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Responders' Responsibility: Liability and Immunity in Public Health Emergencies

SHARONA HOFFMAN*

Many experts predict the advent of a public health emergency resulting from a flu pandemic or bioterrorism attack in the foreseeable future. At the same time, many health care providers express significant concern about liability arising from emergency response activities, as it is unlikely that they would be able to provide optimal care in crisis conditions. They also state that this concern will likely influence their willingness to be involved in response activities. This Article addresses issues that have received little attention in the legal literature: liability and immunity in public health emergencies. The Article provides a first-of-its-kind comprehensive analysis of the different theories of liability that might be used by plaintiffs and the sources of immunity that are currently available to public health emergency responders. I will argue that the existing immunity scheme is a patchwork that leaves many gaps and unanswered questions. In particular, it largely excludes paid individual and corporate health care providers who may bear the greatest burden during a public health emergency as hundreds or thousands of patients simultaneously seek medical treatment. The specter of liability may induce these parties to refuse to participate in emergency response efforts, and the unavailability of immunity could thus significantly compromise public welfare. Moreover, the risk of liability raises questions of justice because, unlike their more risk-averse counterparts, those that do treat patients, perhaps at great risk to their own health, would face potential liability rather than be rewarded for their altruism or professionalism. Consequently, the Article will craft recommendations for statutory reforms to remedy the piecemeal and deficient liability protection system that applies to health care providers responding to public health emergencies.

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* Senior Associate Dean for Academic Affairs, Co-Director of Law-Medicine Center, Professor of Law, and Professor of Bioethics, Case Western Reserve University School of Law. Wellesley College, B.A.; Harvard Law School, J.D.; University of Houston, LL.M. in Health Law. © 2008, Sharona Hoffman. Professor Hoffman served as a Guest Researcher at the Centers for Disease Control and Prevention's (CDC) Public Health Law Program from January through April 2007. I would like to thank Jessica Berg, Jonathan Entin, Rick Goodman, Jacqui Lipton, Tony Moulton, Andy Podgurski, Jennifer Ray, Dan Stier, and Lisa Thombly for their comments on previous drafts. Earlier versions of this paper were presented at a CDC Public Health Law Symposium, an informal lunch at the University of Virginia School of Law, the Cities Readiness Initiative Regional Meeting in Dallas, Texas, and the AMA/CDC Second National Congress on Health System Readiness in Washington, D.C. I am grateful for the comments and suggestions I received during those presentations. The opinions expressed in this Article are mine alone.

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INTRODUCTION

According to many experts, an influenza pandemic will likely develop in the foreseeable future, and it could sicken or kill tens of millions of people worldwide if appropriate interventions are not implemented.¹ In addition, in the wake of 9/11, the anthrax exposures, and Hurricane Katrina, it is painfully evident that bioterrorist attacks and natural disasters can also cause public health emergencies of significant proportions. Consequently, federal and state governmental agencies, such as the Centers for Disease Control and Prevention (CDC) and state public health departments, have undertaken major emergency planning initiatives.² These include extensive training and educational programs

1. See Jeffrey K. Taubenberger et al., *The Next Influenza Pandemic*, 297 JAMA 2025, 2025 (2007) (stating that “most experts believe another influenza pandemic will occur”); Jeff Nesmith, *Group: Pandemic Could Cost U.S. \$683 Billion*, ATLANTA J.-CONST., Mar. 23, 2007, at C1, C3 (reporting on a study that “assumed that a bird flu outbreak would kill 2 million Americans and sicken 30 percent of the population”); Gretchen Reynolds, *The Flu Hunters*, N.Y. TIMES MAG., Nov. 7, 2004, at 37, 39 (noting “the assumption that another pandemic is inevitable” and the fact that the 1918 flu pandemic killed between 20 and 50 million people internationally and 500,000 in the United States); Homeland Security Council, *National Strategy for Pandemic Influenza Implementation Plan 1* (May 2006), available at http://www.whitehouse.gov/homeland/nspi_implementation.pdf (stating that “it is projected that a modern pandemic could lead to the deaths of 200,000 to 2 million people in the United States alone”); U.S. Dep’t of Health & Human Servs., *HHS Pandemic Influenza Strategic Plan 18* (2005), available at <http://www.hhs.gov/pandemicflu/plan/pdf/part1.pdf> (assuming that in case of a pandemic disease, “the clinical disease attack rate will be 30% in the overall population”).

2. See Public Health Security and Bioterrorism Preparedness and Response Act of 2002, Pub. L. No. 107-188, 116 Stat. 594 (codified as amended in scattered sections of 42 U.S.C.), amended by Pandemic and All-Hazards Preparedness Act, Pub. L. No. 109-417, 120 Stat. 2831 (2006) (establishing grants for state and local governments to undertake activities designed to enhance public health emergency preparedness); Centers for Disease Control and Prevention, Public Health Law Program, <http://>

that often involve major professional organizations and academic centers.³

Public health emergencies raise acute concerns about liability for health care professionals.⁴ In a recent survey designed by the American Public Health Association, almost sixty percent of clinicians indicated that having medical malpractice insurance coverage would be important (24.3%) or essential (35.4%) to their decision to travel out of state to provide assistance during an emergency.⁵ Almost seventy percent of respondents answered that immunity from civil lawsuits would be an important (35.6%) or essential (33.8%) factor when considering whether to volunteer in an emergency.⁶ Indeed, even if a defendant is ultimately found not to be liable and prevails in court, the financial, emotional, and reputational costs of litigation can be devastating regardless of the outcome.⁷

Although a variety of sources of immunity currently exist, they constitute a patchwork that leaves many gaps and unanswered questions.⁸ This Article will explore the contemporary immunity scheme and highlight its deficiencies.⁹ In particular, it will focus on an often ignored segment of the responder population: paid workers and entities that contribute to response efforts.¹⁰ These include, among others, hospitals, clinics, and their employees, who might be inundated with hundreds or thousands of patients at the height of a crisis. Although these parties may bear the brunt of response duties, little if any immunity is available to them because immunity statutes primarily cover governmental responders and individual volunteers.¹¹ The Article will argue that the

www2a.cdc.gov/phlp/about.asp (describing the emergency preparedness goals of the CDC's Public Health Law Program).

3. See, e.g., AMA/CDC Second National Congress on Health System Readiness, <http://www.ama-assn.org/ama/pub/category/17239.html> (conference that took place in Washington, D.C. in July 2007); CDC Public Health Law Program, Public Health Emergency Law & Forensic Epidemiology Training, <http://www2.cdc.gov/phlp/phep.asp> (offering training concerning a variety of legal topics including "Protection of People" and "Management of Property"); University of Minnesota Center for Public Health Preparedness, Free Online Trainings and Resources, <http://www.sph.umn.edu/umncphp/phep.html> (offering computer training modules that include the topics of disease surveillance and investigation, contact investigation, isolation and quarantine, and special populations).

4. See Janelle A. Rhyme, *Likely Ethical, Legal, and Professional Challenges Physicians Will Face During an Influenza Pandemic*, 68 N.C. MED. J. 51, 52 (2007) (listing the need for liability protection as one of the "concerns that may contribute to a physician's reluctance to provide care in a health crisis situation").

5. See *Prefatory Note* to UNIF. EMERGENCY VOLUNTEER HEALTH PRACTITIONERS ACT 4 (Nat'l Conference of Comm'rs on Unif. State Laws, Current Draft for Consideration Concerning Reserved Sections 11 and 12, 2007) (on file with author) (discussing electronic survey sent to 10,000 American Public Health Association (APHA) members, to which 1077 individuals responded).

6. *Id.*

7. Tim Cramm et al., *Ascertaining Customary Care in Malpractice Cases: Asking Those Who Know*, 37 WAKE FOREST L. REV. 699, 715-16 (2002) (noting malpractice litigation's psychological toll on physicians).

8. See *infra* Parts III & IV.

9. See *infra* Parts III & IV.

10. See *infra* section IV.C.

11. See *infra* Parts III & IV.

exclusion of paid workers and entities from immunity protection is imprudent because it creates barriers to effective emergency response initiatives. Furthermore, it raises important questions of justice. While some health care providers may refuse to participate in response activities because of liability concerns,¹² those who do treat patients, perhaps at great risk to their own health, would face potential liability rather than be rewarded for their altruism or professionalism. This Article will offer recommendations to remedy the piecemeal, incomplete, and confusing nature of the existing immunity scheme.¹³

A public health emergency can be defined as the occurrence of a health condition or imminent threat of illness posing a high likelihood of a large number of deaths, serious or long-term disabilities, or other significant harm to a substantial number of people that is believed to be caused by (1) bioterrorism; (2) a novel, or previously controlled or eliminated, infectious or biological agent; (3) a natural disaster; (4) an accidental chemical release or a chemical attack; or (5) a nuclear accident or attack.¹⁴ This definition excludes small-scale events such as an isolated tornado that might impact the health of a local community to a more limited degree. A natural disaster such as Hurricane Katrina, however, might lead to a public health emergency if it threatens or causes the outbreak of widespread illness.

In order to meet medical needs that will arise during a public health emergency, the health care profession will have to achieve surge capacity.¹⁵ Doing so will involve volunteers, health care professionals, public and private hospitals and clinics, vaccine manufacturers, governmental authorities, and many others.

Operating in emergency circumstances, however, is likely to give rise to numerous issues of liability for health care providers. Providers may face inadequate resources, an insufficient number of qualified personnel, overwhelming demand for services, and other obstacles stemming from the natural or man-made disaster that caused the emergency.¹⁶ In this environment, caregivers may not be able to adhere to normal treatment procedures.¹⁷ They may be forced to provide less-than-optimal services to many patients, which could lead

12. See *supra* notes 4–7 and accompanying text (discussing a survey of health care providers that focused on clinicians' concerns about liability).

13. See *infra* Part V.

14. MODEL STATE EMERGENCY HEALTH POWERS ACT § 104(m) (Ctr. for Law & the Public's Health, Discussion Draft 2001), available at <http://www.publichealthlaw.net/MSEHPA/MSEHPA.pdf>.

15. See generally James G. Hodge, Jr. et al., *The Legal Framework for Meeting Surge Capacity Through the Use of Volunteer Health Professionals During Public Health Emergencies and Other Disasters*, 22 J. CONTEMP. HEALTH L. & POL'Y 5 (2005). The authors define "surge capacity" as "the number of critical casualties arriving per unit of time that can be managed without compromising the level of care." *Id.* at 7.

16. See HEALTH SYS. RESEARCH, INC., ALTERED STANDARDS OF CARE IN MASS CASUALTY EVENTS 1 (2005), available at <http://www.ahrq.gov/research/altstand/altstand.pdf> [hereinafter ALTERED STANDARDS OF CARE] (stating that mass casualty events "could compromise, at least in the short term, the ability of local or regional health systems to deliver services consistent with established standards of care").

17. See *infra* note 62 and accompanying text for discussion of the standard of care in emergency situations.

to injury or even death in some cases.¹⁸

If the purpose of liability is to deter misconduct and provide compensation for injured parties,¹⁹ what standards of liability should apply in a public health emergency? Is it appropriate to provide full or limited immunity to various parties? As noted by Daniel Sokol, a British medical ethicist, “[i]n light of the potentially catastrophic impact of avian influenza on human health and economic well-being, this topic [duty of care] should engender a burst of activity and debate in hospitals, universities, and medical journals.”²⁰

This Article will focus on liability and immunity relating only to health care providers. While many parties may be involved in emergency response, including transportation workers, food suppliers, rescuers, and others, health care providers have unique skills, qualifications, and licensing requirements. These, in turn, can generate particular concern about liability and litigation, which may justify immunity for public policy reasons. The Article’s recommendations will also focus only on declared public health emergencies. Although other declared²¹ and undeclared emergencies may give rise to similar concerns, these types of emergencies vary widely in scope and circumstance, and are thus less conducive to blanket immunity provisions. For example, a tornado might destroy a residential area and a hospital, but other health care providers in the region will be able to address adequately the medical needs of affected individuals. A far-reaching immunity scheme is therefore not justified for such a scenario.

