IN THE SUPREME COURT

OF THE STATE OF ARIZONA

ROBIN ROEBUCK, Plaintiff/Appellant/Respondent, v. MAYO CLINIC, et al., Defendants/Appellees/Petitioners.	Arizona Supreme Court No. CV-23-0262-PR Court of Appeals Division One No. 1 CA-CV 22-0508 Maricopa County Superior Court Case No. CV2021-090429

BRIEF OF *AMICUS CURIAE* ARIZONA CHAMBER FILED WITH THE WRITTEN CONSENT OF ALL PARTIES

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IDENTITY AND INTEREST OF *AMICUS CURIAE*

The Arizona Chamber of Commerce and Industry (the "ACCI") is a non-profit organization that advocates for free-market public policies and works to ensure economic growth and prosperity for all Arizonans. Its membership includes businesses operating in Arizona that wish to speak with a common voice on a range of issues relating to the ACCI's goal of creating and maintaining a predictable, fair, and efficient business environment. Many of its members are healthcare providers who participated in the State's response to the COVID-19 pandemic. The ACCI has an interest in the outcome of this case because of the qualified immunity A.R.S. § 12-516 provides to those members. Further, ACCI championed Senate Bill 1377—codified as A.R.S. §§ 12-515, -516—in Arizona's Legislature because it provides reasonable protections for responsible actors who worked tirelessly during the pandemic to assist the State. ACCI's members also provide healthcare in emergency, charity, and educational settings, and the outcome of this case could affect statutes regulating conduct in those situations.

INTRODUCTION AND SUMMARY OF ARGUMENT

For the reasons explained in Petitioners' Petition for Review and Supplemental Brief, A.R.S. § 12-516 does not offend the anti-abrogation clause. In addition, the ACCI made three arguments in its Amicus Brief in support of the Petition for Review. First, the statutory gross negligence standard of care does not offend the anti-abrogation clause because it is a contextual standard of care akin to the many alternative standards of care present in the nascent medical malpractice common law of the statehood era; second, a right of action for medical malpractice

was not clearly established in Arizona common law at statehood; and third, A.R.S. § 12-516 is a legislative extension of derivative sovereign immunity.

Here, in accord with the Court's order granting review, this brief will add to but not repeat those arguments. Specifically, it will expand on the two arguments that were more briefly addressed earlier. First, notwithstanding the argument in Respondent's Supplemental Brief, the right of action for medical malpractice was not clearly established in Arizona common law at statehood. Second, the ACCI will expand on its derivative sovereign immunity argument.

Though ACCI's arguments were not at issue in the courts below, this Court can consider them. *State v. Robertson*, 249 Ariz. 256, 258 ¶ 9 (2020). Further, this Court's most recent anti-abrogation case, *Torres v. Jai Dining Servs. (Phoenix), Inc.*, 536 P.3d 790, 796 (Ariz. 2023), had not been decided prior to the court of appeals' opinion below. *Torres* made clear that the anti-abrogation clause only preserves rights of action cognizable at the time of statehood. 536 P.3d 790 at 796.

I. A right of action for medical malpractice was not clearly established in Arizona common law at statehood.

Torres held that the anti-abrogation clause extends only to rights of action "'based in' a right cognizable at the time of statehood." *Torres*, 536 P.3d at 796. Respondent contends that the right of action for "simple or ordinary negligence" against medical providers "was established" at statehood. Resp. Supp. Br. at 10 (citing *Nunez v. Prof. Trans. Mgmt. of Tucson*, 229 Ariz. 117, 121 ¶ 19 (2012); *Acton v. Morrison*, 62 Ariz. 139, 142 (1945); and *Fowler v. Sergeant*, 1856 WL 6922, at *1 (Pa. 1865)). However, the authorities cited by Respondent did not consider the status

of Arizona law in the statehood era, and thus did not make that claim. Rather, the cases cited to common law, generally.

