & Bradbury, 2020). But we must also consider the unintended consequences of the immunity absence. We believe that the solution is a careful weighing of the two categories of consequences and the selection of appropriate measures for the system. The law of unintended consequences must also be considered from the perspective of

non-intervention: the absence of immunity doesn't bring more protection to patients, but less. One of the side effects of a lack of immunity is the amplification of opacity aimed at developing informal models of protection, that is an instinctive defense of the professional body. Opposition to immunity from professional bodies could be a signal.

8. Answers to some arguments against professional immunity

Professional immunity could give professionals the wrong impression of the absence of any responsibility. However, the same type of effect can have the idea of applying force majeure or unforeseeable circumstance. Considered in terms of this article, professional immunity could be a more appropriate approach. We agree that the pandemic isn't a license to act negligently (Poole, 2020), professional immunity in the form indicated by us excluding such an interpretation.

The relationship of trust between patients and doctors could be affected by the debates on professional immunity (Bilotta et al., 2020). We agree that this is a real risk, it being added to other causes that we believe could contribute to increasing distrust. However, we don't believe that it's an argument for the specific debate of this article, because the increase of trust by censoring topics of debate can lead us to unacceptable solutions, respectively to the exclusion of all delicate topics. We could come to the wrong conclusions such as: we shouldn't talk about the selection criteria or withdrawal of life support, the number of deceased patients, etc., meaning that in general we shouldn't address issues that damage the image of the system. We believe that trust must be based on transparency, with discussions on immunity being part of this area.

The idea of using the pandemic context as an opportunity to reset relationships with patients, avoiding immunity being the necessary condition (Duignan & Bradbury, 2020), *may sound convincing.* However, such hypotheses are counter-factual, they operating with ideal patient models, which appreciate the efforts of professionals and limit their actions against professionals to those based on ethics. Desires don't necessarily become certainties, one of the three reasons why patients file a complaint, indicated by the same authors, being given by the attempt to use this possibility in the absence of injury (Duignan & Bradbury, 2020). We can anticipate, at least equally, that the action in court against specialists who have done their duty honestly can have the effect of increasing the distance from patients. The variability of practices according to cultural and legal contexts must also be taken into consideration.

The difficulty to establish the medical staff that would qualify for immunity was also indicated (Duignan & Bradbury, 2020). The application of two principles could clarify the problem: **a) The principle of proportionality**: the level of protection shall be directly proportionate to the extent of the changes in normal operating conditions. It allows identification of places, staff categories and level of protection. **b) The principle of graduality** can complement the level of adequacy: immunity must be proportional to the deviation from the reference standards, with the level of novelty and unpredictability of new situations, with the "distance" between the specialty in which the professional is forced to work during the pandemic, compared to the basic specialization.

The indication of cases in which the courts have indicated the importance of the context (Poole, 2020), *giving the courts the decisive role in establishing the existence or absence of liability*, raises several issues if we look at it from the perspective of an argument against immunity: (a) the approach is possible only in *common law* systems; (b) the system is operating in normal conditions, creating the right by judges decision, having the time as fundamental condition; (c) the model brings with it a high degree of unpredictability, with professionals having to guess how the courts will interpret situations in the future, given that they have to make decisions now, every day. Trying to model the efficiency of this approach by using experts to judge (in court) each situation (Poole, 2020) is the introduction of additional difficulties. Beyond the fact that it's applicable only to states that have this practice, there's the issue of establishing experts in a situation intensely dominated by the unknown. The intervention of retrospective confirmation bias could give the experts the impression that a therapeutic solution discovered at the end of the pandemic, from several attempts, was the correct solution, known, since the beginning of the tests.