The Article proposes a comprehensive approach to immunity for health care providers who serve as public health emergency responders to replace the piecemeal scheme that currently exists.²² It thus responds to the demand for legal reform that has been voiced by health care providers.²³ The Article will suggest that the federal and state public health emergency response statutes be amended to fully address the issue of immunity for public and private sector employees, whether they be paid or volunteers, as well as for entities that are health care providers and are involved in response activities.

18. See HHS Pandemic Flu Plan, Executive Summary, <http://www.hhs.gov/pandemicflu/plan/overview.html> (stating that “it is unlikely that there will be sufficient personnel, equipment, and supplies” during a pandemic flu).

19. See W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS 5 (5th ed. 1984) [hereinafter PROSSER & KEETON] (stating that the purpose of the law of torts is “directed toward the compensation of individuals”); STEVEN SHAVELL, FOUNDATIONS OF ECONOMIC ANALYSIS OF LAW 268 (2004) (“Reduction of risk through deterrence of harm is the true purpose of liability today, but compensation and avoidance of strife were also important historically.”).

20. Daniel K. Sokol, *Virulent Epidemics and Scope of Healthcare Workers’ Duty of Care*, 12 EMERGING INFECTIOUS DISEASES 1238, 1240 (2006), available at <http://www.cdc.gov/ncidod/EID/vol12no08/pdfs/06-0360.pdf>.

21. For a discussion of different types of emergencies, see *infra* notes 28–54 and accompanying text.

22. See *infra* section V.B.

23. INST. OF MED., ETHICAL AND LEGAL CONSIDERATIONS IN MITIGATING PANDEMIC DISEASE 13, 65, 71 (2007), available at <http://www.nap.edu/catalog/11917.html> (emphasizing the need for liability protection in the event of a pandemic disease outbreak).

The proposal is designed to balance the needs of disaster victims with those of responders and the best interests of society at large. It aims to encourage involvement in response efforts without excusing gross negligence and intentional misconduct. In addition, the proposal is designed to control the volume of litigation in the aftermath of a public health emergency. In such emergencies, many if not most patients would be treated in sub-optimal conditions and would thus not receive the level of care that they could ordinarily expect. Litigation restrictions could help control court dockets and prevent malpractice insurance costs from rising dramatically because health care providers would not be inundated by lawsuits for which insurers would have to pay. Finally, the proposal aims to regulate the quality of treatment available during public health emergencies by addressing the degree to which volunteers should be subject to oversight and the extent to which licensure requirements should be enforced during emergencies. The need for widespread availability of care is thus weighed against the importance of providing responsible medical attention.²⁴

The Article will proceed as follows. Part I will discuss federal and state declarations of emergency and describe the various parties whose likely involvement in public health emergency response activities will make them vulnerable to liability.

Parts II and III provide a first-of-its-kind comprehensive survey of the laws of liability and immunity that apply to public health emergencies. This survey will offer a valuable tool for policymakers, lawyers, and public health officials who are preparing for and implementing public health emergency responses. Part II will examine a variety of causes of action that might be asserted by disaster victims, and Part III will survey sources of liability protection that are currently found in federal and state law.

Beyond thoroughly surveying existing law, the Article provides significant synthesis, analysis, and original recommendations. Part IV will synthesize the contemporary immunity scheme and argue that it leaves considerable gaps and uncertainties. Part V will analyze the ethical objectives of legal liability and the incentives and disincentives that should be incorporated into immunity statutes. It will also offer detailed recommendations for legislative changes in the form of a comprehensive statutory immunity provision that promotes human welfare and ethical conduct in the unique circumstances of public health emergencies.

I. SETTING THE STAGE: DECLARATIONS OF EMERGENCY AND EMERGENCY RESPONDERS

Because this Article addresses liability and immunity in public health emergencies, it is important to establish what a public health emergency is, how it differs from other types of emergencies, what formal actions are taken to declare states of emergency, and who is expected to respond to public health emergencies.

24. See *infra* section V.A.

This Part analyzes these issues.

A. DECLARATIONS OF EMERGENCY

Public health emergencies raise acute concerns for health care providers regarding liability. Natural and man-made disasters are formalized as emergencies upon a declaration by a governmental authority. Emergencies can be declared at both the federal and state levels by the President of the United States, the Secretary of the U.S. Department of Health and Human Services (HHS), a state governor, and sometimes by other local authorities.²⁵ In some cases general emergencies are declared, and in other instances public health emergencies are declared pursuant to specific statutory provisions.²⁶ Declarations of emergency allow governmental authorities to exercise special powers and to suspend certain legal requirements that would be excessively burdensome.²⁷ Consequently, such declarations are often essential to achieving effective emergency responses.

1. Federal Declarations of Emergency

The President can declare an emergency or a major disaster in accordance with the Robert T. Stafford Disaster Relief and Emergency Assistance Act (Stafford Act).²⁸ A federal declaration of emergency may be triggered by a governor's request, when a governor represents that "the situation is of such severity and magnitude that effective response is beyond the capabilities of the State and the affected local governments and that Federal Assistance is necessary."²⁹ The President may also declare a federal emergency in cases involving an area in which "the United States exercises exclusive or preeminent responsibility and authority."³⁰ Such an emergency was declared by President Clinton after the bombing of the Alfred P. Murrah Federal Building in Oklahoma City in 1995.³¹ The President may also declare a major disaster when asked to do so by a governor upon a finding that the "disaster is of such severity and magnitude that effective response is beyond the capabilities of the State."³²

Furthermore, the President may declare an emergency under the National Emergencies Act.³³ While the law does not specify the circumstances under which an emergency might be declared, one commentator reports that Presi-

25. MARC ROBERTS ET AL., *MASS MEDICAL CARE WITH SCARCE RESOURCES* 27–29 (2007) [hereinafter *MASS MEDICAL CARE*], <http://www.ahrq.gov/research/mce/mceguide.pdf>.

26. *Id.* at 27–28.

27. *See infra* notes 39–47 and accompanying text.

28. 42 U.S.C. §§ 5121–5206 (2000).

29. *Id.* § 5191(a).

30. *Id.* § 5191(b).

31. Letter from President William J. Clinton to James Lee Witt, Federal Emergency Management Agency Director (Apr. 19, 1995), *available at* http://frwebgate.access.gpo.gov/cgi-bin/getpage.cgi?dbname=1995_public_papers_vol1_misc&page=553&position=all.

32. 42 U.S.C. § 5170.

33. 50 U.S.C. § 1621 (2000).

dents declared thirty-eight national states of emergency under the Act between 1976 and mid-2004.³⁴ One such emergency was declared by President Bush on September 14, 2001, after the 9/11 attacks.³⁵

The Public Health Service Act allows the HHS Secretary to declare a public health emergency in case of a disease, disorder, or bioterrorist attack that justifies such a declaration.³⁶ A “Determination that a Public Health Emergency Exists” was made by the Secretary both on September 11, 2001,³⁷ and on August 31, 2005, in the wake of Hurricane Katrina.³⁸

Under section 1135 of the Social Security Act, which is also section 143(a) of the Public Health Security and Bioterrorism Preparedness and Response Act of 2002,³⁹ the Secretary may waive or modify certain legal requirements that apply to health care providers furnishing goods or services in an emergency area.⁴⁰ Section 1135 waivers are authorized for a limited duration⁴¹ if the Secretary has declared a public health emergency under the Public Health Services Act and the President has also declared an emergency or disaster pursuant to the National Emergencies Act or the Stafford Act.⁴² On September 4, 2005, for example, in response to Hurricane Katrina, the Secretary of HHS issued a waiver relating to five categories of legal requirements.⁴³ The waiver addressed the following: (1) certain conditions of participation in Medicare, Medicaid, and the State Children’s Health Insurance Program (SCHIP); (2) state licensure requirements; (3) sanctions under the Emergency Medical Treatment and Active Labor Act (EMTALA); (4) Medicare Advantage patients’ use of out-of-network providers; and (5) sanctions under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy regulations.⁴⁴

34. Kim Lane Scheppelle, *Small Emergencies*, 40 GA. L. REV. 835, 843–44 (2006).

35. Proclamation No. 7463, 66 Fed. Reg. 48,199 (Sept. 18, 2001).

36. 42 U.S.C. § 247d(a) (2000 & Supp. II 2002).

37. Tommy G. Thompson, Secretary, Dep’t of Health and Human Servs., *Determination that a Public Health Emergency Exists* (Sept. 11, 2001) (on file with author).

38. Michael O. Leavitt, Secretary, Dep’t of Health and Human Servs., *Determination that a Public Health Emergency Exists* (Aug. 31, 2005) (on file with author).

39. See Pub. L. No. 107-188, § 143(a), 116 Stat. 594, 627–29 (2002) (codified at 42 U.S.C. § 1320b-5 (Supp. IV 2004)).

40. 42 U.S.C. § 1320b-5 (Supp IV 2004). The requirements relate to the Medicare, Medicaid, and SCHIP programs; state licensure requirements; EMTALA; and the HIPAA Privacy Rule. *Id.* § 1320b-5(b); see also Elizabeth Weeks, *After the Catastrophe: Disaster Relief for Hospitals*, 85 N.C. L. REV. 223, 249–50 (2006) (discussing the suspension of various legal requirements in the aftermath of Hurricane Katrina).

41. 42 U.S.C. § 1320b-5(e).

42. *Id.* § 1320b-5(g)(1).

43. Michael O. Leavitt, Secretary, Dep’t of Health and Human Servs., Waiver Under Section 1135 of the Social Security Act (Sept. 4, 2005), <http://www.hhs.gov/katrina/ssawaiver.html>.

44. *Id.* For a brief discussion of EMTALA and HIPAA, see *infra* sections II.B.3 and II.G. Section 1135 also allows the Secretary to waive sanctions under the Stark self-referral law, which prohibits physicians from referring patients to any entity in which they or their immediate family members have an ownership interest or with which they have other financial relationships. See 42 U.S.C. § 1320b-5(b)(4) for the waiver provision and 42 U.S.C. § 1395nn for the Stark self-referral law. These

2. State Declarations of Emergency

Some states have public health emergency statutes that authorize the governor to declare a public health emergency.⁴⁵ Typically, the statutes provide the governor or state public health authorities with a variety of powers once a public health emergency has been declared.⁴⁶ These may include the power to (1) suspend statutory provisions relating to state business or the rules and regulations of state agencies, as necessary; (2) use all available state and local resources for emergency response purposes; (3) change the functions of state governmental agencies, as needed; (4) mobilize the state militia; (5) provide and seek aid in cooperation with other states pursuant to relevant interstate emergency compacts; and (6) seek aid from the federal government.⁴⁷

Following the 9/11 attacks, the Centers for Law and the Public's Health at Georgetown University and Johns Hopkins University drafted the Model State Emergency Health Powers Act (MSEHPA) at the request of the CDC.⁴⁸ According to the Center, as of July 15, 2006, thirty-seven states and the District of Columbia had incorporated at least some parts of the model act or closely related provisions into their state laws.⁴⁹

States whose laws do not specifically address public health emergencies can declare general emergencies.⁵⁰ Every state has developed a process for declaring a general emergency or disaster.⁵¹ In some cases, governors may issue dual declarations, declaring a general emergency first and a public health emergency subsequently.⁵² Dual declarations, however, may lead to some confusion and complications if procedures or powers with respect to the two types of emergen-

modifications facilitate fast and efficient patient treatment in an emergency and relieve providers of worry concerning penalties for technical violations of various legal requirements.