To start, whether *Fowler*, an opinion issued by the Supreme Court of Pennsylvania, has any bearing on Arizona's common law is answered in *Nunez.* Arizona is "not bound by decisions of other state courts in advancing our common law." *Nunez*, 229 Ariz. 117, ¶ 20. In *Nunez*, the Court considered the standard of care a common carrier owes its passengers and rejected the standard followed by "most other states." *Id.* at 121-22 ¶¶ 17-23. As in *Nunez*, whether other states recognized medical malpractice or medical negligence has no relevance to whether it was clearly established in Arizona common law at statehood. Simply put, a civil war era Pennsylvania case does not show that a right of action was established in Arizona at the time of statehood.

Similarly, *Nunez*'s proclamation that the "common law imposed upon the surgeon . . . the duty to act as a reasonable surgeon would under the circumstance" does nothing to establish medical malpractice as a remediable injury in *Arizona* common law at statehood. *Nunez*, having been post-*Boswell v. Phoenix Newspapers*, 152 Ariz. 9 (1986), but pre-*Torres*, would not have addressed that question. The Court issued *Nunez* in 2012, and *Nunez* only cites *Acton*, a 1945 case, for its proposition that a surgeon has a duty to act as a reasonable surgeon. The issue in *Acton* was whether fraud tolled a statute of limitations. 62 Ariz. at 143. It contains no discussion of whether a right of action involving medical negligence was available against medical providers at the time of statehood. It merely states the standard of care—as declared in *Butler v. Rule*, 29 Ariz. 405 (1926)—to explain the

context of the underlying claim. Accordingly, the case law proves the negative: Arizona common law did not clearly establish a standard of care for medical malpractice until 1926 in *Butler*.

To be "cognizable," a right of action and its elements must be clearly established in Arizona common law. This Court's opinion in *Flynn v. Campbell* is instructive. 243 Ariz. 76 (2017). There, the Court framed an issue as "cognizable" in the terms of the clearly established elements necessary to meet a legal standard, stating "[a] mistake—factual or legal—is cognizable under Rule 15(c) if it is not 'a deliberate choice to sue one party instead of another while fully understanding the factual and legal differences between the two parties.'" 243 Ariz. at 83. Here, the elements of medical malpractice actions were not clearly established, or cognizable, in Arizona law at statehood.

In this way a medical malpractice claim is much like the dram-shop action in *Torres* or the negligence claim in *Dickey v. City of Flagstaff*, 205 Ariz. 1, 3 ¶ 9 (2003) ("Therefore, to fall within the protection of the anti-abrogation provision of the Arizona Constitution, [Plaintiff]'s right of action for simple negligence against the City must have existed at common law or have found its basis in the common law at the time the constitution was adopted."). By failing to show that a right of action for a medical malpractice claim was clearly established by 1912, Plaintiff has failed to show a protected right of action. *See Dickey*, 205 Ariz. at 3 ¶ 9 (holding that anti-abrogation clause did not apply because plaintiff "failed to establish that a right of action for simple negligence, against a municipality engaged in a governmental

function, existed at common law"). The Court should hold that A.R.S. § 12-516 is a lawful regulation of medical malpractice claims.

II. The Court should consider the issue of whether the State extended its sovereign immunity to healthcare workers who respond to a public health crisis.

Derivative sovereign immunity is recognized in federal case law and in some states. *See, e.g.*, *Campbell-Ewald Co. v. Gomez*, 577 U.S. 153, 166-69 (2016) (discussing the limits of derivative sovereign immunity); *Yearsley v. W.A. Ross Constr. Co.*, 309 U.S. 18, 20-21 (1940); *Patterson v. City of Danville*, 875 S.E.2d 65, 69-73 (Va. 2022) (holding detention center physician had protection of derivative sovereign immunity because his employer had a constitutional and statutory duty to provide medical care); *Nettles v. GTECH Corp.*, 606 S.W.3d 726, 732 (Texas 2020) (explaining when a government contractor is extended derivative immunity); *Evans v. Mayer Tree Service, Inc.*, 162 N.E.3d 70, 71 (Mass. App. 2020) (recognizing federal derivative sovereign immunity as a defense against state tort claims). Extending sovereign immunity under common law principles is appropriate when an actor "engages in a governmental function . . . for the public welfare." *Patterson*, 875 S.E.2d at 69. In the wake of the COVID-19 public health emergency, the State had to enlist private providers to assist in prevention, response, and mitigation of the spread of the disease. As explained below, those providers acted as an extension of the government response and should enjoy the same immunity that the government would if similarly situated.