Duignan correctly states that *malpractice continues to exist during the pandemic* (Duignan & Bradbury, 2020). We agree that malpractice continues to exist during the pandemic period, and responsibility must be a correlative one. The problem is the risk of introducing in the malpractice area damages that are either not caused by professionals, or are caused by them, but in the conditions in which they acted in good faith. Malpractice continues to exist; however, the conditions for identifying malpractice cases need to be changed. If we consider guilty an employee who understands to work continuously 24 hours or more, for example, because he has no one to perform those services he provides, given that the risks of error are known to be directly proportional to the condition of fatigue, then either we block the hospitals and professionals' efforts to provide the most appropriate

response to the pandemic, helping as many patients as possible, or move the costs of a social benefit on the shoulders of these professionals. We must keep in mind that discussions on this topic are usually carried out after the professionals have chosen the collective good and the efforts adjacent to it, the risks of individual injuries being already at stake. Only the good settlement of the problem reveals its true dimension.

Some authors believe that occupational immunity would cancel patients' ability to seek further compensation (Duignan & Bradbury, 2020). There are two answers to this statement: 1. The version of professional immunity based on employee's civil protection by extending financial coverage covers the problem. 2. The professionals immunity considers only their protection against civil and criminal liability, not the annulment of patients' right to compensation. Within the distance between the responsibility of the staff and the one of the unit/societies remains an accessible space for compensation. In addition, the protection of patients in this direction can be increased by taking responsibility by the state/mutualisation of compensation costs. The purpose of professional immunity is to protect professionals from unfairly shifting costs to them, not to invalidate patients' right to compensation.

Occupational immunity would send patients the inappropriate message of a decline in healthcare quality, suggesting that patients are no longer entitled to adequate health care (Tomkins et al., 2020). Given that, as we present in this article, the possibilities for the provision of medical services are subject to a whole series of limitations, this is actually an argument for the lack of transparency and it wants to support the need to maintain an illusion. In the case of this argument, the opposition to immunity seems to be motivated by ideological reasons, based on promoting a lack of transparency. In the case of this argument, the immunity opposition seems to be motivated by ideological reasons, based on lack of transparency. In a reformulation of this argument that could facilitate understanding: *if we introduce professional immunity, then we publicly send the signal that, at the present time, the medical system can't provide medical services in the proper quantity and quality, as population expects; since only a small part of the population will realize that this is the reality, it's preferable to maintain an illusion of safety, based on much greater curative possibilities than they actually exist.* We can easily see that this approach can contribute to non-compliance with public safety rules by the population, in fact amplifying the problem. The transparency and the cold shower provided by the grip to reality can increase the level of population caution. Which brings into question the obligation to inform the population correctly and completely.

It's relevant to consider that in the current context professionals couldn't be accused if they act in good faith, are not negligent and don't intentionally harm patients (Klitzman, 2020). However, these conditions aren't enough, the need for the standards of care existence in crisis conditions (Crisis Standards of Care - SOC), as detailed as possible, being an additional condition (Klitzman, 2020).

Professional immunity is superfluous because the standards by which doctors are judged are those of a reasonable doctor action, forcing them to adapt to the context (Tomkins et al., 2020). This argument raises three key issues: a) Adapting standards and judgment criteria to the context is part of the sense of professional immunity, in the manner described by us in this article. From this perspective, it's an argument in favor of immunity, not against it. b) The operation of this argument is based on establishing an average level of medical practice in relation to other colleagues in the same specialization, using the reference of a reasonable doctor. Or, as we have shown, the COVID-19 pandemic puts a whole series of doctors in the situation of working outside the specific framework of their own specialization and professional experience. The benchmark called 'the reasonable doctor' proves to be dysfunctional in such situations, and it must be replaced by other benchmarks that haven't passed the test of time though. For example, the 'reasonable doctor in the specialty of infectious diseases' must be doubled by the 'reasonable surgeon who works in infectious diseases specialty' and so on for all specializations. c) It is based on an assertion such as "it matters the role, not the person" (Poole, 2020), which is valid in significant predictable contexts. This assertion becomes problematic in extraordinary contexts, such as COVID-19 pandemic, which increase the person's share. The unpredictability of disease evolution, doubled by the fact that the environment, brings into question both new elements and much longer oscillation intervals for traditional variables.