45. See, e.g., LA. REV. STAT. ANN. § 29:766A (2007); N.J. STAT. ANN. § 26:4-2 (West 2007); S.C. CODE ANN. § 25-1-440(a) (2007). For a list and summary of different states' definitions of "public health emergency" see Dep't of Health & Human Servs., Health Res. and Servs. Admin., *Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP)—Legal and Regulatory Issues*, app. A at 74–78 (Draft Report, May 2006) [hereinafter *ESAR-VHP*], available at [ftp://ftp.hrsa.gov/bioterror/May_06_Legal_Report.pdf](http://ftp.hrsa.gov/bioterror/May_06_Legal_Report.pdf).

46. See, e.g., GA. CODE ANN. §38-3-22 (1995 & Supp. 2007); S.C. CODE ANN. § 25-1-440 (2007); see also MODEL STATE EMERGENCY HEALTH POWERS ACT § 403(a) (Ctr. for Law & the Public's Health, Discussion Draft 2001), available at <http://www.publichealthlaw.net/MSEHPA/MSEHPA.pdf>.

47. See *supra* note 46.

48. See MODEL STATE EMERGENCY HEALTH POWERS ACT § 104(m) (Ctr. for Law & the Public's Health, Discussion Draft 2001), available at <http://www.publichealthlaw.net/MSEHPA/MSEHPA2.pdf>.

49. See Center for Law and the Public's Health, Model State Public Health Laws, <http://www.publichealthlaw.net/Resources/Modellaws.htm>. The states are: Alabama, Alaska, Arizona, California, Connecticut, Delaware, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Louisiana, Maine, Maryland, Minnesota, Missouri, Montana, Nevada, New Hampshire, New Jersey, New Mexico, North Carolina, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Wisconsin, and Wyoming, as well as the District of Columbia.

50. *ESAR-VHP*, *supra* note 45, at 24–25. For a list of state laws and their definitions of "emergency" or "disaster," see *id.* app. B at 79–89.

51. MASS MEDICAL CARE, *supra* note 25, at 27.

52. *Id.*; *ESAR-VHP*, *supra* note 45, at 25–26.

cies are inconsistent.⁵³ In addition, in some jurisdictions, other authorities, such as the state department of health or a local executive officer, can declare an emergency.⁵⁴

B. EMERGENCY RESPONDERS

Numerous parties might be involved in emergency response, and each of them could be vulnerable to liability. Some of the key participants are likely to be the following:

- *Hospitals*: Hospitals will treat patients in their own wards and emergency rooms and might establish satellite operations in other locations, such as stadiums.
- *Health Care Professionals*: Health care providers, such as doctors, nurses, physician assistants, and other clinicians will provide services at their places of employment or other sites to which they are assigned.
- *Volunteers*: Health care workers from unaffected areas might travel to affected locations and volunteer their assistance. Retirees, students, and others with some medical training might also wish to assist in providing treatment during a public health emergency. While many will work through volunteer registries,⁵⁵ nonprofit organizations, or state agencies, some volunteers might rush to the scene and try to operate independently.⁵⁶
- *Volunteer Coordinators and Registry Operators*: Entities that host or coordinate volunteers, such as the Red Cross or volunteer registry operators, could play a key role in emergency response. Volunteer coordinators will supply and supervise volunteers, and registry operators, such as those associated with the Health Resources and Services Administration's Emergency System for Advanced Registration of Volunteer Health Professionals (ESAR-VHP), will register volunteer respond-

53. *ESAR-VHP*, *supra* note 45, at 25–26; *MASS MEDICAL CARE*, *supra* note 25, at 28.

54. *See, e.g.*, COLO. REV. STAT. § 24-32-2109 (2006) (authorizing the principal executive officer of a local political subdivision to declare a “local disaster emergency”); MO. REV. STAT. § 192.460 (2000) (addressing radiation control and providing that when the Department of Health “finds an emergency exists requiring immediate action to protect the public health or welfare, it may issue an order reciting the existence of an emergency and requiring that such action be taken as it deems necessary to meet the emergency”).

55. *See* James G. Hodge, Jr. et al., *Risk Management in the Wake of Hurricanes and Other Disasters: Hospital Civil Liability Arising from the Use of Volunteer Health Professionals During Emergencies*, 10 MICH. ST. J. MED. & L. 57, 60–61 (2006) (explaining that “[t]hese state-based electronic systems seek to pre-qualify volunteers through advance verification of their credentials, licenses, accreditations, and hospital privileges”).

56. *See* Memorandum from Ctr. for Law and the Public's Health, *Hurricane Katrina and Rita Responses—Legal Lessons*, <http://www.publichealthlaw.net/Research/PDF/Katrina%20-%20Legal%20Lessons%20Learned.pdf> (outlining and analyzing some of the legal challenges related to “the deployment and utilization of volunteer health professionals”).

ers and verify their credentials.⁵⁷ In the aftermath of Hurricane Katrina, the ESAR-VHP enabled twenty-one states to send 8300 health professionals to assist in response efforts.⁵⁸

- *Federal, State, and Local Entities, Officials, and Employees:* Federal, state, and local authorities, such as public health departments and their employees, will be involved in decisionmaking concerning various aspects of emergency response, including the distribution of scarce resources, implementation of quarantine orders, and other matters. Public employees, such as CDC workers, might also provide medical assistance, conduct rescue operations, and perform other tasks.
- *Producers of Vaccines and Other Medical Supplies:* Vaccine manufacturers and producers of other drugs, devices, and biologics could be asked to greatly accelerate their rate of production in response to demand during an emergency. Such acceleration could compromise the producers' ability to comply with ordinary Food and Drug Administration (FDA) protocols.⁵⁹

Emergencies can be declared by the government in a variety of circumstances, and they can involve a multitude of responders from different segments of society and the workforce. It can be anticipated that in the chaos of an emergency, some of the care provided will be sub-optimal and some of the measures taken will be greeted with hostility and challenged in court. Consequently, it is appropriate to focus on potential theories of litigation, available immunity, and the extent to which concerns about liability could affect response activities and health outcomes.

II. POTENTIAL CAUSES OF ACTION

Once a public health emergency is declared, the various responders described above will be expected to spring into action. They may, however, be reluctant to do so because of the prospect of litigation, as plaintiffs might bring a large number of causes of action against responders in the aftermath of a public health emergency. Although negligence may be the first theory of liability to

57. *ESAR-VHP*, *supra* note 45, at 52 (discussing administration of ESAR-VHP and the liability that might arise from such activities); UNIF. EMERGENCY VOLUNTEER HEALTH PRACTITIONERS ACT § 11 (Nat'l Conference of Comm'rs on Unif. State Laws, Current Draft for Consideration Concerning Reserved Sections 11 and 12, 2007) (on file with author) (discussing the liability of source, coordinating, and host entities).

58. *Hospital Disaster Preparedness: Past, Present, and Future: Hearing Before the Subcomm. on Oversight and Investigations of the H. Comm. on Energy & Commerce*, 109th Cong. 3 (2006) (statement of John O. Agwunobi, Assistant Secretary for Health, Dep't of Health and Human Servs.), available at <http://energycommerce.house.gov/reparchives/108/Hearings/01262006hearing1772/Agwunobi.pdf>.

59. See Biodefense and Pandemic Vaccine and Drug Development Act of 2005, S. 1873, 109th Cong. § 6 (establishing "liability protections for pandemic and epidemic products and security countermeasures").

come to mind, it is by no means the only theory. While the different theories are not equally likely to be asserted or to be successful, in the aggregate, their existence might generate considerable anxiety for providers and constitute a formidable barrier to clinicians' participation in response activities.⁶⁰ This Part will survey and analyze the various types of cases that might be brought against public health emergency responders.

A. NEGLIGENCE

Individuals who are dissatisfied with the care they receive during a public health emergency or who believe they were injured because of inadequate treatment are most likely to file negligence cases, particularly medical malpractice suits. The elements of a negligence claim are (1) a duty of care owed by the defendant to the plaintiff, (2) breach of that duty through conduct that fails to meet the applicable standard of care, (3) harm or injury, and (4) a causal link between the injury and the breach of duty.⁶¹

The most complicated of these factors is the standard of care. The standard of care in each case is fact-specific and dependent upon the particular circumstances at issue. It is determined based on an assessment of whether the defendant "proceed[ed] with such reasonable caution as a prudent man would have exercised under such circumstances."⁶² Consequently, by definition, the standard of care in an emergency would take into account the exigent conditions in which providers were working. Some mistakes that might ordinarily constitute negligence may not give rise to liability because they were reasonable or unavoidable under the circumstances.

It should be noted that some public health commentators speak in terms of "altered standards of care" for public health emergencies.⁶³ Certain professional organizations, such as the American Nursing Association and the Agency for Healthcare Research and Quality, are similarly formulating guidelines for "altered standards of care" during emergencies.⁶⁴ I do not believe that this is the correct terminology, because the standard of care is per se flexible and fact-dependent. Consequently, it is more accurate to state that organizations that are

60. See *supra* notes 4–7 and accompanying text (discussing data that indicates that liability concerns influence physicians' decisions concerning responding to emergencies).

61. PROSSER & KEETON, *supra* note 19, at 164–68.

62. *Vaughn v. Menlove*, (1837) 132 Eng. Rep. 490, 492 (affirming a jury verdict for the plaintiff who was injured when a fire that began in the defendant's haystack burnt down his house); see also Barry R. Furrow, *The Problem of the Sports Doctor: Serving Two (or Is It Three or Four?) Masters*, 50 ST. LOUIS U. L.J. 165, 182 (2005) (explaining that the "standard of care is defined by reference to a physician using the knowledge, skill, and care ordinarily possessed and employed by members of the profession in good standing, good medical practice within the area of specialty practice, and reasonable, customary, accepted care under the circumstances").

63. See ALTERED STANDARDS OF CARE, *supra* note 16.

64. See generally Jean DeDonder et al., *A Report from ANA's 2007 Quadrennial Policy Conference: Nursing Care in Life, Death, and Disaster*, KAN. NURSE, June–July 2007; ALTERED STANDARDS OF CARE, *supra* note 16 (discussing changes in the delivery of care in response to mass casualty events and offering guiding principles for developing altered standards of care).

developing guidelines for emergencies are addressing the need for “modified care” or “modified standard procedures,” not “altered standards of care.”

At least two negligence lawsuits stemmed from the 2003 SARS outbreak in Toronto, Canada. One is a \$600 million class action, and the other is a \$12 million case, and both involved nurses who became infected while working at a Toronto hospital.⁶⁵ Both allege that the province of Ontario was negligent in handling the SARS outbreak.⁶⁶ These lawsuits demonstrate that emergency responders are in fact vulnerable to suit with respect to their handling of response duties.

1. Corporate Negligence

Hospitals, clinics, and other health care organizations involved in emergency response might be liable under a corporate negligence theory.⁶⁷ Health care organizations can be held liable for failing to safeguard their patients' safety and welfare.⁶⁸ Hospitals have been found to have the following four duties:

- (1) a duty to use reasonable care in the maintenance of safe and adequate facilities and equipment;
- (2) a duty to select and retain only competent physicians;
- (3) a duty to oversee all persons who practice medicine within its walls as to patient care; and
- (4) a duty to formulate, adopt and enforce adequate rules and policies to ensure quality care for the patients.⁶⁹

In order to establish a *prima facie* case of corporate negligence, a plaintiff must show (1) that the hospital deviated from the standard of care; (2) that the hospital has actual or constructive knowledge of the flaws or procedures that caused the injury; and (3) a causal link between the conduct and the harm.⁷⁰

In a public health emergency such as a pandemic or bioterrorist attack, health care organizations are likely to be under tremendous pressure to exceed ordinary capacity and to handle very large numbers of patients quickly and efficiently. At the height of the crisis, these entities might fail to follow standard procedures for facility maintenance, personnel oversight, treatment protocols, and other matters. Various deficiencies in the care provided by health care organizations could lead to corporate negligence claims.

2. Vicarious Liability: Respondeat Superior and Ostensible Agency

Organizations can be held liable for the actions of their employees through

65. *SARS Lawsuits Will Go Ahead*, WINDSOR STAR, Aug. 24, 2005, at A6; *SARS Suit*, 173 CANADIAN MED. ASSOC. J. 744 (2005).

