No. 71PA24 THREE-A DISTRICT

SUPREME COURT OF NORTH CAROLINA

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DORIS GRIFFIN LAND and ELLIOTT LAND, Plaintiffs-Appellees, v. KORI B. WHITLEY, M.D., PHYSICIANS EAST, P.A. d/b/a GREENVILLE OB/GYN, PITT COUNTY MEMORIAL HOSPITAL, INC. d/b/a VIDANT MEDICAL CENTER, and PITT COUNTY MEMORIAL HOSPITAL, INC. d/b/a VIDANT SURGICENTER, Defendants-Appellants.	From Pitt County

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BRIEF OF AMICI CURIAE NORTH CAROLINA HEALTH CARE FACILITIES ASSOCIATION, NORTH CAROLINA SENIOR LIVING ASSOCIATION, AND NORTH CAROLINA ASSISTED LIVING ASSOCIATION IN SUPPORT OF DEFENDANTS-APPELLANTS

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[1] There is no person or entity other than the amici curiae, their members, and/or their counsel, who helped write this brief or who contributed money for its preparation.

INTEREST OF AMICI CURIAE

Amici are the statewide associations of nursing homes, assisted living facilities, and skilled nursing facilities in North Carolina that house and care for many of our State's seniors.[2] Amici write to amplify Defendants' concerns about the consequences of the Court of Appeals' decision on all health care providers and to highlight its harmful effects on long-term care facilities[3] and, by extension, some of our State's most vulnerable citizens who depend on their shelter and care.

The General Assembly unanimously passed the Emergency or Disaster Treatment Protection Act to provide broad immunity from liability to health care providers during the Covid public health

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[2] There are 422 licensed nursing homes and 581 adult care homes in North Carolina. *Nursing Homes/Homes for the Aged Licensed by the State of North Carolina Department of Health and Human Services – Division of Health Service Regulation As of 7/2024*, NH_WebReportAlphabeticalPdf (ncdhhs.gov) (last visited July 27, 2024); *Adult Care Homes/Homes for the Aged Licensed by the State of North Carolina Department of Health and Human Services – Division of Health Service Regulation As of 7/2024*, Adultcare_WebReportPDF (ncdhhs.gov) (last visited July 27, 2024). The North Carolina Health Care Facilities Association's members are skilled nursing and post-acute care facilities. The members of the North Carolina Senior Living Association and the North Carolina Assisted Living Association are assisted living facilities, or licensed adult and family care homes.

[3] Amici's members are collectively referred to in the brief as "long-term care facilities."

emergency. The Court of Appeals' narrow construction of the Act will deprive amici's members[4] of the intended immunity in most cases, and its lowering of the pleading standard for gross negligence will likely be exploited to deprive them of immunity in all cases and may thwart other public policy. Affirming the Court of Appeals' holdings would perpetuate the harmful effects of Covid on long-term care facilities for years to come. For the reasons that follow, Amici respectfully urge the Court to reverse.

ISSUES ADDRESSED IN THE BRIEF

I. Did the Court of Appeals err in narrowly construing the Emergency Or Disaster Treatment Protection Act to only provide immunity for negligence or injuries caused by Covid, when the General Assembly passed the Act with the express intent to provide broad immunity to health care providers from liability for negligence during the public health emergency?

II. Did the Court of Appeals establish a new, diminished pleading standard for gross negligence by accepting allegations that merely label negligence as "gross negligence," without requiring the specific types of facts our courts traditionally demanded to support a conclusion of gross negligence?

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[4] Amici's members are entitled to immunity afforded by the Emergency or Disaster Treatment Protection Act, because it grants immunity to "health care facilities" that are therein defined to include entities licensed under Chapter 131D (adult care homes) and Chapter 131E (nursing homes and other skilled nursing facilities) of the General Statutes. N.C.G.S. §§ 90-21.133 and 90-21.132.

INTRODUCTION

Covid was an unprecedented worldwide public health crisis that threatened the health, safety, and welfare of every North Carolinian. It became clear at the onset of Covid that our State would depend on our health care providers to defend us. While we implored and expected health care providers to remain steadfast on the front lines of Covid in service to our State, our elected representatives took deliberate measures to protect them to ensure the stability of our public health system.

Our representatives understood that it was impossible for health care providers and facilities to conduct operations as usual during the public health emergency or to deliver the same continuity and quality of care as before, and that it was inconceivable to expect them to continue to deliver health care during the crisis, but then later hold them accountable for mistakes they would inevitably make during such extraordinary and trying times. So, with full bipartisan support, our legislature unanimously passed the Emergency or Disaster Treatment Protection Act to promote the health, safety, and welfare of the citizens of our State by broadly protecting health care providers and facilities from liability during the Covid public health emergency.

The Court of Appeals' decision construing and applying the Act is incorrect, because it effectively limits the immunity to only being available when each act or omission allegedly contributing to the plaintiff's injuries was *caused* by Covid. Not only is this interpretation of the Act unwieldy and unworkable, but it is not what the General Assembly intended. It is evident in the plain language, purpose, title, legislative history, and context of the Act that the General Assembly intended to grant *broad* immunity to health care providers who delivered health care during the public health emergency, *not* to limit the immunity to liability only for negligence or injuries *caused* by Covid.

The Court of Appeals also erred by failing to require the plaintiffs to sufficiently plead gross negligence, which is necessary to overcome immunity. That error nullifies the immunity granted by the legislature and may thwart other public policies our legislature seeks to achieve by demanding a showing of gross negligence.

Our State's health care providers and facilities relied on the Act's insulation from liability as they navigated the pandemic. While they were trying to defend their staff, patients, and residents from the virus and prevent its spread within their facilities, they were bound to comply

with constantly-changing government Covid directives—all while striving to meet all the needs of their patients and residents amidst severe staffing shortages. In addition to increased administrative, operational, and regulatory burdens imposed by Covid, long-term care facilities dealt with the added threat of agency enforcement, such as monetary penalties or facility closures if they failed to meet Covid infection control standards. Long-term care facilities are still struggling to overcome Covid-induced staffing shortages and financial deficits.

If health care providers and facilities had been forced to bear these hefty burdens while also facing the specter of liability for negligence during the extraordinary circumstances of the pandemic, they might have found that the only viable alternative was to retreat from the front lines of Covid. Our legislators knew that increased exposure to liability during the pandemic was an untenable, destabilizing force, so they took action in the best interests of our State to remove it.