A. Extending derivative sovereign immunity is appropriate when a private party is acting on behalf of the State.

Patterson explains Virginia's well-developed conception of derivative sovereign immunity. It sets out a two-part test: (1) determine the scope of the entity's immunity; and (2) determine whether the government is functioning through its servants. *Patterson*, 875 S.E.2d at 69-70. This second step requires analyzing "four, non-exclusive factors: '(i) the nature of the function performed by the employee; (ii) the extent of the [governmental employer's] interest and involvement in the function; (iii) the degree of control and direction exercised by the [governmental employer] over the employee; and (iv) whether the act complained of involved the use of judgment and discretion.'" *Id.* at 70 (quoting *Messina v. Burden*, 321 S.E.2d 657, 663 (1984)). *Patterson* is especially pertinent here because Virginia case law in this area has developed largely in the context of medical providers.

In *Patterson*, the Virginia Supreme Court explained that providing health care to indigent patients was an essential government function that satisfied the first two factors of the second step. *Id.* at 70 (citing *Pike v. Hagaman*, 787 S.E.2d 89 (Va. 2016)). That is, providing indigent health care is both an important government interest and a natural government function. For the third and fourth factors, the court acknowledged a surface level tension between employer control and a medical provider's discretion. *Id.* at 71. In the context of a medical professional, however, the government's control must necessarily be limited to maximize the use of the employee's specialized training. *Id.* Much of a medical provider's work involves considerable discretion rather than "ministerial" work. *Id.* at 70. Nevertheless, a

medical provider still may have sovereign immunity for his professional acts when he "had no discretion to decline to accept a particular person as a patient," "[t]he clinic determined the equipment that the physician would use and the procedures that he was authorized to perform," or "was required to obey state-established rules, to employ state-prescribed methods" and to "follow state-standardized procedures." *Id.* at 71 (internal quotations omitted).

Though *Patterson* involved an employee of a local government, nothing should limit this Court from recognizing sovereign immunity for private actors. In the federal context, private parties often enjoy immunity when engaging in government functions. For example, government contractors "obtain certain immunity in connection with work which they do pursuant to their contractual undertakings with the United States." *Campbell-Ewald Co.,* 577 U.S. at 166 (quoting *Brady v. Roosevelt S.S. Co.*, 317 U.S. 575, 583 (1943)).

Private citizens engaged in public service also enjoy immunity under the common law. *See Filarsky v. Delia*, 566 U.S. 377 (2012). "Sometimes . . . private individuals will work in close coordination with public employees, and face threatened legal action for the same conduct." *Id.* at 391. Failing to protect private employees working alongside government employees—who often enjoy some sort of immunity—will leave private employees "holding the bag." *Id.* Recognizing this limited immunity for private parties performing public functions "protect[s] government's ability to perform its traditional functions." *Id.* at 389 (quoting *Wyatt v. Cole*, 504 U.S. 158, 167 (2012)) (alteration in *Filarsky*). The public interest in shielding a private actor who performs tasks for a public purpose allows

governments to use talented candidates who may otherwise decline public service. *Id.* at 391.

B. The Legislature has authority to decide the parameters of the State's sovereign immunity.

In Arizona, as in many states, the legislature has authority to codify the scope of its sovereign immunity. *See Clouse v. State*, 199 Ariz. 196, 199 ¶ 14 (2001) ("The legislature's decision to codify the doctrine of sovereign immunity was consistent with the approach taken in other jurisdictions."). In *Clouse*, the Court held that the immunity clause gave the legislature the power to require a plaintiff prove gross negligence for failing to retain a criminal suspect. *Id.* at 198 ¶ 5. Further, *Clouse* explicitly explained the relationship between the immunity clause and the anti-abrogation clause. The immunity clause, found in article IV, part 2, section 18 of the Arizona Constitution, is a specific legislative power and "applies only and specifically to 'suits brought against the state.'" *Id.* at 199 ¶ 11. The anti-abrogation clause is a general clause that broadly applies to "the right of action to recover damages for injuries." *Id.* When there is a conflict, the specific provision of the immunity clause controls over the general provision in the anti-abrogation clause. *Id.*