66. *See supra* note 65.

67. *See Darling v. Charleston Cmty. Mem'l Hosp.*, 211 N.E.2d 253, 257 (Ill. 1965) (recognizing cause of action for corporate negligence).

68. *See Thompson v. Nason Hosp.*, 591 A.2d 703, 707 (Pa. 1991).

69. *Id.* (internal citations omitted).

70. *Rauch v. Mike-Mayer*, 783 A.2d 815, 827 (Pa. Super. Ct. 2001).

the theories of respondeat superior and ostensible agency. The doctrine of “respondeat superior,” literally, “let the superior answer,” establishes that an employer is responsible for the acts of its employees in the course of their employment.⁷¹ Thus, hospitals, for example, may be held liable for the conduct of nurses, residents, interns, and other health professionals. In many instances, physicians are considered independent contractors rather than employees, and this status shields hospitals from liability for their acts.⁷² At times, however, courts have found that a hospital’s imposition of rules and regulations upon staff physicians is enough to undercut the doctors’ independent contractor status and expose the hospital to liability.⁷³

An alternative theory of liability is ostensible agency. Even if a doctor is found to be an independent contractor, a hospital might be liable for her wrongdoing if the doctor is deemed to be its “ostensible agent.”⁷⁴ A court can find ostensible agency if (1) the patient looks to the entity rather than the specific physician for care, and (2) the hospital “holds out” the doctor as its employee.⁷⁵ The ostensible agency theory is particularly applicable to emergency room care, as patients generally seek medical treatment from emergency departments without regard to who the attending physician will be.⁷⁶ The ostensible agency theory is likely to be particularly relevant in cases arising from public health emergencies. In the event of a pandemic or epidemic of virulent influenza, bioterrorist attack, or other emergencies, patients are likely to flood emergency rooms rather than turn to individual physicians.

B. PRIVACY AND CONFIDENTIALITY

Negligence is not the only theory that plaintiffs might use to sue emergency responders. In public health emergencies involving untold numbers of victims, health care providers might not have the luxury of safeguarding the privacy of

71. BLACK’S LAW DICTIONARY 1338 (8th ed. 2004).

72. *See, e.g.*, *Kashishian v. Port*, 481 N.W.2d 277, 280 (Wis. 1992) (holding that even though a physician was a member of the hospital’s staff and was required to comply with hospital policies, no master-servant relationship existed); *Albain v. Flower Hosp.*, 553 N.E.2d 1038, 1044 (Ohio 1990) (finding that the physician’s staff privileges did not make the hospital vulnerable to respondeat superior liability for his actions).

73. *See, e.g.*, *Mduba v. Benedictine Hosp.*, 384 N.Y.S.2d 527, 529 (N.Y. App. Div. 1976) (finding that a physician was a hospital employee rather than an independent contractor because the hospital controlled the way he operated its emergency room). *See generally* Martin C. McWilliams, Jr. & Hamilton E. Russell, III, *Hospital Liability for Torts of Independent Contractor Physicians*, 47 S.C. L. REV. 431 (1996).

74. *See* *Simmons v. St. Clair Mem’l Hosp.*, 481 A.2d 870, 874 (Pa. Super. Ct. 1984).

75. *Id.*; *Burless v. W. Va. Univ. Hosp., Inc.*, 601 S.E.2d 85, 95–96 (W. Va. 2004) (discussing ostensible agency theory and proof criteria).

76. *See* *Torrence v. Kusminsky*, 408 S.E.2d 684, 692 (W. Va. 1991) (“[W]here a hospital makes emergency room treatment available to serve the public as an integral part of its facilities, the hospital is estopped to deny that the physicians and other medical personnel on duty providing treatment are its agents. Regardless of any contractual arrangements with so-called independent contractors, the hospital is liable to the injured patient for acts of malpractice committed in its emergency room, so long as the requisite proximate cause and damages are present.”).

all patient information. Furthermore, they may be under significant pressure to provide information to members of the media who will aggressively cover the story twenty-four hours a day. Physicians thus may inadvertently leave medical records where they can be seen by third parties or disclose the details of certain patients' conditions to reporters. The legal provisions that address breaches of privacy and confidentiality are discussed in this subsection.

1. The Tort of Invasion of Privacy

In limited circumstances in which responders publicly disclose private medical facts concerning patients, the affected individuals might turn to the common law tort cause of action for invasion of privacy.⁷⁷ Under the common law, the right to privacy can be invaded by "unreasonable publicity given to the other's private life."⁷⁸

The tort of invasion of privacy consists of four elements: (a) public disclosure; (b) of a private fact; (c) that would be objectionable and offensive to a reasonable person; and (d) that is not of legitimate public concern.⁷⁹ In the words of the *Restatement (Second) of Torts*, "[e]very individual has some phases of his life and his activities and some facts about himself that he does not expose to the public eye [including] many unpleasant or disgraceful or humiliating illnesses."⁸⁰

2. The Tort of Breach of Confidentiality

In the alternative, plaintiffs could utilize the tort theory of breach of confidentiality.⁸¹ The elements of breach of confidentiality are (1) the existence of a doctor-patient relationship, and (2) a physician's or medical entity's disclosure to a third party of confidential information that was gained pursuant to this relationship.⁸² In *Horne v. Patton*, for example, a claim was brought for wrongful disclosure of medical information to a patient's employer.⁸³ The court ruled that a doctor has a duty not to disclose patient information obtained in the course of treatment and that a private cause of action exists in cases where the duty is breached.⁸⁴ Courts have based the patient's right of confidentiality upon

77. See RESTATEMENT (SECOND) OF TORTS § 652D (1977); Eduardo W. Gonzalez, Comment, "Get That Camera Out of My Face!" An Examination of the Viability of Suing "Tabloid Television" for Invasion of Privacy, 51 U. MIAMI L. REV. 935, 939-44 (1997) (discussing the applicability and internal limitations of the invasion of privacy tort).

78. RESTATEMENT (SECOND) OF TORTS § 652A (1977).

79. See *Diaz v. Oakland Tribune*, 188 Cal. Rptr. 762, 766 (Cal. Ct. App. 1983) (reporting that the jury found defendant liable for publicizing fact that plaintiff had gender-corrective surgery).

80. RESTATEMENT (SECOND) OF TORTS § 652D cmt. b (1977).

81. See Peter A. Winn, *Confidentiality in Cyberspace: The HIPAA Privacy Rules and the Common Law*, 33 RUTGERS L.J. 617, 652-58 (2002) (discussing the common law tort theory of breach of confidentiality and its implications).

82. Kimberly Rathbone, *The Strict Ohio Supreme Court Decisions in Biddle: Third Party Law Firm Held Liable for Including Disclosure of Medical Information*, 15 J.L. & HEALTH 189, 196-97 (2001).

83. *Horne v. Patton*, 287 So. 2d 824, 825-26 (Ala. 1973).

84. *Id.* at 829-30.

a variety of sources, including privilege statutes protecting physician-patient communications, licensing statutes prohibiting the disclosure of patient information without authorization, and medical ethics principles articulated in the Hippocratic Oath and other sources.⁸⁵ An action for breach of confidentiality can be maintained regardless of the degree to which the information has been publicly distributed or its offensiveness, and there is no requirement to prove the intent of the perpetrator.⁸⁶

3. The Health Insurance Portability and Accountability Act Privacy Rule

The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule requires health care providers to safeguard patient privacy in a variety of ways. For example, with some exceptions, covered entities must obtain a patient's permission before speaking to third parties about the individual's medical condition,⁸⁷ distribute privacy notices containing information concerning use and disclosure of patients' health records,⁸⁸ allow patients to inspect their health records and request that they be modified or used restrictively,⁸⁹ and implement various administrative, physical, and technical security measures for systems storing electronic health records.⁹⁰ In an emergency in which relatives and the media are clamoring for information about patients, and unprecedented volumes of health records must be processed, many of these requirements might be impractical or unrealistic. It should be noted that HIPAA does not offer a private cause of action to aggrieved individuals, though it does provide for governmental enforcement.⁹¹ The regulations also establish exceptions for disclosures and use of protected health information for purposes of public health activities and the aversion of serious threats to public health and safety.⁹²

C. THE AMERICANS WITH DISABILITIES ACT AND THE REHABILITATION ACT

In a public health emergency, responders might find it difficult to care properly for individuals with disabilities and to accommodate all of their needs.⁹³ For example, hastily established field clinics may not be fully accessible to people with particular disabilities, American Sign Language interpreters may not be available to communicate with the deaf, and written materials that are distributed to the public may not be produced in Braille for the blind. These

85. Winn, *supra* note 81, at 654–55.

86. *Id.* at 657–58 (comparing the torts of invasion of privacy and breach of confidentiality).

87. 45 C.F.R. § 164.510 (2007).

88. *Id.* § 164.520(a).

89. *Id.* §§ 164.520, 164.522.

90. *Id.* §§ 164.302–164.318.

91. See 45 C.F.R. §§ 160.300–160.552; Sharon Hoffman & Andy Podgurski, *In Sickness, Health, and Cyberspace: Protecting the Security of Electronic Private Health Information*, 48 B.C. L. REV. 331, 337, 342 (2007).

92. 45 C.F.R. § 164.512.

93. See ALTERED STANDARDS OF CARE, *supra* note 16, at 30–31 (discussing concerns relating to care for populations with special needs).

difficulties might give rise to claims under the Americans with Disabilities Act (ADA)⁹⁴ or section 504 of the Rehabilitation Act.⁹⁵

Title II of the ADA prohibits disability-based discrimination with respect to public services.⁹⁶ Individuals with disabilities may not be denied the benefits of programs, activities, and services, such as public transportation provided by public entities, nor can they be subjected to discrimination by such entities because of their disabilities.⁹⁷

Title III of the ADA prohibits disability-based discrimination by public accommodations.⁹⁸ A "public accommodation" is a private entity whose operations affect commerce, including a "pharmacy, insurance office, professional office of a health care provider, hospital, or other service establishment."⁹⁹ Public transportation services provided by private entities are covered under this Title.¹⁰⁰ Both Title II and Title III provide a private cause of action for aggrieved individuals.¹⁰¹ Under Title II, however, private plaintiffs may seek only injunctive relief, attorneys' fees, and costs, though the Attorney General may pursue damages on behalf of discrimination victims.¹⁰² In addition, under the ADA, covered entities need not accommodate individuals with disabilities if doing so would constitute an undue hardship.¹⁰³

Section 504 of the Rehabilitation Act of 1973¹⁰⁴ is narrower than the ADA but will be pertinent to some circumstances arising from a public health emergency. The law establishes that qualified individuals with disabilities may not be excluded from, denied the benefits of, or subjected to discrimination by covered programs and activities solely because of their disabilities.¹⁰⁵ Those covered by this section include programs or activities that receive federal financial assistance and those conducted by an executive agency of the United

94. 42 U.S.C. §§ 12101–12213 (2000).

95. 29 U.S.C. § 794 (2000 & Supp. II 2002).

96. 42 U.S.C. §§ 12131–12165.

97. *Id.* § 12132. A "public entity" is defined as (1) a state or local government; (2) an instrumentality of a state or local government; or (3) the National Railroad Passenger Corporation and any other commuter authority. *Id.* § 12131. Damages have been allowed against states in Title II cases. In *Tennessee v. Lane*, 541 U.S. 509 (2004), the Supreme Court held that private citizens may sue a state under Title II of the ADA to enforce their right of access to a courthouse and that Eleventh Amendment immunity did not bar such an action.

98. 42 U.S.C. §§ 12181–12189.

99. *Id.* § 12181(7)(F).

100. *Id.* § 12184.

101. *Id.* §§ 12133, 12188.