The Court should uphold the policy choice our legislature made. The Court of Appeals' narrow construction and application of the Act will deprive health care providers and facilities of the intended immunity in most cases. And, the Court of Appeals' lowering of the pleading standard

for gross negligence will likely be exploited to deprive them of immunity in all cases and may thwart important public policy in other areas. The holdings below open the floodgates of litigation against health care providers and facilities,[5] heaping defense costs and litigation burdens on health care providers and long-term care facilities still struggling to overcome staffing shortages and financial deficits caused by the pandemic. Affirming the decision below would perpetuate the harmful effects of Covid on long-term care facilities for years to come, would likely result in more forced closures of long-term care facilities, and could destabilize our public health system to the detriment of the patients it exists to serve.

Therefore, amici respectfully urge this Court to reverse the Court of Appeals' decision.

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[5] The Act grants immunity for acts and omissions through the end of the Covid emergency declaration, or 15 August 2022, and the statute of limitations for personal injury actions is at least three years. Therefore, there could be many more lawsuits filed against health care providers and facilities until and after 15 August 2025. Of course, some lawsuits take years to litigate, at great expense.

BACKGROUND

COVID-19 ("Covid") was an unprecedented worldwide public health crisis that threatened the stability of health care systems around the world.[6] On 31 January 2020, the World Health Organization and the Secretary of the United States Department of Health and Human Services (DHHS) declared public health emergencies due to Covid.[7] On 10 March 2020, Governor Cooper declared a state of emergency in North Carolina, invoking the Emergency Management Act. Exec. Order No. 116, Cooper (Mar. 10, 2020); N.C.G.S. § 166A-19.10 *et seq*.

One week later, the North Carolina Department of Health and Human Services (NCDHHS) confirmed that the number of Covid cases continued to rise. Exec. Order No. 118, Cooper (Mar. 17, 2020). Several executive orders in the following weeks sought to manage and stop the spread of the disease. *See*, *e.g.*, Exec. Order No. 120, Cooper (Mar. 23, 2020); Exec. Order No. 121, Cooper (Mar. 27, 2020). By 27 March 2020, NCDHHS had documented 763 cases of Covid across 60 counties and

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[6] Nkengasong, J.N., *COVID-19: unprecedented but expected*, Nat Med 27, 364 (2021), https://doi.org/10.1038/s41591-021-01269-x.
[7] *CDC Museum COVID-19 Timeline*, CDC Museum COVID-19 Timeline | David J. Sencer CDC Museum | CDC (last visited July 27, 2024).

widespread transmission. Exec. Order No. 121, Cooper (Mar. 27, 2020).

From the onset of the pandemic, executive orders identified health care professionals as "integral to ensuring the state [was] best situated to respond to and mitigate the threat posed by [Covid]," Exec. Order No. 117, Cooper (Mar. 14, 2020), and prioritized the "critical need to support healthcare providers, nursing and adult group home staff, . . . and others working to keep communities safe and healthy during the [Covid] pandemic," Exec. Order No. 119, Cooper (Mar. 20, 2020). One order suspended certain childcare regulations and waived certain health department regulations to address needs of health care providers for childcare for their school-aged children. Exec. Order No. 119, Cooper (Mar. 20, 2020).

Executive orders issued in March and April 2020, which aimed to fortify our public health system, significantly impacted health care providers and facilities and altered the delivery of health care services in our State. As examples, executive orders in March ordered the following:

- Persons licensed in other states, territories, or the District of Columbia were allowed to provide health care services in North Carolina. Exec. Order No. 116, Cooper (Mar. 10, 2020).

- Health care facilities were designated as

essential businesses and were ordered to (a) maintain at least six feet distance from other individuals, (b) wash hands using soap and water for at least twenty seconds as frequently as possible or use hand sanitizer, (c) regularly clean high-touch surfaces, and (d) facilitate online or remote access by customers if possible. Exec. Order No. 121, Cooper (Mar. 27, 2020).

- Long-term care facilities were ordered to restrict visitation of all visitors and non-essential health care personnel in skilled nursing facilities and adult care homes. Exec. Order No. 120, Cooper (Mar. 23, 2020).[8]

By early April 2020, North Carolina's health care providers expressed concern that health care facilities would not be sufficient to care for those who got sick. Exec. Order No. 130, Cooper (Apr. 8, 2020). A forecast by experts from universities and research organizations estimated that by the end of May 2020, 250,000 North Carolinians would be infected with Covid, even with social distancing measures in place. *Id.*

On 8 April 2020, the Governor issued Executive Order No. 130,

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[8] NCDHHS recommended urging limitations on visitors at long-term care facilities and other measures to control the spread of Covid in long-term care settings. *North Carolina Department of Health and Human Services' Recommendations on Visitation in Long-term care Facilities to Reduce Risk of Transmission of COVID-19* (Mar. 13, 2020), Microsoft Word - NCDHHS COVID-19 Visitation Guidance for LTC Facilities 2020-03-13; *see also* Exec. Order No. 120, Cooper (Mar. 23, 2020).

urging North Carolina to take all reasonable actions to expand capacity of its health care system. *Id.* The order granted NCDHHS and occupational licensing boards authority to waive or suspend legal and regulatory constraints and delegated authority to health care licensure boards to waive licensure requirements for health care personnel. *Id.* This allowed persons with inactive or no North Carolina licenses, skilled but unlicensed volunteers, and certain students to provide health care services. *Id.* The order specifically affected delivery of health care services by long-term care facilities by permitting waivers of limitations on nursing home facility licensed bed capacity, waiving requirements for certain in-person applications or assessments for DHHS programs, and relaxing regulations on adult care homes for background checks. *Id.*

To address health care workers' concerns about "a lack of malpractice insurance or potential liability if they were to serve North Carolinians during this pandemic," Executive Order No. 130 extended immunity from liability provided by the Emergency Management Act, codified at N.C. Gen. Stat. § 166A-19.60, to all licensed health care providers and others authorized by the order to provide health care. *Id.* The order made clear that they were being "requested to provide

emergency services to respond to the [Covid] pandemic" and that the order "intend[ed] to provide insulation from liability to the maximum extent authorized by N.C. Gen. Stat. § 166A-19.60, except in cases of willful misconduct, gross negligence, or bad faith." *Id.*

The General Assembly also chose to sustain our public health system by insulating health care providers from liability. On 2 May 2020, both houses unanimously passed the Act "to promote the public health, safety, and welfare of all citizens by broadly protecting the health care facilities and health care providers in this State from liability that may result from treatment of individuals during the COVID-19 public health emergency under conditions resulting from circumstances associated with the COVID 19 public health emergency." N.C.G.S. § 90-21.131.