Tingle uses the example of never event as an argument for the persistence of negligence during the epidemic, as justifying the existence of liability (Tingle, 2020). We agree that the risk of "never event" increases in the pandemic context, it being determined by the specifics of this context. The shortening of time for each intervention, the increasing difficulty of performing professional gestures caused by protective equipment, staff fatigue, lack of materials, lack of professional experience of new employees are just a few examples of variables that reduce the possibility of control. The risk of "never event" is highly related to the way the units are organized, including specific prevention procedures. However, one of the pandemic effects is the rapid restructuring of most health units, with a consequence that the prevention

capacity of unforeseen events is reduced. In this context, the relevance of the debate on changing responsibilities becomes visible. From another perspective, pandemic-specific interventions can bring with them their own types of "never event". The problem with these events is that they are discovered later, taking into consideration the incidence of various errors.

Immunity risks diluting candor obligations (Duignan & Bradbury, 2020). The specific context of the pandemic significantly diminished the possibility of honoring the candor obligation, severe patient's condition, the difficulty of relations with the patients' family and the shortage of staff being the most significant variables. In the conditions of resources deficit, the principle of fair redistribution is operative (Fisher et al., 2020), being able to consider the decrease or even the suspension of the principles of bioethics application (Sandu, 2020). If the fulfillment of this obligation is objectively difficult, it's natural that the protection of professionals to be adequate at this level.

Italy has rejected professional immunity because it risks protecting against serious negligence, both for staff and healthcare units, whose victim was the staff was (Cioffi & Rinaldi, 2020). The introduction of immunity, in the form indicated by us, implies an increase in adequacy to situations, which can have the effect of increasing equity for both staff and patients. Regulation could work more effectively than the forms of partial deregulation required by the application of previous rules.

Mainly, we can agree that, given the existence of a clear legal framework, *the entire institutional path of legal action against professionals can contribute to the act of justice*. However, this option is the subject of a discussion based only on normal times, it's being based on the possibility for professionals to train properly and have all the necessary resources. However, as we have already shown, these conditions are not met during the COVID-19 pandemic.

Indication of other sources of protection existence, such as force majeure, the fact that guilt must be proved by the injured party and the difficulty of proving the causal relationship (Martin-Fumadó et al., 2020) in fact raises additional issues, many of them may could being interpreted as arguments in favor of immunity.

We consider that force majeure isn't an appropriate solution for the following reasons: (a) Force majeure seems to be a form of protection for staff, but not for patients. (b) Force majeure revokes the right of professionals to take action against the unit in the absence of protection means. (c) However, there's a much more complicated issue regarding the invocation of force majeure: determining the duration of its application. The definition of force majeure as an external, unpredictable, absolutely invincible and inevitable event, as well as the way how knowledge evolved

during the pandemic suggests the many difficulties posed by determining whether or not to apply force majeure for each pandemic period. (d) Force majeure is too general, suspending the possibility of adapting the analysis tools to the particularities of pandemic evolution and to the variability of its impact on different areas, types of units, etc..

The difficulty in demonstrating the causal relationship on the injured party, obviously accentuated in the context of pandemic, is related to the procedural side, which can't be invoked as an argument in the discussions on the merits. From the weight of proving the guilt (or its absence) we can't deduce the need to cancel the right, but we can ascertain the need for a *no-fault system*, which would ensure the compensation of those injured.

9. Some arguments in favor of professional immunity

There is a fundamental argument related to the interest of patients: *the absence of professional immunity in such cases risks activating the mechanisms of action specific to defensive medicine*. Given the lack of resources, defensive medicine tends to focus its negative effects on patients. The existence of defensive medicine shows that in the absence of legal interventions for the introduction of professional immunity/limitation of professional liability to the concrete possibilities specific to the context created by the COVID-19 pandemic, both health professionals and patients will suffer.