102. *Id.* § 12188(a)–(b); see also James C. Harrington, *The ADA and Section 1983: Walking Hand in Hand*, 19 REV. LITIG. 435, 441 (2000) (discussing the availability of damages under the ADA).

103. 42 U.S.C. § 12182(b)(2)(A); H.R. REP. NO. 101-485, pt. 3, at 51 (1990), as reprinted in 1990 U.S.C.C.A.N. 445, 474 (stating that "title II incorporates the regulations applicable to federally conducted activities under Section 504 with respect to program accessibility, existing facilities and communications, which requires that the agency demonstrate that access cannot be accomplished without imposing an undue burden after considering all available resources").

104. 29 U.S.C. § 794 (2000 & Supp. II 2002).

105. *Id.* § 794(a).

States or the U.S. Postal Service.¹⁰⁶ Organizations providing health care services that receive federal assistance are specifically mentioned as covered entities.¹⁰⁷ The Rehabilitation Act, like the ADA, exempts accommodations that would impose an undue burden on an entity.¹⁰⁸

The federal government has recognized the importance of considering the needs of individuals with disabilities in developing emergency preparedness plans. The Department of Justice has issued guidance for local governments entitled “Making Community Emergency Preparedness and Response Programs Accessible to People with Disabilities.”¹⁰⁹ A 2006 report issued by the Department of Homeland Security found that individuals with disabilities were inadequately integrated into emergency readiness plans and urged improvements in the areas of evacuation, transportation, communication, emergency public information, sheltering, and health services.¹¹⁰ In addition, President Bush issued Executive Order 13,347 on July 22, 2004, which is entitled “Individuals with Disabilities in Emergency Preparedness” and promotes consideration of the safety and security of the disabled during emergencies.¹¹¹ The Executive Order established the Interagency Coordinating Council on Emergency Preparedness and Individuals with Disabilities in the Department of Homeland Security.¹¹² Furthermore, the Pandemic and All-Hazards Preparedness Act¹¹³ added section 2814 concerning “at-risk individuals” to the Public Health Service Act.¹¹⁴ This section provides that the HHS Secretary will “oversee the implementation of the National Preparedness goal of taking into account the public health and medical needs of at-risk individuals in the event of a public health emergency.”¹¹⁵ Finally, The Post-Katrina Emergency Management Reform Act of 2006 created the position of Disability Coordinator in the Federal Emergency Management Agency (FEMA).¹¹⁶

Individuals who feel mistreated during a public health emergency would face several hurdles in asserting claims under the Rehabilitation Act or the ADA. They would be required to prove that the alleged wrong was due specifically to

106. *Id.*; see also *Moddero v. King*, 82 F.3d 1059, 1060 (D.C. Cir. 1996) (involving a challenge to the U.S. Office of Personnel Management’s health insurance plan and stating that the Office was subject to section 504 because it was an executive agency of the United States).

107. See 29 U.S.C. § 794(b)(3)(A)(ii).

108. See 28 C.F.R. § 39.150(a)(2) (2007).

109. U.S. DEP’T OF JUSTICE, AN ADA GUIDE FOR LOCAL GOVERNMENTS: MAKING COMMUNITY EMERGENCY PREPAREDNESS AND RESPONSE PROGRAMS ACCESSIBLE TO PEOPLE WITH DISABILITIES, <http://www.usdoj.gov/crt/ada/emerpreguideprt.pdf>.

110. U.S. DEP’T OF HOMELAND SECURITY, NATIONWIDE PLAN REVIEW PHASE 2 REPORT 41, 46–47 (June 16, 2006), http://www.dhs.gov/xlibrary/assets/Prep_NationwidePlanReview.pdf.

111. Executive Order No. 13,347, 69 Fed. Reg. 44,573, 44,573 (July 22, 2004).

112. *Id.*

113. Pub. L. No. 109-417, 120 Stat. 2831 (2006).

114. 42 U.S.C.A. § 300hh-16 (West Supp. 2007).

115. *Id.* § 300hh-16(1). “At-risk individuals” are defined as “children, pregnant women, senior citizens and other individuals who have special needs in the event of a public health emergency, as determined by the Secretary.” *Id.* § 300hh-1(b)(4)(B).

116. 6 U.S.C.A. § 321b (West 2006).

their disability rather than to general exigent circumstances and that the defendant could have accommodated their needs without undue hardship despite the crisis. Nevertheless, in some cases of egregious misconduct that is injurious to people with disabilities, disability discrimination claims could be successful. For example, if individuals with disabilities are deemed to be a low priority for triaging purposes because officials prefer saving the lives of healthier people, ADA violations could be found.

D. CONSTITUTIONAL CLAIMS

Aggrieved individuals might assert constitutional claims in addition to tort allegations if they are dissatisfied with the treatment they received from public entities or officials during a public health emergency. Possible theories include violation of bodily integrity; deprivation of life, liberty, or property without due process of law; or infringement of equal protection rights.¹¹⁷ For example, if a community of African-Americans feels that it was mistreated or underserved during an emergency because the individuals are black, the group might file suit alleging equal protection violations. Those subject to forced vaccinations or quarantines might sue for violations of liberty or bodily integrity under the Fourteenth Amendment.

Individual state officials could also be sued for violation of civil rights under § 1983,¹¹⁸ which provides that “[e]very person who, under color of any statute, ordinance, [or] regulation . . . of any State . . . subjects . . . any citizen . . . to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured.”¹¹⁹ The statute does not provide a cause of action against state entities¹²⁰ but can be an effective litigation vehicle against state officials who are challenged in their individual capacity.¹²¹ Under the Supreme Court’s *Bivens*¹²² doctrine, suit is similarly authorized against federal officials.

E. CRIMINAL LIABILITY

Some conduct on the part of health care providers could also give rise to criminal liability. For example, if a physician withholds or withdraws treatment from critically ill patients or prescribes excessive pain medication to them, thereby expediting death, she may face criminal charges.¹²³ In 2005, Louisi-

117. See U.S. CONST. amend. XIV; E. Haavi Morreim, *Medical Research Litigation and Malpractice Tort Doctrine: Courts on a Learning Curve*, 4 HOUS. J. HEALTH L. & POL’Y 1, 75 (2003).

118. 42 U.S.C. § 1983 (2000).

119. *Id.*

120. *Lapides v. Bd. of Regents*, 535 U.S. 613, 617 (2002) (asserting that states are not “persons” for purposes of section 1983 claims for money damages).

121. MARK R. BROWN & KIT KINPORTS, *CONSTITUTIONAL LITIGATION UNDER § 1983*, at 192 (2003).

122. See *Bivens v. Six Unknown Named Agents of Federal Bureau of Narcotics*, 403 U.S. 388, 395 (1971) (allowing for damages to redress Fourth Amendment violations by federal officials).

123. See *State v. Naramore*, 965 P.2d 211, 213, 224 (Kan. Ct. App. 1998) (recounting conviction of doctor for attempted murder of one patient and intentional and malicious second-degree murder of

ana's attorney general launched an investigation into allegations that elderly patients had been euthanized in the immediate aftermath of Hurricane Katrina.¹²⁴ The attorney general ultimately decided not to pursue charges against two nurses that were allegedly implicated, and the grand jury declined to issue an indictment against the accused physician, Dr. Anna Pou.¹²⁵ Patient deaths during future public health emergencies might lead to similar accusations.¹²⁶ When an emergency strikes and the demand for respirators exceeds supply, for example, physicians might be tempted to remove respirators from hospitalized elderly patients in order to give them to newly admitted younger patients, who are more likely to live long and productive lives if they recover. Such acts, however, could be considered killings under criminal law. In addition, health care providers who perform medical procedures for which they are not licensed could be criminally prosecuted under state statutes that establish the permissible scope of practice for various professionals.¹²⁷

F. THE TORT OF BREACH OF FIDUCIARY DUTY

A separate tort for which plaintiffs might be awarded damages is breach of fiduciary duty, which arises from a fiduciary's obligation to promote the interests of his beneficiaries rather than his own interests.¹²⁸ A key aspect of fiduciaries is that they are entrusted with the power and discretion to make certain decisions that cannot be monitored or limited ahead of time by the entrustor.¹²⁹ As a result, the law imposes certain obligations on the fiduciary. Fiduciary duties consist of a duty of care, which requires diligence of fiduciaries who are making decisions on behalf of beneficiaries, and a duty of loyalty, which obligates fiduciaries to promote the beneficiaries' best interests instead of their own.¹³⁰ Fiduciary principles have been applied to a diverse variety of relationships, including trustee-beneficiary, guardian-ward, insurance company-insured, priest-penitent, and bank-customer.¹³¹

second patient because of medications doctor administered when patients were critically ill); Giles R. Scofield, *Exposing Some Myths About Physician-Assisted Suicide*, 18 SEATTLE U. L. REV. 473, 480 (1995) (stating that a physician who discontinues life-sustaining treatment on her own initiative could be prosecuted).

124. Bruce Weber, *Storm and Crisis: Hospital Inquiry*, N.Y. TIMES, Oct. 28, 2005, at A19.

125. Susan Okie, *Dr. Pou and the Hurricane—Implications for Patient Care During Disasters*, 358 NEW ENG. J. MED. 1, 1 (2008).

126. See generally Kenneth Kipnis, *Forced Abandonment and Euthanasia: A Question from Katrina*, 74 SOC. RES. 79 (2007) (exploring circumstances under which it might be justifiable to withhold scarce medical resources from some patients during an emergency).

127. Mary Beck, *Improving America's Health Care: Authorizing Independent Prescriptive Privileges for Advanced Practice Nurses*, 29 U.S.F. L. REV. 951, 967 (1995) (providing the example of nurses who engage in practices that exceed the limitations delineated in the Nurse Practice Act).

128. DAN B. DOBBS, *THE LAW OF TORTS* 1392–93 (2000).

129. See E. Haavi Morreim, *The Clinical Investigator as Fiduciary: Discarding a Misguided Idea*, 33 J.L. MED. & ETHICS 586, 588 (2005).

130. See Carl H. Coleman, *Duties to Subjects in Clinical Research*, 58 VAND. L. REV. 387, 425–26 (2005) (discussing the two components of fiduciary obligations).

131. *Id.* at 425.

Plaintiffs may find little success bringing breach of fiduciary duty claims against physicians or other clinicians.¹³² Courts have often held that such claims were equivalent to medical malpractice claims and could not be sustained separately.¹³³ The Supreme Court has also cast doubt on the ability of plaintiffs to sue health care entities for breach of fiduciary duty.¹³⁴ However, some claims of egregious misconduct by providers might be sustainable.¹³⁵ For example, if a medical director were to subordinate patients' interests in an emergency by denying medical tests that could be conducted despite scarce resources or by refusing to refer patients to available specialists purely for profit motives, the patients might be able to sue successfully for breach of fiduciary duty under state law.¹³⁶

G. VIOLATION OF OTHER FEDERAL AND STATE STATUTES

Many other laws could be inadvertently or intentionally violated during a public health emergency. A comprehensive list is beyond the scope of this Article, but a few representative examples follow.

- State constitutions generally contain their own equality mandates,¹³⁷ which might be violated in the context of emergency response. Many states also have civil rights statutes that prohibit discrimination based on disability¹³⁸ or other protected classifications,¹³⁹ which could form the basis for litigation.

132. See generally Maxwell J. Mehlman, *Dishonest Medical Mistakes*, 59 VAND. L. REV. 1137, 1154–73 (2006) (discussing factors that are undermining fiduciary protections).

133. See, e.g., *D.A.B. v. Brown*, 570 N.W.2d 168, 171 (Minn. Ct. App. 1997) (finding that the claim for breach of fiduciary duty was a mischaracterized claim for malpractice); *Spoor v. Serota*, 852 P.2d 1292, 1294–95 (Colo. Ct. App. 1992) (holding that the plaintiffs' claim for breach of fiduciary duty duplicated their malpractice cause of action).