North Carolina's policy choice to immunize health care providers during the pandemic aligned with similar measures across the nation.[9] The Secretary of the United States Department of Health and Human Services urged governors to shield health care professionals from liability

[9] American Medical Association, *Liability protections for health care professionals during COVID-19* (Apr. 8, 2020), Liability protections for health care professionals during COVID-19 | American Medical Association (ama-assn.org).

"to extend the capacity of our nation's health care workforce to provide care on the frontlines of the [Covid] crisis."[10] Twenty-eight states passed Covid immunity statutes.[11] For example, the Georgia COVID-19 Pandemic Business Safety Act granted immunity during Covid to health care providers and facilities including nursing homes and assisted living facilities. *Arbor Mgmt. Servs., LLC v. Hendrix*, 364 Ga. App. 758, 875 S.E.2d 392 (2022). Other states relied on executive orders and good Samaritan statutes.[12] It was universally understood that Covid "rapidly alter[ed] the provision of health care services across the country," based on guidance from CDC and other federal, state, and local directives.[13]

ARGUMENT

I. The General Assembly intended to grant broad immunity to health care providers who delivered health care during the public health emergency, not to restrict the immunity to liability only for negligence or injuries caused by Covid.

The decision below effectively restricts the immunity provided by

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[10] Azar, Alex M., Secretary, U.S. Department of Health and Human Services (Mar. 24, 2020), Governor-Letter-from-Azar-March-24.pdf (nga.org).

[11] National Conference of State Legislators, Report, COVID-19: State Health Actions (Sept. 27, 2021), COVID-19: State Health Actions (ncsl.org).

[12] AMA, *supra* note 9.

[13] AMA, *supra* note 9.

the Act to situations where every single act or omission that allegedly contributed to the plaintiff's injuries was directly caused by Covid. Not only is this interpretation unwieldy and unworkable, but it is not what the General Assembly intended. The plain language, purpose, title, context, and legislative history of the Act compel the conclusion that the legislature intended to grant *broad* immunity to health care providers who delivered health care *during* the public health emergency, *not* to limit the immunity to liability only for negligence or injuries *caused* by Covid.

"The primary goal of statutory interpretation is to accomplish legislative intent, which, in the first instance, is discerned from the plain language of the enactment." *N.C. Farm Bureau Mut. Ins. Co., Inc. v. Hebert*, 385 N.C. 705, 711, 898 S.E.2d 718, 724, *reh'g denied*, 900 S.E.2d 661 (N.C. 2024) (citing *N.C. Farm Bureau Mut. Ins. Co. v. Lunsford*, 378 N.C. 181, 188, 861 S.E.2d 705, 712 (2021)). "If the statute's plain language is clear and unambiguous, this Court applies the statute as written and does not engage in further statutory construction." *Id.* (citing *Lunsford*, 378 N.C. at 189, 861 S.E.2d at 712)). "If the plain language of the statute is ambiguous, however, we then look to other methods of

statutory construction such as the broader statutory context, the structure of the statute, and certain canons of statutory construction to ascertain the legislature's intent." *Wynn v. Frederick*, 385 N.C. 576, 581, 895 S.E.2d 371, 377 (2023), *reh'g denied*, 896 S.E.2d 254 (N.C. 2024) (marks omitted).

A. The plain language of the Act is unambiguous and does not require the causal link the Court of Appeals imposed.

The threshold question for the Court in interpreting the Act is whether its plain language is clear and unambiguous. *See Hebert*, 385 N.C. at 712, 898 S.E.2d at 724. When a statute is unambiguous, the Court "must dispassionately give effect to the plain language." *Id.* *See Lunsford*, 378 N.C. at 192, 861 S.E.2d at 714 ("To give effect to the public policy considerations motivating the General Assembly's legislative choice . . . , we must apply the definition . . . chosen by the representatives of the people . . .").

The immunity provision plainly states that all health care providers and facilities are immune from civil liability for damages allegedly caused by acts or omissions in the course of arranging for or providing health care services, as long as the defendant was arranging

for or providing health care services in good faith during the Covid emergency, and the arrangement or provision of health care services was impacted directly or indirectly by the defendant's decisions or activities in response to or resulting from the pandemic (or those of the facility or entity where the defendant provided health care).

§ 90-21.133. Immunity.

(a) Notwithstanding any law to the contrary, except as provided in subsection (b) of this section, any health care facility, health care provider, or entity that has legal responsibility for the acts or omissions of a health care provider shall have immunity from *any* civil liability for *any harm or damages* alleged to have been sustained as a result of an act or omission *in the course of arranging for or providing health care services* only if all of the following apply:

(1) The health care facility, health care provider, or entity is arranging for or providing health care services *during* the period of the COVID-19 *emergency* declaration, including, but not limited to, the arrangement or provision of those services pursuant to a COVID-19 emergency rule.

(2) The arrangement or provision of *health care services* is *impacted*, *directly or indirectly*:

a. By a health care facility, health care provider, or entity's *decisions or activities in response to or as a result of the* COVID-19 *pandemic*; or

> b. By the decisions or activities, in response to or as a result of the COVID-19 pandemic, of a health care facility or entity where a health care provider provides health care services.
>
> (3) The health care facility, health care provider, or entity is arranging for or providing health care services in good faith.
>
> (b) The immunity from any civil liability provided in subsection (a) of this section shall not apply if the harm or damages were caused by an act or omission constituting gross negligence, reckless misconduct, or intentional infliction of harm by the health care facility or health care provider providing health care services; provided that the acts, omissions, or decisions resulting from a resource or staffing shortage shall not be considered to be gross negligence, reckless misconduct, or intentional infliction of harm.

N.C.G.S. § 90-21.133 (emphasis added).

The plain language of the Act unambiguously creates broad immunity, for several reasons.

First, "health care services" are defined broadly, to include not only treatment, but also clinical direction, supervision, management, and administrative or corporate services provided by a health care provider or facility "during the period of the COVID-19 emergency declaration." N.C.G.S. § 90-21.132(8).