The most important recommendation is the legal protection of health workers in *the situation of deciding who to allocate fans to and who to deprive of them* (Cohen et al., 2020). It's an extraordinary intervention, carried out in accordance with the principle of redistributive justice, which can't be judged in relation to the standards applicable to normal situations. In this context, it's obvious the risk of being sued, civil and criminal, that health workers face because they will refuse or stop supporting artificial ventilation without the consent of patients (Cohen et al., 2020). The absence of legal protection forces medicine to protect through the "first come, first served" allocation model, which is more unfair and less effective, leading to the loss of a large number of lives (Cohen et al., 2020).

The examples provided by reality are relevant for highlighting potential problems: in Italy they started criminal prosecutors for situations during the crisis (D'Aloja et al., 2020). The path that prosecutors follow in such cases is to identify the standard of care specific to the crisis period. This approach involves the presumption of knowing how to protect patients. However, this presumption is incorrect in the current context, with professionals and units facing uncertainty (D'Aloja et al., 2020).

Immunity is a solution against the legislative/ legal ambiguity of health professionals, bringing legal clarity to situations (Al-Azri, 2020). There is uncertainty about the moment when conditions that brought professional immunity into question will disappear (Klitzman, 2020). The protection is also of patient, with staff freed from fear of further action (Cioffi & Rinaldi, 2020).

Urgent activities carried out during the pandemic, in conditions different from the standard ones, may not comply with the rules, for practical reasons (Teo et al., 2020). Therefore, as long as a healthcare provider acts reasonably, in good faith and in accordance with medical protocols and guidelines, civil or criminal liability shouldn't apply to him (Teo et al., 2020).

The defense derived from the interpretation of the law isn't enough, it transfers to the professionals the costs related to the transposition in practice. Even if, for example, the invocation of force majeure (Martin-Fumadó et al., 2020) is a relevant argument that can be taken into consideration in some situations (for example, in the case of unforeseen influxes of patients), it requires verification of the factual and legal situation, in each case, entailing both financial, time and emotional costs for professionals, and an increased degree of uncertainty about the future. The uncertainty of future professional responsibility for the present facts can generate high costs for patients and society, the set of behaviors specific to defensive medicine having, in our estimation, the highest probability.

9.1. Overton Window

The risks of malpractice allegations to health professionals are also dependent on Overton Window, which is what society in general or a specific community considers to be normal/desirable. Overton Window is the interval within a particular public policy it's agreed by society; a range of acceptability that any policy must take into consideration. The theory also considers another type of dynamics, based on changing the range of acceptability. The dynamic is determined by the society changing values and expectations. This approach suggests that politicians aren't so much pioneers as pursuers of the paths set by the population's willingness to accept one policy or another. The COVID-19 pandemic is one of the contexts in which the range of acceptability for certain approaches is constantly changing, the most obvious example being the universalization of surgical mask use, respectively the rapid slip in the area of social values of this type of behavior.

We can't anticipate post-pandemic social changes, including those related to expectations from health professionals. However, we know that there have been changes in social values that have determined the judgment

of social behaviors developed under the rule of other values/historical contexts. In question aren't only the jumps from one model of society to another (events beginning with the French Revolution and ending with the collapse of communism being relevant examples), but also social repositioning generated by certain currents of political correctness that are characterized by judging past behaviors from the perspective of present values. With regard to global events, the rule seems to be rather the suspension of the *tempus regit actum* principle as a form of legitimation of the new socio-political values. We can already observe socio-political currents that place the inevitably restrictive medical rules during the pandemic under the sign of medical dictatorship, prudence forcing us to consider scenarios where they come to power.