134. See *Pegram v. Herdrich*, 530 U.S. 211, 214–15 (2000) (involving a petitioner whose appendix ruptured because of an HMO's delay in treatment and holding that the HMO's mixed eligibility and treatment decisions do not constitute fiduciary acts under ERISA).

135. See, e.g., *Drolet v. Healthsource, Inc.*, 968 F. Supp. 757, 760–61 (D.N.H. 1997) (allowing claim for breach of fiduciary duty under ERISA against an HMO because it allegedly made false statements and misrepresentations to beneficiaries).

136. See Thomas R. McLean & Edward P. Richards, *Managed Care Liability for Breach of Fiduciary Duty After Pegram v. Herdrich: The End of ERISA Preemption for State Law Liability for Medical Care Decision Making*, 53 FLA. L. REV. 1, 4, 41–44 (2001) (arguing that HMOs may be sued under state fiduciary laws); Mehlman, *supra* note 132, at 1172 (arguing that patients should be allowed to use breach of fiduciary duty theories to sue doctors for dishonest medical mistakes and that “the attacks on fiduciary principles must be turned back”).

137. Robert F. Williams, *Equality Guarantees in State Constitutional Law*, 63 TEX. L. REV. 1195, 1196–97 (1985).

138. See Ruth Colker & Adam Milani, *The Post-Garrett World: Insufficient State Protection Against Disability Discrimination*, 53 ALA. L. REV. 1075, 1113–14 (2002) (discussing how the protection offered by state statutes compares to that available under the ADA).

139. See, e.g., OHIO REV. CODE ANN. § 4112.02(a) (LexisNexis 2007) (providing that it is unlawful “[f]or any employer, because of the race, color, religion, sex, national origin, disability, age, or ancestry of any person, to discharge without just cause, to refuse to hire, or otherwise to discriminate against that person with respect to hire, tenure, terms, conditions, or privileges of employment, or any matter directly or indirectly related to employment”).

- State licensure requirements for health care professionals may be violated in cases where volunteer clinicians who are licensed in one state travel to another state to provide emergency assistance or perform tasks for which they are not credentialed.¹⁴⁰
- EMTALA requires that hospital emergency rooms screen all patients who seek treatment from them for an emergency condition.¹⁴¹ Individuals found to have such a condition must either be stabilized or transferred to another hospital if doing so will not excessively endanger them, regardless of their ability to pay.¹⁴² The statute provides for both administrative penalties and a private cause of action for those aggrieved by EMTALA violations.¹⁴³ Emergency rooms that are flooded with patients during a catastrophic event might not be able to comply with EMTALA's mandates.
- Emergency responders might also find it difficult to comply with complex Medicare, Medicaid, and SCHIP rules relating to payment for services.¹⁴⁴

H. SUMMARY

As mentioned previously, during a public health emergency, health care providers may not be vulnerable to sanctions and penalties under some of the above provisions. Certain requirements relating to EMTALA, HIPAA, and the Medicare, Medicaid, and SCHIP programs may be modified or waived when the HHS Secretary has declared a public health emergency and the President has declared an emergency or disaster pursuant to the Stafford Act or the National Emergencies Act, as was done in the aftermath of Hurricane Katrina.¹⁴⁵ Similarly, under some state emergency laws,¹⁴⁶ the governor of a state may modify or suspend statutory provisions relating to state business or state agency rules and regulations if compliance with those laws would likely hinder response

140. See *ESAR-VHP*, *supra* note 45, at 29 (discussing state laws that mandate licensing of health care professionals).

141. 42 U.S.C. § 1395dd(a) (2000).

142. *Id.* § 1395dd(b)–(c).

143. *Id.* § 1395dd(d) (2000 & Supp. IV 2004).

144. See Public Health Security and Bioterrorism Preparedness and Response Act of 2002 § 143, 42 U.S.C. § 1320b-5(b) (Supp. IV 2004) (addressing the applicability of these standards during a public health emergency that is declared by the HHS Secretary); Weeks, *supra* note 40, at 249–50.

145. See *supra* notes 39–43 and accompanying text; see also 42 U.S.C. § 1320b-5(b), (e) (Supp. IV 2004) (discussing Secretary's authority "to temporarily waive or modify the application of" certain provisions and the duration of the waiver); Michael O. Leavitt, Secretary, Dep't of Health and Human Servs., Waiver Under Section 1135 of the Social Security Act (Sept. 4, 2005), <http://www.hhs.gov/katrina/ssawaiver.html> (waiving various requirements of EMTALA, HIPAA, Medicare, Medicaid, and SCHIP following Hurricane Katrina).

146. See *supra* note 49 and accompanying text (discussing the adoption of the MSEHPA by state legislatures).

activities or exacerbate the threat to public welfare.¹⁴⁷

Nevertheless, a large number of causes of action are theoretically available to those who wish to challenge emergency response activities. Responders' concerns about liability, consequently, are not ungrounded and may well affect their willingness to serve during public health emergencies. I now turn to an exploration of the extent to which emergency responders might enjoy immunity with respect to lawsuits associated with public health emergencies.

III. THE EXISTING IMMUNITY LANDSCAPE

Responders are not as vulnerable to liability as the existence of so many causes of action might suggest. Numerous sources of immunity are available to different parties involved in public health emergencies. This Part provides an overview of immunity protections under federal and state laws that apply to public sector actors, volunteers, and private sector responders.

A. IMMUNITY FOR PUBLIC SECTOR ACTORS

Public sector actors may be protected by government immunity for tort claims, immunity for constitutional claims, and immunity arising from mutual aid agreements.¹⁴⁸

1. Government Immunity for Tort Claims

Federal, state, and local governmental entities and their employees or agents who respond to a public health emergency within the scope of their official duties may be protected against tort lawsuits by state or federal immunity statutes.¹⁴⁹ Under the common law, the states and the federal government are shielded by sovereign immunity from tort actions,¹⁵⁰ and immunity extends to federal and state agencies as well.¹⁵¹

Most states, however, have enacted laws that limit state sovereign immunity,¹⁵² and a determination as to whether responders associated with a state or local governmental entity can be sued in state court for a tort will thus depend

147. See COLO. REV. STAT. §24-32-2104(7)(a) (2006) (allowing the governor to “[s]uspend the provisions of any regulatory statute prescribing the procedures for conduct of state business or the orders, rules, or regulations of any state agency, if strict compliance with the provisions of any statute, order, rule, or regulation would in any way prevent, hinder, or delay necessary action in coping with the emergency”); MODEL STATE EMERGENCY HEALTH POWERS ACT art. IV, § 403 (Ctr. for Law & the Public’s Health, Discussion Draft 2001), available at <http://www.publichealthlaw.net/MSEHPA/MSEHPA.pdf>.

148. Public sector actors may also be protected under state law. See discussion *infra* section III.D.

149. See, e.g., David B. Resnik, *Liability for Institutional Review Boards*, 25 J. LEGAL MED. 131, 172 (2004).

150. See DAN DOBBS & PAUL HAYDEN, *TORTS AND COMPENSATION* 393 (2001) (explaining that the concept of sovereign immunity is a carryover from the English common law, which established that “[t]he King can do no wrong”).

151. *Id.*

152. *Id.* at 394.

on the relevant state law.¹⁵³ Nevertheless, states generally retain immunity for officials' discretionary decisions.¹⁵⁴

Many state courts have decided cases involving emergency response. In *City of Daytona Beach v. Palmer*, the Florida Supreme Court found against plaintiff who had alleged negligence on the part of the city's firefighters.¹⁵⁵ It held that decisions concerning how to fight a fire or rescue victims and what equipment to send to a fire were discretionary judgments subject to immunity.¹⁵⁶ Similarly, in *Ayres v. Indian Heights Volunteer Fire Department*, the Supreme Court of Indiana found that the state's Tort Claims Act protects government entities and their employees from liability relating to negligence claims associated with discretionary functions, and that the defendants were therefore entitled to immunity with respect to allegations of negligent conduct arising from response to a fire.¹⁵⁷ By contrast, in *Gordon v. City of Henderson*, the Tennessee Supreme Court preserved negligence claims alleging that firemen were intoxicated and absent from their duty station because these failures did not fall within the "discretionary function" exception of the Tennessee Governmental Tort Liability Act.¹⁵⁸

Like the states, the federal government has generally waived its sovereign immunity under the Federal Tort Claims Act (FTCA).¹⁵⁹ The FTCA, however, retains immunity for federal officials who execute their statutory or regulatory duties with due care and are sued in federal court.¹⁶⁰ Immunity is also preserved for cases involving a "failure to exercise or perform a discretionary function or duty on the part of a federal agency or an employee of the Government,"¹⁶¹ as well as for claims of assault, battery, misrepresentation, deceit, or interference with contract rights, among others.¹⁶² These exceptions may apply to many federal officials who are accused of misconduct while performing duties related to emergency response.

In *Berkovitz v. United States*, the Supreme Court explained that the defense of sovereign immunity applies only when a federal employee's actions are a matter

153. See, e.g., ALASKA STAT. § 09.50.250 (Michie 2006); COLO. REV. STAT. ANN. §24-10-106 (West 2006); GA. CODE ANN. §50-21-23 (2006); TEX. CIV. PRAC. & REM. CODE §101.021 (2005).

154. John V. Jacobi, *Prison Health, Public Health: Obligations and Opportunities*, 31 AM. J.L. & MED. 447, 477 (2005) (noting that states retain immunity for discretionary judgments despite instituting limited waivers of liability). See generally, Ken Lerner, *Governmental Negligence Liability Exposure in Disaster Management*, 23 URB. LAW., 333-53 (1991) (discussing various sources of immunity for governmental actors involved in emergency response). Lerner concludes that "[t]ort suits over alleged flaws in disaster response have almost always been dismissed." *Id.* at 352.

155. *City of Daytona Beach v. Palmer*, 469 So.2d 121, 122 (Fla. 1985).

156. *Id.* at 123.

157. *Ayres v. Indian Heights Volunteer Fire Dep't*, 493 N.E.2d 1229, 1234-35 (Ind. 1986).

158. *Gordon v. City of Henderson*, 766 S.W.2d 784, 786-87 (Tenn. 1989).

159. 28 U.S.C.A. §§ 2671-2680 (West 2007).

160. 28 U.S.C. § 2680(a) (2000).

161. *Id.*

162. *Id.* § 2680(h).

of choice and that it is based on considerations of public policy.¹⁶³ The discretionary functions exception will not apply when a statute, regulation, or policy specifically prohibits the course of action in question.¹⁶⁴ Consequently, the FTCA's exemption did not bar causes of action relating to the National Institutes of Health's licensing a vaccine without receiving required safety data or determining compliance with applicable standards, or to the FDA's approval of unsafe vaccine lots contrary to its own policy.¹⁶⁵ Similarly, in *Downs v. United States*, the court found that the actions of a Federal Bureau of Investigation (FBI) agent in response to a plane hijacking were not entitled to immunity as discretionary functions under the FTCA because he failed to follow standard FBI procedures.¹⁶⁶ By contrast, in *Kennewick Irrigation District v. United States*, the Ninth Circuit found that the FTCA's discretionary function exception barred the plaintiffs' claim of negligence relating to the design of an irrigation canal.¹⁶⁷ However, the exception did not apply to a claim based on negligent construction of the canal because workers were bound by safety and engineering standards that removed their discretion.¹⁶⁸

2. Immunity for Constitutional Claims

The defense of governmental immunity will often be available for constitutional claims against state and federal governmental entities and their employees. First, the Eleventh Amendment provides that states cannot be sued for damages in federal court.¹⁶⁹ Eleventh Amendment immunity has been interpreted to extend to cases asserting constitutional claims in state court¹⁷⁰ and to agencies and other arms of the state.¹⁷¹ The amendment bars all suits for damages or retroactive relief against state governments that are sued by any party other than a different state or the federal government.¹⁷² Likewise, the

163. *Berkovitz v. United States*, 486 U.S. 531, 536–37 (1988).