Second, "impact" is also broad. The impact of the defendant's decisions or activities in response to the pandemic on the defendant's arrangement or provision of health care services can be direct or indirect. The Court should give meaning to the legislature's inclusion of the word "indirect." *See C Invs. 2, LLC v. Auger*, 383 N.C. 1, 24, 881 S.E.2d 270, 286 (2022) ("[T]he purpose of statutory construction is to ensure every word or phrase provides meaning and that none are surplusage."). By allowing both direct and indirect impact, the legislature intended to immunize defendants whose decisions or activities responding to or resulting from the pandemic had *any* impact on their arrangement or provision of health care services during the public health emergency. Because the statute does not require any particular type or kind of impact, a defendant need only show that its decisions or activities responding to or resulting from the pandemic had *any* impact *whatsoever* on its arrangement or provision of health care services during the emergency. Importantly, the statute does not state that the arrangement or provision of health care services must be impacted at all by Covid.

Third, the legislature's choice to make both "decisions or activities" and "health care services" plural challenges the notion that a defendant's

burden in establishing entitlement to immunity is as granular or onerous as the Court of Appeals held. The legislature could have—but did not—required defendants to identify a *specific* decision or activity in response to the pandemic that impacted a *specific* health care service in which there was an act or omission contributing to the plaintiff's *specific* injury. Thus, a defendant is merely required to show that its decisions or activities in response to the pandemic, *generally*, had some impact on the defendant's arrangement or provision of health care services, *generally*.

Fourth, the exceptions to immunity in subsection b. for gross negligence, reckless misconduct, and intentional infliction of harm show the legislature's intent to immunize health care providers and facilities from negligence and other causes of action that might arise while defendants provided health care services during the emergency.

In sum, the Act provides immunity to health care providers and facilities for damages allegedly caused by their good-faith acts or omissions in the course of arranging for or providing health care services during the Covid public health emergency, as long as they can show that their decisions or activities in response to or resulting from the pandemic

had some impact on their arrangement or provision of health care services.

However, the Court of Appeals held that "the second element of the Act requires Defendants to show Mrs. Land's care was affected, directly or indirectly, *by the COVID-19 pandemic*" and that "Defendants' affidavits fail to establish a *causal link* between the impact of COVID-19 and Mrs. Land's care or treatment." *Land v. Whitley*, 898 S.E.2d 17, 25 (N.C. Ct. App. 2024) (emphasis added). These conclusions cannot be derived from the text alone, and "we must not read into a statute language that simply is not there." *See Lunsford*, 378 N.C. at 189, 861 S.E.2d at 712 (citing *Boseman v. Jarrell*, 364 N.C. 537, 554, 704 S.E.2d 494 (2010) (Hudson, J., dissenting)).

The plain language of the Act does not include the causation requirement the Court of Appeals imposed. The statute simply does not state that, for the immunity to attach, Covid must have impacted the plaintiff's treatment. Indeed, the statute does not even state that Covid must have impacted anything. Instead, the statute requires a defendant seeking immunity to show that its *decisions or activities in response to or resulting from the pandemic* had any impact whatsoever on its

arrangement or provision of health care services during the public health emergency. The Court "ordinarily resist[s] reading words or elements into a statute that do not appear on its face." *Dean v. United States*, 556 U.S. 568, 571, 129 S. Ct. 1849, 1853 (2009).

If the General Assembly intended to require a defendant seeking immunity to establish that the Covid pandemic impacted *the plaintiff's care*, specifically, the legislature would or could have used words necessary to achieve that end. By contrast, New York's Covid immunity statute did contain express language requiring defendants to show that plaintiffs' care was impacted. New York Public Health Law § 3082 granted health care providers immunity from any liability for any harm or damages alleged to have been sustained as a result of an act or omission in the course of arranging for or providing health care services in good faith, as long as the defendant was arranging for or providing health care services pursuant to a Covid emergency rule or otherwise in accordance with applicable law, and "*the treatment of the individual* [was] impacted by" the defendant's "decisions or activities in response to or as a result of the COVID-19 outbreak and in support of the state's directives." N.Y. Public Health Law § 3082 (emphasis added).

Importantly, the plain language of North Carolina's Act does not require this showing.

The defendant's burden to establish impact is not a causation requirement. This Court should not rewrite the Act to add such a requirement because it would materially alter the broad immunity the legislature intended. *See Bd. of Educ. of Wilson Cnty. v. Town of Wilson*, 215 N.C. 216, 1 S.E.2d 544, 546 (1939) ("Whatever may have been the legislative intent relative to this situation, it was not expressed, and we may not interpolate provisions which are wanting in the statute and thereupon adjudicate the rights of parties thereunder.").

The Court of Appeals erred when it imposed the causation requirement because the Act is unambiguous and does not contain one.

B. Even if this Court decides the Act is ambiguous, the Act must be liberally construed to fulfill its purpose to broadly protect health care providers from liability during the public health emergency.

The Act is unambiguous and therefore should be applied as written, not only because the plain language is clear, but also because the Act is not susceptible to the Court of Appeals' interpretation. The Court of Appeals' interpretation is unreasonable because it effectively limits the immunity to cases where every act or omission allegedly contributing to

the plaintiff's injuries was directly caused by Covid. Indeed, under that interpretation, few health care providers would qualify for the immunity granted by our legislature.

If a statute's plain language is ambiguous or susceptible to multiple reasonable interpretations, the Court should follow the legislature's express directive that it "shall be liberally construed to achieve its public health emergency purpose as outlined in G.S. 90-121.131." N.C.G.S. § 90-21.134. *See Hebert*, 385 N.C. at 707, 898 S.E.2d at 721.

> **§ 90-21.131. Purpose.**
> It is the purpose of this Article to promote the public health, safety, and welfare of all citizens by broadly protecting the health care facilities and health care providers in this State from liability that may result from treatment of individuals during the COVID-19 public health emergency under conditions resulting from circumstances associated with the COVID-19 public health emergency. A public health emergency that occurs on a statewide basis requires an enormous response from State, federal, and local governments working in concert with private and public health care providers in the community. The rendering of treatment to patients during such a public health emergency is a matter of vital State concern affecting the public health, safety, and welfare of all citizens.

N.C.G.S. § 90-21.131.