Medicine is an area of social life that can understand the value of prevention. Legal acts of a preventive nature increase the level of protection against judgments past based on axiological twists. We must keep in mind that the interpretation of professional gestures can change, from the current tolerance determined by all the emotions specific to this period, placed under the sign of fear, to judging them by forgetting the context. The normal pulling the plug of the ventilator for a patient with no chance of survival, in order to save other patients that need ventilators, specific to this period, can easily become a criminal act when viewed from the perspective of specific post-pandemic normality values. The most relevant area for such comparisons is battlefield medicine. With the mention that now is all about civilian area carried out practices, which aren't protected by the rules specific to the military field.

10. Possible solutions

Fisher believes that the chances of a situation correct analysis increase by using the "wave of ignorance" (Fisher et al., 2020) postulated by John Rawls, each of us having to forget our multiple affiliations and interests to correctly judge a situation. The doctor's ability to become a patient and the patient to become a doctor could support meditation on responsibility.

Professional immunity implies a suspension of the medical cases trial by using the rules applicable to the normal conditions of activity. Because it's difficult to establish both benchmarks and concrete situations, the solution is to summarize efforts to identify situations of gross negligence (and other like) and compensation of patients, equivalent to extending Samaritan-type protection to all employees. It usually doesn't apply in case of gross negligence, criminal attitude or intoxication. Given the existence of a significant level of protection applicable to volunteers, liability arises only

in the case of 'willful, without conscience, grossly negligent, reckless, criminal conduct or an intentional crime' (Rothstein, 2010) a solution for professional immunity could be its use as a reference level for personnel involved in the fight against COVID-19. This rule can be clearly extended to doctors required to practice in another specialization.

The government has an obligation to provide legal support for health workers, including from the perspective of future lawsuits risk (Kirkpatrick et al., 2020). One solution is to extend the coverage of malpractice insurance to absolutely all situations in the new context, the example of Spain being a relevant one (Martin-Fumadó et al., 2020). If we agree that it's/ will be particularly difficult to determine whether doctors acted negligently during the pandemic (Tomkins et al., 2020), then this is an argument in the favor of immunity, indicating the irrelevance of maintaining certain types of responsibilities such as negligence specific ones (we don't include gross negligence), in favor of the need to introduce a no-fault mechanism for compensating patients.

A form of *no-fault system* is needed to compensate certain categories of patients because extreme strategies such as "the dead are guilty" or "the staff is guilty" constitute an asymmetric transfer of pandemic costs. The introduction of *no-fault system* is timely and in order to avoid a large number of lawsuits, exacerbated by the economic crisis (Oliva et al., 2020). This type of balance is necessary to maintain confidence in the system, the establishment of a compensation fund can release a significant part of the pressure on the shoulders of health professionals. Establishing a compensation fund, the rights being granted through the use of mediators, using the rules applicable to compensation for damages (Parisi et al., 2020) seems to be a necessary part of the solution.

For example, in the UK doctors are protected against the payment of compensation in the case of allegations related to the specific medical practice COVID-19, this measure being considered sufficient by some authors (Tomkins et al., 2020). Even if it's insufficient, the measure is useful. It must be considered a partial form of professional immunity, in this case being canceled the obligation to pay compensation, one of the forms of suspension of liability specific to professional immunity. Along with the example of the United Kingdom, the one of Spain can also be indicated: the insurance companies provided the necessary coverage for all the atypical situations during the pandemic (Martin-Fumadó et al., 2020), this being in fact a form of protection/immunity.

11. Conclusions

We can consider that this pandemic represents a new situation, extremely demanding from the perspective of adaptations to its context. The multitude of changes is too wide to allow the functioning of traditional social and professional mechanisms. Professional immunity means the protection of professionals in relation to care standards and assessment of the activity applicable under normal conditions. If it was possible both to adapt the legal framework (or legal precedents) to the concrete conditions generated by the pandemic and the ability to document and complete and correct assessment of each situation, discussions on professional immunity would become obsolete. It isn't yet possible to implement them at a satisfactory level. We can hope that these conditions will be met in the future, trying to identify appropriate solutions for subsequent ethical regulations.