164. *Id.* at 536.

165. *Id.* at 542–47.

166. *Downs v. United States*, 522 F.2d 990, 994–98 (6th Cir. 1975).

167. *Kennewick Irrigation Dist. v. United States*, 880 F.2d 1018, 1029 (9th Cir. 1989).

168. *Id.* at 1026–27.

169. U.S. CONST. amend. XI. The text reads as follows: “The Judicial power of the United States shall not be construed to extend to any suit in law or equity, commenced or prosecuted against one of the United States by Citizens of another State, or by Citizens or Subjects of any Foreign State.” *Id.* Congress can abrogate the states' sovereign immunity, but only if it passes legislation under section 5 of the Fourteenth Amendment, which gives it “power to enforce [that Amendment] by appropriate legislation.” *BROWN & KINPORTS*, *supra* note 121, at 196.

170. *Alden v. Maine*, 527 U.S. 706, 712 (1999) (holding that “the powers delegated to Congress under Article I of the United States Constitution do not include the power to subject nonconsenting States to private suits for damages in state courts”).

171. *See* *Edelman v. Jordan*, 415 U.S. 651, 663 (1974); *Ford Motor Co. v. Dep't of Treasury*, 323 U.S. 459, 463 (1945); RICHARD H. FALLON ET AL., *HART AND WECHSLER'S THE FEDERAL COURTS AND THE FEDERAL SYSTEM* 985 (5th ed. 2003).

172. *See* *Alden v. Maine*, 527 U.S. 706, 754 (1999); JOHN E. NOWAK & RONALD D. ROTUNDA, *CONSTITUTIONAL LAW* 49 (6th ed. 2000); Carlos Manuel Vazquez, *What is Eleventh Amendment Immunity?*, 106 *YALE L.J.* 1683, 1685–86 (1997).

doctrine of federal sovereign immunity protects the United States from being sued without its consent.¹⁷³ Entities such as Veterans' Administration hospitals could therefore not be sued for money damages for constitutional violations. By contrast, county or city hospitals could be sued under federal law because Eleventh Amendment immunity does not extend to local government entities.¹⁷⁴

Second, while the Eleventh Amendment does not extend to public officials, the defense of qualified immunity shields federal and state government officials who are performing discretionary functions in their official capacities from liability for civil damages unless their conduct violates "clearly established statutory or constitutional rights of which a reasonable person would have known."¹⁷⁵ Consequently, individual governmental actors can be held liable only if they could be expected to have known that their actions would result in a violation of rights.¹⁷⁶ Proving such knowledge is difficult, but not impossible.

To illustrate, in *Lazaro v. University of Texas Health Science Center*, the court found against a student who had been dismissed from medical school and alleged violations of his equal protection and due process rights.¹⁷⁷ The court held that the medical school was entitled to sovereign immunity and its Interim President and Associate Dean were entitled to qualified immunity in their official capacities.¹⁷⁸ Similarly, in *Martinez v. Simonetti*, the Second Circuit held that a police officer was entitled to qualified immunity in a case challenging an arrest because his decision to arrest the plaintiff was a discretionary function and his conduct was reasonable.¹⁷⁹ By contrast, in *In re Cincinnati Radiation Litigation*, the court rejected the defendants' claim of qualified immunity relating to experimental radiation treatments to which the plaintiffs did not consent.¹⁸⁰ The court found that the defendants' egregious misconduct violated the plaintiffs' clearly established due process right to liberty and bodily integrity.¹⁸¹

Whether constitutional immunity is available to state and federal officials will depend on the circumstances of each case, though such a defense is likely to apply in many instances. It is significant to note, however, that the CDC and state and local governmental agencies have been engaging in extensive public

173. See DOBBS & HAYDEN, *supra* note 150.

174. *Id.* at 1057; see *Monell v. N.Y. Dep't of Soc. Servs.*, 436 U.S. 658, 690 n.54 (1978).

175. See *Harlow v. Fitzgerald*, 457 U.S. 800, 818 (1982); see also *Davis v. Scherer*, 468 U.S. 183, 191 (1984) (stating that "[w]hether an official may prevail in his qualified immunity defense depends upon the 'objective reasonableness of [his] conduct as measured by reference to clearly established law'").

176. See cases cited *supra* note 175. If the plaintiff fails to allege a violation of clearly established law in the complaint, the defendant will be entitled to dismissal of the suit prior to the commencement of discovery under Federal Rule of Civil Procedure 12(b)(6). See, e.g., *In re Cincinnati Radiation Litigation*, 874 F. Supp. 796, 808 (S.D. Ohio 1995).

177. *Lazaro v. Univ. of Tex. Health Sci. Ctr.*, 830 S.W.2d 330, 331, 333 (Tex. App. 1992).

178. *Id.* at 332-33.

179. *Martinez v. Simonetti*, 202 F.3d 625, 635 (2d Cir. 2000).

180. *Cincinnati Radiation*, 874 F. Supp. at 822.

181. *Id.* at 810-13.

health emergency preparedness training activities for a number of years.¹⁸² These programs include discussions of appropriate investigative methods, quarantine, and other practices that affect civil rights.¹⁸³ It is possible that parties will rely on such well-publicized programs in litigating constitutional cases. Plaintiffs may try to overcome qualified immunity defenses by alleging that government officials deviated from the proper procedures that they had been taught and thus should not be entitled to immunity. Conversely, defendants who adhered to guidelines they were trained to follow could use their training and compliance with guidelines for defense purposes.

3. The Emergency Management Assistance Compact and Other Mutual Aid Agreements: Immunity for States and Their Officers or Employees

In 1996, Congress approved the Emergency Management Assistance Compact (EMAC).¹⁸⁴ EMAC is a mutual aid agreement that has been enacted by all states and is triggered by a gubernatorial declaration of emergency and request for assistance.¹⁸⁵ It establishes licensure reciprocity, providing that individuals who hold licenses, certificates, or permits issued by one state shall be deemed to have the appropriate credentials for purposes of rendering assistance to another state requesting aid pursuant to the compact.¹⁸⁶ EMAC also provides immunity to any “party state or its officers or employees” offering assistance in another state in accordance with the compact, so long as the party acted in good faith; that is, without willful misconduct, gross negligence, or recklessness.¹⁸⁷

182. See Public Health Security and Bioterrorism Preparedness and Response Act of 2002, Pub. L. No. 107-188, 116 Stat. 594 (codified as amended in scattered sections of 42 U.S.C.), amended by Pandemic and All-Hazards Preparedness Act, Pub. L. No. 109-417, 120 Stat. 2831 (2006) (establishing grants for state and local governments to undertake goals designed to enhance public health emergency preparedness); CDC Public Health Law Program, <http://www2a.cdc.gov/phlp/about.asp> (describing the emergency preparedness activities of the CDC's Public Health Law Program).

183. See, e.g., CDC Public Health Law Program, Public Health Emergency Law & Forensic Epidemiology Training, <http://www2.cdc.gov/phlp/phe1.asp> (offering training concerning a variety of legal topics including “Protection of People” and “Management of Property”); University of Minnesota Center for Public Health Preparedness, Free Online Trainings and Resources, <http://www.sph.umn.edu/umncph/phe1.html> (offering computer training modules that include the topics of disease surveillance and investigation, contact investigation, isolation and quarantine, and special populations).

184. H.R.J. Res. 193, 104th Cong., § 1, 110 Stat. 3877 (1996).

185. *Id.* at 3877 (stating that “[t]he purpose of this compact is to provide for mutual assistance between the states entering into this compact in managing any emergency disaster that is duly declared by the Governor of the affected state, whether arising from natural disaster, technological hazard, man-made disaster, civil emergency aspects of resources shortages, community disorders, insurgency, or enemy attack”); Daniel D. Stier & Richard A. Goodman, *Mutual Aid Agreements: Essential Legal Tools for Public Health Preparedness and Response*, 97 AM. J. PUB. HEALTH S62, S62 (2007).

186. H.R.J. Res. 193, at 3880.

187. *Id.* The liability provision states:

Officers or employees of a party state rendering aid in another state pursuant to this compact shall be considered agents of the requesting state for tort liability and immunity purposes; and no party state or its officers or employees rendering aid in another state pursuant to this compact shall be liable on account of any act or omission in good faith on the part of such forces while so engaged or on account of the maintenance or use of any equipment or supplies

EMAC, however, does not elucidate who exactly can be considered officers or employees of a party state.¹⁸⁸ For example, does the term include individuals who are deputized by a state for the purpose of responding to a particular emergency, such as Hurricane Katrina?¹⁸⁹ This problem has been addressed explicitly by a few state statutes that deem responders under EMAC to be state employees for liability purposes,¹⁹⁰ but it is ignored in many other states. According to one source, in the aftermath of Hurricane Katrina, “many states were unable or uncertain about how to avail themselves of the services of volunteers” who offered their assistance.¹⁹¹

Several states have also entered into regional mutual aid agreements. Examples are the Pacific Northwest Emergency Management Arrangement, which authorizes cooperation among Washington, Idaho, Oregon, Alaska, British Columbia, and the Yukon Territory,¹⁹² and the International Emergency Management Assistance Memorandum of Understanding, which provides for mutual assistance among several Northeastern states and Canadian provinces in managing emergencies stemming from natural or man-made disasters and technological hazards.¹⁹³ Some regional agreements offer immunity to participants and others do not.¹⁹⁴

in connection therewith. Good faith in this article shall not include willful misconduct, gross negligence, or recklessness.

Id.

188. *ESAR-VHP*, *supra* note 45, at 48.

189. Dan Stier, *Liability Protection for Volunteers Under the Emergency Management Assistance Compact*, (April 10, 2006) (unpublished manuscript, on file with author) (describing the efforts of some states to secure liability protection for teams of volunteers sent to assist in recovery efforts after Hurricane Katrina).

190. *See* IND. CODE ANN. § 10-14-3-19(d) (West 2006) (providing that when “a mobile support unit is deployed outside Indiana under the emergency management assistance compact, an individual serving as a member of a mobile support unit who is not an employee of the state is considered an employee of the state for purposes of the compact”); IOWA CODE ANN. § 135.143.2 (2007) (providing that a “member of a public health response team . . . shall be considered an employee of the state under [EMAC and] . . . shall be afforded protection as an employee of the state under [state law]”); ME. REV. STAT. ANN. tit. 37-B, § 784-A (2006) (providing that a health care provider “designated by the Maine Emergency Management Agency to render aid in another state under [EMAC] . . . is deemed to be an employee of the State for purposes of immunity from liability”).

191. Stier & Goodman, *supra* note 185.

192. Pacific Northwest Emergency Management Arrangement, Annex B, art. I (2005) (on file with author) [hereinafter PNEMA].

193. International Emergency Management Assistance Memorandum of Understanding (July 18, 2000), *available at* http://www.scics.gc.ca/cinfo00/85007918_e.html [hereinafter IEMAMOU] (entered into by Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, Connecticut, Quebec, New Brunswick, Prince Edward Island, Nova Scotia, and Newfoundland); *see also* Memorandum of Agreement (on file with author) [hereinafter MOA] (entered into by public health laboratories of New Mexico, Colorado, Utah, and Arizona for purpose of establishing terms of providing assistance in the event that one of the laboratories is temporarily disabled); Memorandum of Understanding (Aug. 15, 2004) (on file with author) [hereinafter MOU] (entered into by public health laboratories of Alaska, Idaho, Oregon, and Washington to address potential laboratory surge capacity).