The Court should construe the provisions of the Act liberally to fulfill the legislature's purpose to broadly protect health care facilities and providers "from liability that may result from treatment of individuals during the COVID-19 public health emergency." N.C.G.S. §§ 90-21.131 and -21.134. This simple purpose statement anticipates increased exposure to liability during the unprecedented and uncontrollable circumstances of the pandemic and seeks to promote the public health, safety, and welfare of all of our State's citizens by protecting health care providers against mistakes they would inevitably make during the emergency. Liberal construction aiming to fulfill this purpose does not involve judicial narrowing or altering the plain language.

In order to arrive at its holdings, the Court of Appeals applied its narrow interpretation of the Act demanding a "causal link" with Covid to each step in the sequence of Mrs. Land's care. *See Land*, 898 S.E.2d at 25. It appears that the Court of Appeals recognized that Defendants established that the Covid pandemic impacted certain aspects of Mrs. Land's care. *See id.* However, the Court of Appeals ultimately concluded that because Defendants failed to establish how Covid impacted one link

in the chain of her care, that Defendants failed to establish the "causal link" the Court of Appeals added to the statute. *See id.* This narrow construction and application of the Act effectively limits immunity to only being available when each and every act or omission allegedly contributing to the plaintiff's injuries was *caused* by Covid.

A liberal construction of the Act aiming to fulfill its purpose would not force trial courts deciding if immunity applies to do what the Court of Appeals did here: to parse out the defendant's interactions with the plaintiff granularly and in piecemeal fashion, closely examining each discrete step in the plaintiff's treatment and care to determine if every link in the alleged chain of the defendant's acts and omissions (framed however the plaintiff chooses) was discretely impacted by Covid, or whether there was a justification or excuse for each of the defendant's acts or omissions that could be attributed to Covid—and then, if there is any break in the chain, to necessarily conclude that the defendant is not entitled to immunity. Given the plain language of the immunity provision and the Act's express purpose, it is not plausible that our legislators intended for courts to have to perform these mental gymnastics to grant immunity.

Other persuasive sources support the interpretation of the Act that amici urge this Court to adopt. For example, The National Consumer Voice for Quality Long-Term Care, an organization that advocates for residents of nursing homes, published that as of June 1, 2021, twenty-eight states including North Carolina had passed legislation or executive orders providing immunity from liability for negligent care to assisted living facilities.[14] It recognizes that most of these laws "grant facilities broad protections from harm experienced by residents during the pandemic, regardless of whether the harm was the result of COVID-19 exposure or infection" and opines that, "[b]ecause of the far-reaching effects of COVID-19, it is likely that most claims would fall within the immunity provisions." *Id.* Most states use broad language that "will likely cover most harm experienced during COVID-19." *Id.*

The Court of Appeals' narrow construction and strained application of the Act are unwieldy and produce the absurd result that the only practical circumstance in which a health care provider could qualify for immunity is when it can show that Covid caused all of the alleged acts or

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[14] *State Immunity Laws and Executive Orders Relating to Long-Term Care Facilities* (June 24, 2021) (State_Immunity_Summary_Final.pdf (theconsumervoice.org)) (last visited July 20, 2024).

omissions or alleged injuries. Indeed, under that interpretation, few health care providers would qualify for the immunity granted by our legislature. Allowing the Court of Appeals' narrow interpretation would actually undermine the purpose of the Act because it would simply leave no room for the honest mistakes the legislature intended to insulate from liability.

C. The Act's title, legislative history, and context affirm the legislature's intent to grant broad immunity for negligence during Covid, with no causation requirement.

If the Court determines that the plain language of the Act is ambiguous, the Court can consider other methods and canons of statutory construction to ascertain the legislature's intent. *See Wynn v. Frederick*, 385 N.C. at 581, 895 S.E.2d at 377. (marks omitted). The Act's title, legislative history, and context affirm that the legislature intended to provide broad immunity to health care providers for treating people during Covid, without the causation requirement the Court of Appeals imposed.

The title "Emergency Or Disaster Treatment Protection Act" conveys the simple meaning that the Act is intended to protect treatment during an emergency or disaster. Put another way, the Act was passed

for the purpose of treatment protection. The Act essentially allowed health care providers to justifiably treat people during the pandemic, without fear of liability.

The legislative history of the Act, though brief, is strong. The Act was passed unanimously by both houses of North Carolina's General Assembly and was signed into law by Governor Cooper. *See* Act of May 2, 2020, ch. 3, § 3D.7.(a), 2020 N.C. Sess. Laws 2, 25-27. The fact that immunity from liability for health care providers was granted by a unanimous legislative decision shows that our legislators were united in their desire to sustain our State's public health system by insulating health care providers from liability for negligence during the unprecedented emergency. While still serving on the Court of Appeals, then-Judge Riggs suggested recently that courts should follow the text of statutes the legislature has passed unanimously. *See McKinney v. Goins*, 290 N.C. App. 403, 431, 892 S.E.2d 460, 479 (2023) ("[T]he General Assembly's unanimous enactment of the SAFE Child Act and its Revival Window was a united response to developing science. . ."). Similarly, during the early months of the pandemic, our legislature's unanimous enactment of the Act was a united response to the developing science and

circumstances of Covid. Our courts should not now rewrite the Act our elected representatives unanimously passed.

Notably, the Act was amended only once, to clarify that the immunity applies during the entire period of the public health emergency.[15] Even when it was widely understood how broad the immunity was, the General Assembly did not amend the Act to narrow the immunity, nor did it repeal the Act.

The context of the Act's enactment should inform the Court's determination of legislative intent. *See State ex rel. N. Carolina Milk Comm'n v. Nat'l Food Stores, Inc.*, 270 N.C. 323, 332, 154 S.E.2d 548, 555 (1967) ("While the cardinal principle of statutory construction is that the words of the statute must be given the meaning which will carry out the intent of the Legislature, that intent must be found from the language of Act, its legislative history[,] and the circumstances surrounding its adoption which throw light upon the evil sought to be remedied.").

The context of our legislature's passage of the Act was the sudden onset of an unprecedented worldwide public health emergency. The Act

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[15] Section 3D.7-b of 2020 N.C. Sess. Laws 3, as amended by 2021 N.C. Sess. Laws 3,s. 2.13-a, eff. 3/11/2021.

was passed shortly after the Governor Cooper issued Executive Order No. 130, which extended immunity from liability provided by North Carolina's Emergency Management Act to all licensed health care providers and others authorized by that executive order to provide health care. Exec. Order No. 130, Cooper (Apr. 8, 2020).