In considering whether the legislature could extend this "qualified immunity" under the immunity clause, the Court surveyed other states with similar constitutional provisions: "As far as we can determine, every jurisdiction that has construed such a constitutional immunity clause has held that the provision gives the legislature authority to determine the scope of governmental immunity." *Id.* at 200

¶ 18. Arizona, along with many other states, "abolished the judicially-created doctrine of sovereign immunity." *Id.* But many of those same states allowed the legislature to reinstate some form of immunity under their similar immunity clauses. *Id.* That is exactly what is happening here.

The Arizona Supreme Court abolished total sovereign immunity in 1963. *Stone v. Arizona Highway Comm.*, 93 Ariz. 384 (1963). After *Stone*, the State had immunity "only when necessary to avoid severely hindering a governmental function or thwarting an established public policy." *Smyser v. City of Peoria*, 215 Ariz. 428, 433 ¶ 11 (App. 2007). The Court recognized that the legislature would play the dominant role in shaping the state's immunity. *Ryan v. State*, 134 Ariz. 308, 310 (1982) ("We do not recoil at the thought that the legislature may in its wisdom wish to intervene in some aspects of this development."). And the legislature has acted to do just that, adopting numerous statutes in response to the Court's invitation. *See Clouse*, 199 Ariz. at 199 ¶ 13 (citing A.R.S. §§ 12-820-826); *see also Dickey*, 205 Ariz. 1, 3-5 ¶¶ 8-18 (holding that Arizona's recreational use statute, A.R.S. § 33-1551, did not violate the anti-abrogation clause). In other words, the right to sue the state is a matter of "legislative grace." *Clouse*, 199 Ariz. at 201 ¶ 17 (citing *Haddendam v. Washington*, 550 P.2d 9, 12 (Wash. 1976)).

C. A.R.S. § 12-516 grants Petitioners immunity in this case.

Like the statutes discussed in *Clouse* and *Dickey*, A.R.S. § 12-516 offers limited immunity. It applies only to health care providers and institutions that assist *the State's response* to a declared state of emergency for a public health pandemic.

A.R.S. § 12-516(A). The Court should view the statute as an extension of the State's sovereign immunity.

During the COVID-19 public health emergency, private providers and hospitals were conscripted to support the State's response. The State's directives to health care workers and institutions began on March 19, 2020, when the Governor implemented a ban on elective surgeries to preserve personal protective equipment. Governor Douglas A. Ducey, State of Arizona Executive Order 2020-10 (March 19, 2020). The State soon after made healthcare and public health operations an "essential function." Governor Douglas A. Ducey, State of Arizona Executive Order 2020-12 (March 23, 2020). The same day, the Governor required healthcare providers to submit reports regarding the spread of COVID-19 to the Arizona Department of Health Services and promised that providers acting in good faith would be protected from criminal and civil liability. Governor Douglas A. Ducey, State of Arizona Executive Order 2020-13 (March 23, 2020).

The State's control over the pandemic response only escalated from there. The State passed H.B. 2668, which increased provider rates for hospitals and doctors participating in the Arizona Health Care Cost Containment System. The State also required insurance companies to expand telemedicine coverage, and mandated that hospitals increase their bed capacity, optimize staffing, and activate their facility emergency plans. Governor Douglas A. Ducey, Sate of Arizona Executive Order 2020-16 (March 26, 2020). Governor Ducey also recognized the State's "compelling need to maximize participation of medical providers and health care facilities in treating COVID-19 patients to ensure Arizonans have access to treatment when

needing." Governor Douglas A. Ducey, State of Arizona Executive Order 2020-27 (April 9, 2020). Executive Order 2020-27, titled "The 'Good Samaritan' Order: Protecting Frontline Healthcare Workers Responding to the COVID-19 Outbreak," recognized the State needed help from all health professionals and health care institutions and offered them limited immunity when responding to the COVID-19 public health emergency. *Id.* The legislature later codified these protections in A.R.S. § 12-516.