The identical action of SARS-CoV-2 coupled with a certain standardization of interventions against the COVID-19 pandemic tends to function as a revealer of the different societies ability to respond adequately to such threats. Obviously, the variability of the social irrationality dose often takes the form of a change in the number of citizens who die due to COVID-19. Inadequate cognitive grip on reality translates into social costs. The main issue addressed in this article is the risk of transferring the cost of ignorance shown by a certain part of society, a visible ignorance in the inadequate expectations of medical science, on health professionals. In this cost transfer, the limits of scientific knowledge risk being reinterpreted in the form of medical malpractice. In addition, the costs and risks specific to any probing period prior to axiological repositioning also tend to be shifted to the area of responsibility of healthcare professionals. The problem with professional immunity is the avoidance of shifting the costs of some of the consequences of the pandemic on health professionals as they aren't responsible for the costs because they couldn't be avoided.

Arguments for resolving situations by applying legal principles, existing provisions or on the basis of common law, can be translated in the absence of clear rules. The lack of rules is determined both by the limits faced by certain communities in trying to adapt their axiological options to reality and to act according to them and by the interest of a part of society to maintain an area of anomie. The absence of rules benefits for informal networks of influence, which mediate neo-feudal privileges. For health professionals, the lack of rules accentuates the level of uncertainty.

We can anticipate that one of the post-pandemic period problems will be the deterioration of citizens' trust in health professionals. The lack of transparency during the pandemic will exacerbate distrust. The absence of a protection form of healthcare professionals will contribute to increased opacity and, consequently, distrust.

One of the arguments in favor of professional immunity is the protection of patients against defensive medicine. The very high level of uncertainty should correspond professionally to a comparative level of abstention. Or, what health professionals do during this period is the exact opposite of defensive medicine.

Given the need to adapt liability to the context, professional immunity could only be related to the agreement on the term used for the set of measures intended to transpose this adaptation. Immunity actually means resizing the responsibility of professionals according to the context. Uncertainty is a defining feature of the context. Less knowledge means more victims. More victims risk more responsibility. However, less scientific knowledge must mean less professional responsibility, because the limits of responsibility are given by the extent of what's possible, which is dependent on the knowledge limits.

The variability of legal systems can generate the false impression that professional immunity is an exaggeration, many of the arguments against immunity being generated by the system specifics to which each of the authors refers. Professional immunity as an adequacy of responsibility to the context is an objective, the ways to achieve it being dependent on the legal specifics of each state. Transposition solutions need to be linked to community-specific social values (legal variations may suggest some differences), as they may be diverse; a diversity that includes the possibility of several variants in the same legal system.

The need for measures specific to professional immunity isn't identical in each of the states, depending on the specifics of the legal system, social values, characteristics of measures taken to combat the pandemic, the degree of transparency of each health system, the level of influence of bioethical principles. However, this need doesn't start from "any measure", as the appropriate minimum level of protection seems to be the introduction of a no-fault model for compensating patients. Starting from this level, characteristics of the immunity of professionals must be added, meant to adapt the responsibility to the specific conditions.

A theoretical alternative to the current situation can be thought: creating a set of rules specific to this pandemic. It would aim at a dynamic model of adapting professional responsibility to the context, ensuring

compliance with country-specific legal systems and satisfying the local specificity generated by the difference between the values of different communities. The low speed of reaction and the evolution of knowledge decrease the probability of the effectiveness of this approach in this pandemic, it remaining to be built later, as a form of preparation for similar events.

Extraordinary situations require extraordinary legal provisions and/or adequate interpretations of existing provisions. Since the question arises as to whether laws allow for appropriate interpretation exist, the solution to the construction of a general legal framework, at least having the legal status of a recommendation, is the most appropriate, it's the responsibility of some international institutions whose object of activity is included in the area of rights and health protection. The COVID-19 pandemic has somehow forced an additional step towards broadening discussions on universal human rights, and we need to consider ways of putting them into practice in the context of limited resources.

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