The pandemic "rapidly alter[ed] the provision of health care services across the country," based on guidance from CDC and other federal, state, and local directives.[16] In addition to CDC guidelines imposed on long-term care facilities, CMS[17] and the Occupational Safety and Health Administration (OSHA)[18] issued federal directives and guidelines that applied to these facilities.

State agency directives were issued by NCDHHS[19] and the North

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[16] American Medical Association, *Liability protections for health care professionals during COVID-19* (Apr. 8, 2020), Liability protections for health care professionals during COVID-19 | American Medical Association (ama-assn.org).

[17] CMS, COVID-19 Data & Updates, COVID-19 Data & Updates | CMS (last visited July 30, 2024).

[18] OSHA ALERT, *COVID-19 Guidance for Nursing Home and Long-Term Care Facility Workers*, COVID-19 Guidance for Nursing Home and Long-Term Care Facility Workers (osha.gov) (last visited July 30, 2024).

[19] North Carolina Department of Health and Humans Services, *Guidance for Long-Term Care Providers and Facilities*, Long-Term Care Facilities | NC COVID-19 (ncdhhs.gov) (last visited July 31, 2024).

Carolina Department of Labor.[20] By executive order, Governor Cooper established long-term care risk mitigation measures that included ordering skilled nursing facilities and urging adult care homes, "to the extent possible given the constraints on the availability of personal protective equipment," to do the following:

- "Remind staff to stay at home when they are ill and prevent any staff who are ill from coming to work and/or staying at work";
- "Screen all staff at the beginning of their shift for fever and respiratory symptoms," which includes "[a]ctively taking that staff member's temperature" and "[d]ocumenting an absence of any shortness of breath, any new cough or changes in cough, and any sore throat"; and, "[i]f the staff member is ill, the facility must have the staff member put on a facemask and leave the workplace";
- "Cancel communal dining and all group activities, including internal and external activities";
- "Implement universal use of facemasks for all staff while in the facility, assuming supplies are available";
- "Actively monitor all residents upon admission, and at least daily, for fever and respiratory symptoms (shortness of breath, new cough or change in cough, and sore throat), and shall

[20] NCDOL, *Emergency Temporary Standard on Occupations Exposure to COVID-19*, COVID-19 | NC DOL (last visited July 30, 2024).

continue to monitor residents";

- "Notify the local health department immediately about either of the following: (a) Any resident with new, confirmed, or suspected [Covid]. (b) A cluster of residents or staff with symptoms of respiratory illness. A 'cluster' of residents or staff means three (3) or more people (residents or staff) with new-onset respiratory symptoms in a period of 72 hours."

Exec. Order No. 131, Cooper (April 9, 2020).

Amici's members report that Covid disrupted long-term care facilities in many ways, and the impacts of Covid on their operations were numerous, far-reaching, and compromised their ability to maintain continuity and quality of care for their residents. In addition to arranging for and providing care to their residents, management and staff were forced to expend considerable time and financial and human resources on new Covid-related tasks, including:

- tracking and understanding federal, state, and local directives and guidelines;
- developing and implementing new policies and procedures to ensure compliance;
- staying informed of the changing science of Covid, even when our national and State leaders lacked understanding;
- forming committees for continuing monitoring of Covid science, directives, and guidelines;

- developing new patient procedures and protocols, altering existing patient protocols, and establishing alternate treatment procedures;

- modifying infection control policies and procedures that required performing new tasks such as disinfecting, cleaning, filtration, housekeeping, ordering and donning personal protective equipment (PPE), and frequent hand washing;

- implementing and managing policies requiring face masks and attempting to obtain supplies of masks for residents and staff;

- developing and implementing new policies and procedures for staff absenteeism for Covid-related reasons;

- planning and conducting new in-service training programs to teach staff new policies and procedures related to infection control, resident care, no-visitation or limited visitation, contractor admission, staffing, and vaccination;

- implementing and executing mandatory vaccination programs for employed health care workers;

- restructuring buildings to create areas of isolation for Covid-positive residents and space for social distancing of residents and staff;

- regrouping residents to provide for social distancing, which required physically moving residents and their belongings;

- communicating with residents' family members

who could not visit, including facilitating FaceTime calls;

- notifying family members of status of residents more frequently due to no-visitation policies;

- At the same time, facilities lacked the valuable eyes and ears of family members who were not permitted to visit residents due to government mandates;

- creating and posting required notices, directives, and signage for contractors, other visitors, and staff;

- admitting contractors into facilities according to newly developed protocols, such as taking their temperatures and recording contact tracing information; and

- performing tasks previously done by third parties who no longer entered the facilities, such as taking blood to the lab to be tested.

Industry-wide staffing and PPE shortages made it very challenging for long-term care facilities to implement all of these changes and to maintain continuity and quality of care for residents. Specific complications included:

- staffing shortages due to mandatory fourteen-day quarantining when staff tested positive for Covid or were exposed to Covid;

- staffing shortages due to staff being unable to report to work when they lacked childcare due to school closures or when their child caregivers

tested positive for Covid;

- Out of necessity, facilities employed less experienced workers who treated patients, as permitted by government orders and guidelines;

- Out of necessity, many facilities had to use agencies they had never used before to provide staffing for health care and other services for residents; and

- Facilities faced scarcity of needed resources such as PPE, respirators, Covid therapeutics, and vaccines due to limited supply of these products and significant supply chain issues.