The State of Arizona even coordinated patient care and transfers. Among other things, they set up a "Surge Line" to mandate the transfer and treatment of COVID-19 patients to the appropriate level of care. Governor Douglas A. Ducey, State of Arizona Executive Order 2020-38 (May 28, 2020). The Surge Line executive order required hospitals to use the line to transfer patients to facilities outside their healthcare system. *Id.* It also required facilities to accept and transfer patients at the Surge Line's direction and required insurance companies to cover out-of-network healthcare costs at in-network rates if a patient's transfer was facilitated by the Surge Line. *Id.*

All that to say, the State's response to the Public Health Emergency caused by the COVID-19 pandemic comprehensively engaged healthcare providers and facilities in Arizona. The State's pandemic response necessarily required the assistance of medical personnel to care for patients suffering from an illness with no known cure or approved treatments. To further the public interest of increasing the availability of medical providers and medical facilities, the state extended to these healthcare workers its limited sovereign immunity: "[I]t is in the public interest to

afford [health professionals] protection against liability for their good faith efforts to provide assistance in response to the state's *need* to supplement the healthcare workforce[.]" Governor Douglas A. Ducey, Sate of Arizona Executive Order 2020-27 (April 9, 2020) (emphasis added).

If this Court considers accepting here the legislature's grant of derivative sovereign immunity, Virginia's conception of derivative sovereign immunity is helpful. The first step is determining the scope of the immunity offered by A.R.S. § 12-516. *See Patterson*, 875 S.E.2d at 69-70. There is no real dispute that by its terms, A.R.S. § 12-516 would apply to Petitioners. Petitioners are healthcare providers who treated COVID-19 patients in the midst of the public health emergency. Accordingly, the only question should be whether Petitioners were functioning as an arm of the government when they did so. The answer is yes.

Again, the four non-exclusive factors used by Virginia are helpful here: "(i) the nature of the function performed by the employee; (ii) the extent of the [governmental employer's] interest and involvement in the function; (iii) the degree of control and direction exercised by the [governmental employer] over the employee; and (iv) whether the act complained of involved the use of judgment and discretion." *Patterson*, 875 S.E.2d at 70 (quoting *Messina*, 321 S.E.2d at 663 (1984)). The nature of Petitioners' work and the State's interest is easily met. Petitioners were an integral part of the state-wide and state-led response to the COVID-19 Public Health Crisis. Undoubtedly, the State had an interest in all pandemic health-care delivery, including Petitioners' treatment of Respondent.

The third and fourth factors are also met. Medical providers act under government control when they are legally compelled to accept a patient. That is precisely what happened here, as health care providers and facilities raced to support the Government response to the COVID-19 pandemic. The government even directed hospitals in how to maximize bed capacity, address staffing needs, and optimize its facility in order to treat as many patients as possible.

In practical terms, the public health emergency turned the common law on its head. Under common law generally, a person who voluntarily undertakes services for the protection of another is liable for the failure to exercise reasonable care if he causes harm. *See, e.g.*, *Guerra v. State*, 237 Ariz. 183, 185 ¶ 9 (2015) (quoting Restatement (Second) of Torts § 323 (1965)). Importantly, common law afforded that person a *choice* about whether to undertake services in the first instance. During the Public Health Emergency, the State, in the name of furthering its response to the COVID-19 pandemic, left health care providers and facilities with no choice. Affected healthcare workers were thrust into caring for patients because they were "need[ed]" for the state to respond effectively. Governor Douglas A. Ducey, Sate of Arizona Executive Order 2020-27 (April 9, 2020). In exchange, the State extended its sovereign immunity to the necessary providers through A.R.S. § 12-516.

CONCLUSION

A right of action for medical negligence was not clearly established in Arizona common law at statehood, and the legislature is free to regulate it. Additionally, during the COVID-19 Public Health Emergency, the state government took unprecedented steps to enlist health professionals and health care institutions in its

response to the disease. The state issued a multitude executive orders and passed legislation that controlled how private entities were required to assist in prevention, mitigation, and treatment of COVID-19. In exchange, the state offered these providers limited immunity. The Court should reverse the court of appeals and hold that A.R.S. § 12-516 is constitutional.

RESPECTFULLY SUBMITTED this 15th day of October, 2024.

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