Even measures intended by the government to improve infection control or to alleviate the strains on long-term care facilities caused by the pandemic inevitably reduced continuity and quality of patient care. For example, the United States Secretary of DHHS authorized blanket waivers of many CMS requirements for nursing homes, retroactive to 1 March 2020.[21] To separate symptomatic residents from asymptomatic or Covid-negative residents, CMS waived requirements that facilities provide notice and rationale for changing a resident's room and

[21] Centers for Medicare & Medicaid Services, *COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers,* COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers (cms.gov).

regulations ensuring residents could choose roommates and refuse to transfer rooms.[22] CMS also waived requirements that physicians and practitioners make in-person visits to nursing homes.[23] To assist in staffing shortages due to Covid, CMS waived certain requirements for training and certifying nurse aides.[24]

A critical aspect of long-term care is staffing.[25] Pre-existing structural challenges that limited long-term care facilities' ability to hire and retain staff before Covid got worse for nursing homes during the pandemic."[26] Long-term care staff could not socially distance because their jobs require close contact with residents.[27] Early in the pandemic, long-term care facilities lacked PPE needed to prevent transmission of Covid in facilities.[28] PPE shortages put staff at increased risk of

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[22] *Id.*
[23] *Id.*
[24] *Id.*
[25] Huwien Xu, Orna Intrator & John Bowblis, *Shortages of Staff in Nursing Homes During the COVID-19 Pandemic: What are the Driving Factors?*, J. Post-Acute and Long-Term Care Med. (2020), Shortages of Staff in Nursing Homes During the COVID-19 Pandemic: What are the Driving Factors? - Journal of the American Medical Directors Association (jamda.com).
[26] *Id.*
[27] *Id.*
[28] *Id.*

contracting Covid, and with staff suspected of having contracted needing to quarantine for fourteen days, existing staff were often sidelined.[29]

Long-term care facilities implemented infection control protocols, including isolating residents suspected of having Covid, while the ban on visitors "reduced the availability of some informal care provided to residents by visiting relatives."[30] "This created a situation in which time and effort needed from [nursing home] staff increased, yet structural factors made it more difficult to address, creating the potential for a staff shortage."[31] CMS "acknowledged this shortage by temporarily suspending the competency requirement for providing direct care to residents, but the additional $600 per week federal unemployment benefit hurt the ability of [nursing homes] to recruit needed staff."[32]

Long-term care facility staff also suffered from mental health issues during Covid, including burnout.[33] Covid "exacerbated existing vulnerabilities of workers through increasingly unsafe working

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[29] *Id.*
[30] *Id.*
[31] *Id.*
[32] *Id.*
[33] Jennifer C. Morgan, Waqar Ahmad, Yun-Zih Chen & Elizabeth O. Burgess, *The Impact of COVID-19 on the Person-Centered Care Practices in Nursing Homes*, National Library of Medicine (2023) (nih.gov).

conditions, increased workloads, and emotional exhaustion."[34] Long-term care staff experienced "multiple layers of trauma" during the pandemic, including "increased workloads, unclear and often contradictory instruction, emotional overload, stress, fear and exposure to contagion and death, and the dearth of staff and protective equipment."[35] "Uncertainty and fear about the unfolding situation resulted in emotional exhaustion, sleep disturbances, and loss of appetite" for staff and residents.[36] "Nursing home administrators and owners faced problems in organizing and managing physical and human resources to adequately respond to the pandemic and often failed to address the emotional exhaustion among employees and residents."[37]

Covid put long-term care facilities in financial dire straits by increasing their costs and decreasing their revenues.[38] They expended

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[34] *Id.*
[35] *Id.*
[36] *Id.*
[37] *Id.*
[38] Orewa G, Weech-Maldonado R, Feldman S, Becker D, Davlyatov G, Lord J., *Financial Outcomes Associated with COVID-19 in Nursing Homes*, Innov Aging (Dec. 21, 2023), FINANCIAL OUTCOMES ASSOCIATED WITH COVID-19 IN NURSING HOMES - PMC (nih.gov).

extensive resources trying to protect residents and staff from Covid.[39] Costs of PPE, routine testing, and staff support "severely strained" their budgets.[40] In 2020, nursing homes spent roughly $30 billion on PPE and additional staffing alone."[41] The American Health Care Association and National Center for Assisted Living (AHCA/NCAL) estimated that the long-term care industry would lose $94 billion between 2020 and 2021.[42] Declining occupancy due to fewer new residents contributed to the financial crisis for long-term care facilities.[43] Long-term care industry insiders have referred to the pandemic as a "business nightmare."[44] One study found that Covid increased operating cost per patient day and decreased operating margin.[45] The ratio between the increase in operating cost per patient day to the operating revenue per patient

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[39] American Health Care Association and National Center for Assisted Living, *COVID-19 Exacerbates Financial Challenges Of Long-term care Facilities* (Feb. 17, 2021), COVID-19 Exacerbates Financial Challenges Of Long-term care Facilities (ahcancal.org).

[40] *Id.*

[41] *Id.*

[42] *Id.*

[43] *Id.*

[44] *Id.*

[45] Orewa G, Weech-Maldonado R, Feldman S, Becker D, Davlyatov G, Lord J., *Financial Outcomes Associated with COVID-19 in Nursing Homes*, Innov Aging (Dec. 21, 2023), FINANCIAL OUTCOMES ASSOCIATED WITH COVID-19 IN NURSING HOMES - PMC (nih.gov).

doubled.[46] The study predicted facility closures and reduced access to long-term care caused by the "deterioration in financial performance" of long-term care facilities during the pandemic.[47]

Even with government interventions, financial burdens became "too difficult to overcome for many providers": many facilities shuttered, "leaving thousands of vulnerable seniors in search of new care."[48] Because "most residents have multiple underlying health conditions and require a high-level of around-the-clock, specialized care," facility closures "leave residents displaced from their long-standing communities and loved ones, and reduce their options for quality care, especially in rural areas."[49]

Covid's pervasive impact affected all arrangement and provision of care for long-term care residents during the pandemic. The legislature's policy choice to immunize health care providers for negligence while providing care to our State's citizens during Covid is evident in the Act's plain language, title, legislative history, and this chaotic context in which

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[46] *Id.*
[47] *Id.*
[48] *Id.*
[49] *Id.*

it was passed. "The Court may also consider the policy objectives prompting passage of the statute and should avoid a construction which defeats or impairs the purpose of the statute." *O & M Indus. v. Smith Eng'g Co.*, 360 N.C. 263, 268, 624 S.E.2d 345, 348 (2006) (citing *Elec. Supply Co. of Durham,* 328 N.C. 651, 656, 403 S.E.2d 291, 294 (1991)).

II. Allowing plaintiffs to escape properly pleading gross negligence nullifies the immunity granted by the Act and thwarts other important public policy.

The Court of Appeals erred when it allowed conclusory allegations of gross negligence. Lowering the pleading standard for gross negligence nullifies the immunity otherwise granted by the Act and thwarts other public policies our legislature seeks to achieve by demanding a showing of gross negligence, such as the gross-negligence exceptions to many other statutory immunities, the gross-negligence exception to the statutory cap on non-economic damages in medical malpractice actions, and the gross-negligence exception to contributory negligence.

"A pleading which sets forth a claim for relief . . . shall contain . . . [a] short and plain statement of the claim sufficiently particular to give the court and the parties notice of the transactions, occurrences, or series of transactions or occurrences, intended to be proved showing that the

pleader is entitled to relief." N.C.G.S. § 1A-1, 8. "While the concept of notice pleading is liberal in nature, a complaint must nonetheless state enough to give the substantive elements of a legally recognized claim or it may be dismissed under Rule 12(b)(6)." *Raritan River Steel Co. v. Cherry, Bekaert & Holland*, 322 N.C. 200, 205, 367 S.E.2d 609, 612 (1988) (citation omitted).

On a motion to dismiss, the trial court need not accept the plaintiff's conclusory allegations, *Sykes v. Blue Cross & Blue Shield of N. Carolina*, 372 N.C. 318, 323, 828 S.E.2d 489, 494 (2019), legal conclusions or unwarranted deductions, *Sutton v. Duke*, 277 N.C. 94, 98, 176 S.E.2d 161, 163 (1990), or unreasonable inferences, *Strickland v. Hedrick*, 194 N.C. App. 1, 20, 669 S.E.2d 61, 73 (2008) (marks and citations omitted).

The Act expressly states that the "immunity shall not apply if the harm or damages were caused by an act or omission constituting gross negligence, reckless misconduct, or intentional infliction of harm." N.C.G.S. § 90-21.133(b). This Court has defined gross negligence as "wanton conduct done with conscious or reckless disregard for the rights and safety of others." *Parish v. Hill*, 350 N.C. 231, 239, 513 S.E.2d 547, 551 (1999) (citation omitted). "[A]n act is wanton when it is done of

wicked purpose, or when done needlessly, manifesting a reckless indifference to the rights of others." *Id.* at 239, 513 S.E.2d at 551–52 (citation omitted). As this Court has further explained,

> the difference between the two is not in degree or magnitude of inadvertence or carelessness, but rather is *intentional wrongdoing* or *deliberate misconduct* affecting the safety of others. *An act or conduct rises to the level of gross negligence when Act is done purposely* and with knowledge that such act is a breach of duty to others, i.e., a *conscious* disregard of the safety of others. An act or conduct moves beyond the realm of negligence when the *injury or damage* itself is intentional. *Brewer,* 279 N.C. at 297, 182 S.E.2d at 350.

Yancey v. Lea, 354 N.C. 48, 52–53, 550 S.E.2d 155, 157–58 (2001), *superseded on other grounds*, *Piazza v. Kirkbride*, 372 N.C. 137, 827 S.E.2d 479 (2019).

In this case, the Court of Appeals agreed that, in order for a plaintiff to adequately plead gross negligence to overcome the immunity granted by the Act, the plaintiff needs to "provide sufficient facts to support the allegation of gross negligence." *Land*, 898 S.E.2d at 26. However, after the Court of Appeals noted Plaintiffs' allegations of six failures of duties and the summary allegation that the "failures and violations of the standard of care were negligent, careless, reckless, and grossly

negligent," it held that, "[c]onsequently, Plaintiffs' complaint sufficiently allege[d] claims not barred by N.C. Gen. Stat. § 90-21.133(a)." *Id.*

Plaintiffs did not meet their burden to allege any facts supporting the conclusion that there was any intentional wrongdoing or deliberate misconduct by any Defendants, that any of Defendants' alleged acts or omissions were done purposely (much less with a wicked purpose), or that Plaintiffs' alleged injuries or damages, themselves, were intentional. *See Yancey*, 354 N.C. at 52-53, 550 S.E.2d at 157-58; *Parish*, 350 N.C. at 239, 513 S.E.2d at 551; *Doe v. Wake County*, 264 N.C. App. 692, 696, 826 S.E.2d 815, 819 (2019) (citation omitted) (holding that complaint failed to allege "facts which would support a legal conclusion that defendant[s] acted with malice" because plaintiff did not "offer any facts or forecast any evidence that [defendant] took actions that went beyond—at worst—simple negligence").

Instead, Plaintiffs alleged facts that at most support a conclusion of negligence. Plaintiffs' complaint contains conclusory allegations, a legal conclusion that the alleged failures constituted gross negligence, and an unwarranted deduction or unreasonable inference that the alleged failures constituted gross negligence. The Court of Appeals erred

when it accepted Plaintiffs' conclusory allegations, *see Sykes*, 372 N.C. at 323, 828 S.E.2d at 494, legal conclusions, *see Sutton*, 277 N.C. at 98, S.E.2d at 163, unwarranted deductions, *see id.*, and unreasonable inferences, *see Strickland*, 194 N.C. App. at 20, 669 S.E.2d at 73. Indeed, this Court has made clear that a court should not give a jury this question unless and until the court has first tested the alleged facts, considered in the light most favorable to the plaintiff, and determined that they support a conclusion of gross negligence. *Yancey*, 354 N.C. at 57, 550 S.E.2d at 160.

Plaintiffs have not alleged any specific occurrence that, if proved, would show any purposeful or intentional wrongdoing or deliberate misconduct by any Defendants or that Plaintiffs' alleged injuries or damages, themselves, were intentional. Therefore, Plaintiffs have failed to meet the notice pleading standard for gross negligence. *See* N.C.G.S. § 1A-1, 8. Lowering the pleading standard for gross negligence nullifies the immunity otherwise granted by the Act and thwarts other important public policy.

CONCLUSION

The General Assembly unanimously passed the Emergency or

Disaster Treatment Protection Act to provide amici's member facilities and other health care providers broad immunity from civil liability while caring for citizens of this State during Covid. The Court of Appeals erred because the plain language of the Act is unambiguous and does not require the causal link the Court of Appeals imposed; the Act should be liberally construed to fulfill its purpose; the Act's title, legislative history, and context affirm the legislature's intent to grant broad immunity for negligence during Covid, with no causation requirement; and properly pleading gross negligence requires pleading some fact that supports a legal conclusion of gross negligence. For these reasons, amici respectfully urge the Court to reverse the decision by the Court of Appeals.

Respectfully submitted on this the 31st day of July, 2024.

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The undersigned certifies that a copy of the foregoing document has been served on the following counsel of record by e-mail:

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