194. *See* IEMAMOU, *supra* note 193, art. VI (providing immunity for good faith acts and omissions but not for willful misconduct, gross negligence or recklessness); MOA, *supra* note 193, art. 8

B. IMMUNITY FOR VOLUNTEERS

Volunteers responding to public health emergencies will enjoy extensive liability protection under a variety of laws, including Good Samaritan laws and volunteer protection acts.¹⁹⁵

1. Good Samaritan Laws

Good Samaritan statutes are state laws that protect health care professionals or other individuals who render aid at the scene of an accident or emergency against civil liability for negligently causing injury while providing assistance.¹⁹⁶ Most statutes shield volunteers from civil liability for ordinary negligence but not for gross negligence or wanton misconduct, and apply only to those volunteering in good faith and without compensation in response to an emergency,¹⁹⁷ though some statutes cover paid emergency care providers as well.¹⁹⁸ Thus, for example, the Georgia Good Samaritan statute provides as follows:

Any person, including any person licensed to practice medicine and surgery . . . who in good faith renders emergency care at the scene of an accident or emergency to the victim or victims thereof without making any charge therefore shall not be liable for any civil damages as a result of any act or omission by such person in rendering emergency care or as a result of any act or failure to act to provide or arrange for further medical treatment or care for the injured person.¹⁹⁹

Good Samaritan statutes generally cover only individual rescuers and thus would not extend to hospitals, businesses, and other entities providing goods and services at no charge.²⁰⁰

(establishing that “[e]ach party shall be solely responsible for fiscal or other sanctions occasioned as a result of its own violation or alleged violation of requirements applicable to the performance of the agreement”); MOU, *supra* note 193 (stating that each party “shall be responsible for its own acts and omissions”); PNEMA, *supra* note 192, art. VI (providing immunity for good faith acts and omissions but not for willful misconduct, gross negligence or recklessness).

195. Volunteers may also be protected by immunity provisions found in state emergency response statutes, discussed *infra* section III.D.

196. For a list and summary of Good Samaritan statutes, see *ESAR-VHP*, *supra* note 45, at app. D.

197. *Id.* at 46.

198. For statutes that cover paid emergency care providers see, for example, ARIZ. REV. STAT. ANN. § 9-500.02 (2006); IOWA CODE § 147A.10 (2005); KAN. STAT. ANN. § 65-2891 (2002).

199. GA. CODE ANN. § 51-1-29 (2000). Georgia also has several other Good Samaritan provisions that offer immunity to volunteers who provide assistance during a declared emergency; to health care providers who volunteer their services at the request of a hospital, public school, nonprofit organization, or state agency; to those using automated external defibrillators; and to those offering care without compensation in a free clinic. GA. CODE ANN. §§ 51-1-29.1 to 29.4 (2000 & Supp. 2006).

200. See generally *ESAR-VHP*, *supra* note 45, at app. D.

2. Volunteer Protection Acts

The Volunteer Protection Act of 1997, a federal law, extends immunity to volunteers for nonprofit organizations and governmental entities and is not dependent upon the declaration of an emergency.²⁰¹ To enjoy the statute's protection, a volunteer must meet the following conditions: (1) she must act within the scope of her responsibilities; (2) where appropriate, she must be properly licensed, certified, or authorized by the authorities within the state in which the harm occurred; (3) she must not cause harm through willful, reckless, or criminal misconduct, gross negligence, or a "conscious, flagrant indifference to the rights or safety" of the harmed individual; and (4) she must not have caused the harm by operating a mechanism of transportation for which the state requires an operator's license or insurance.²⁰² The Act protects volunteers from economic damages and limits their liability for noneconomic damages.²⁰³ The law also carves out an exception that allows nonprofit organizations and governmental entities to file suit against volunteers who work for them.²⁰⁴ States may opt out of the federal Volunteer Protection Act,²⁰⁵ though thus far only New Hampshire has done so.²⁰⁶

The statute defines "volunteer" to mean an individual who does not receive compensation other than reimbursement for costs.²⁰⁷ The Federal Volunteer Protection Act, therefore, provides significant protection for volunteers responding to a public health emergency, though some volunteers will be excluded by the limitations described above, and entities employing or supervising them are not covered.²⁰⁸

All fifty states have adopted their own volunteer protection statutes that

201. 42 U.S.C. § 14503(a) (2000). The law defines "nonprofit organization" as follows:

(A) any organization which is described in section 501(c)(3) of [the Internal Revenue Code] and [is] exempt from tax under section 501(a) of [that Code] and which does not practice any action which constitutes a hate crime referred to in subsection (b)(1) of the first section of the Hate Crime Statistics Act (28 U.S.C. 534 note); or

(B) any not-for-profit organization which is organized and conducted for public benefit and operated primarily for charitable, civic, educational, religious, welfare, or health purposes and which does not practice any action which constitutes a hate crime referred to in subsection (b)(1) of the first section of the Hate Crime Statistics Act (28 U.S.C. 534 note).

Id. § 14505(4).

202. *Id.* § 14503(a).

203. *Id.* § 14504.

204. *Id.* § 14503(b).

205. *Id.* § 14502(b).

206. N.H. REV. STAT. ANN. § 292 References and Annotations (2006); see Steven D. Gravely & Erin S. Whaley, *A Patchwork of Protection: Sources of Volunteer Immunity for Medical & Public Health Volunteers*, HEALTH LAW. WKLY., Apr. 8, 2005, available at <http://www.troutmansanders.com/mc/art-gravely-whaley.pdf>.

207. 42 U.S.C. § 14505(6).

208. *Id.* It should also be noted that state laws concerning volunteer immunity that are inconsistent with federal law are preempted by the federal statute unless they offer even greater protection to volunteers than does the federal law. *Id.* § 14502(a).

provide varying degrees of liability protection.²⁰⁹ The Virginia State Government Volunteers Act, for example, extends immunity only to volunteers in state service.²¹⁰ Maryland's statute provides immunity only beyond the limits of the volunteer's personal insurance and excludes health care providers and employees of charitable organizations from its definition of "volunteer."²¹¹ Colorado's Volunteer Service Act applies to particular categories of health care providers who volunteer for nonprofit organizations, nonprofit corporations, government entities, and hospitals so long as they are covered by the Federal Volunteer Protection Act.²¹²

C. IMMUNITY FOR PRIVATE SECTOR ACTORS

Private sector actors benefit from a very limited range of immunity protections in specific circumstances. The relevant laws will be discussed in this section.²¹³

1. The Public Readiness and Emergency Preparedness Act

The Public Readiness and Emergency Preparedness Act (PREP Act)²¹⁴ addresses immunity from liability relating to the administration and use of "covered countermeasure[s]," which are defined as certain pandemic or epidemic products, security countermeasures, or drugs, devices and biological products authorized for emergency use.²¹⁵ Immunity is available to manufacturers, distributors, program planners, and their officials, agents, or employees, as well as to those qualified to prescribe, administer, or dispense countermeasures.²¹⁶ Liability protection is triggered by the HHS Secretary's declaring under the PREP Act that a public health emergency exists or is likely to exist and recommending the production, testing, distribution, or use of a covered countermeasure.²¹⁷ Individuals who suffer death or serious injury because of a covered person's willful misconduct are, however, allowed a federal cause of action to which immunity does not apply.²¹⁸ In addition, the Act provides for the establishment of an emergency fund designed to compensate aggrieved individuals for covered

209. *ESAR-VHP*, *supra* note 45, at 44.

210. VA. CODE ANN. § 2.2-3602 (2005).

211. MD. CODE ANN., CTS. & JUD. PROC. § 5-407(a)(11), (c) (LexisNexis 2006).

212. COLO. REV. STAT. § 13-21-115.5(3)(c)(I), (4)(a) (2006). For other examples of state volunteer protection acts, see KY. REV. STAT. ANN. § 411.200 (LexisNexis 2006); OKLA. STAT. ANN. tit. 76, § 32 (West 2008).

213. Private sector actors may also be protected from liability under state law. *See infra* section III.D.

214. 42 U.S.C.A. § 247d-6d (West Supp. 2007).

215. *Id.* § 247d-6d(i)(1).

216. *See id.* § 247d-6d(i)(2).

217. *Id.* § 247d-6d(b)(1). This declaration is different from a declaration of a public health emergency under the Public Health Service Act. *See* 42 U.S.C. § 247d(a) (2000 & Supp. II 2002). For further discussion of public health emergency declarations, see *supra* note 36 and accompanying text.

218. 42 U.S.C.A. § 247d-6d(d) (West Supp. 2007).

injuries associated with countermeasures.²¹⁹ The first PREP Act declaration was issued on January 26, 2007 for the H5N1 vaccine to protect against the avian influenza virus.²²⁰

2. The Project BioShield Act

The Food, Drug, and Cosmetics Act, as amended by the Project BioShield Act of 2004,²²¹ provides that during a declared emergency, the HHS Secretary may authorize the emergency use of a product that is not yet “approved, licensed, or cleared for commercial distribution.”²²² Thus, in 2005, pursuant to this provision, the FDA issued an Emergency Use Authorization for use of the anthrax vaccine Adsorbed to prevent inhalation anthrax in individuals deemed by the Department of Defense to be at heightened risk of exposure.²²³ In future emergencies, responders may likewise be able to administer unapproved medical products under a similar authorization.

D. PROTECTION ARISING FROM STATE EMERGENCY RESPONSE STATUTES

The states whose laws specifically address public health emergencies formulate liability protections in different ways.²²⁴ In very general terms, the statutes can be categorized either as providing liability protection to parties acting pursuant to governmental or legal authority or as providing immunity in a much broader set of circumstances. In addition, some states do not have statutes that specifically address public health emergencies but have laws that govern emergencies in general, many of which also offer responders certain liability protec-

219. *Id.* § 247d-6e(a). See generally Lawrence O. Gostin, *Medical Countermeasures for Pandemic Influenza: Ethics and the Law*, 295 JAMA 554, 555 (2006) (discussing laws related to medical countermeasures and the national Vaccine Injury Compensation Program).

220. Pandemic Countermeasures; Declaration Under the Public Readiness and Emergency Preparedness Act, 72 Fed. Reg. 4710, 4710–11 (Dep’t of Health and Human Servs. Feb. 1, 2007).

221. Pub. L. No. 108-276, 118 Stat. 835 (2004) (codified at 42 U.S.C.A § 247d-6a (West Supp. 2007)).

222. 21 U.S.C. § 360bbb-3(a) (Supp. IV 2004).

223. Authorization of Emergency Use of Anthrax Vaccine Adsorbed for Prevention of Inhalation Anthrax by Individuals at Heightened Risk of Exposure Due to Attack with Anthrax, 70 Fed. Reg. 5452 (Food and Drug Admin. Feb. 2, 2005).

224. MSEHPA contains a model liability section that provides for both state and private immunity. The state immunity provision establishes that states, political subdivisions, and state or local officials are not liable for death, injury, or property damage resulting from activities undertaken pursuant to the Act during a public health emergency. Gross negligence and willful misconduct, however, are not protected. The private liability provision mandates that the following shall enjoy immunity from civil liability for negligently causing death, injury, or property damage: 1) any person who owns or controls property and permits its use during a public health emergency for purposes of sheltering people; 2) any person, firm, or corporation (or agent or employee thereof) that performs a contract with and under the direction of the state or a local government pursuant to the Act; and 3) any person, firm, or corporation (or agent or employee thereof) that provides assistance or advice at the request of the state or a local government pursuant to the Act. Gross negligence and willful misconduct are excluded, as are parties whose acts or omissions caused or partially caused the public health emergency. See MODEL STATE EMERGENCY HEALTH POWERS ACT §§ 804(b)(3)–(4) (Ctr. for Law & the Public’s Health, Discussion Draft 2001), available at <http://www.publichealthlaw.net/MSEHPA/MSEHPA.pdf>.

tions.²²⁵ The following are several examples of the various immunity models.

1. Immunity Tied to Compliance with Government Instructions, Government Contracts, or Requirements of Law During Public Health Emergencies

a. Arizona. Persons or health care providers engaging in activities required by the law, such as reporting or quarantine procedures, are immune from civil or criminal liability so long as they acted in good faith.²²⁶ Individuals are presumed to act in good faith when their actions are required by the law.²²⁷

b. Delaware. The law deems the following to be public employees and thereby eligible for immunity: (1) a person who owns or controls real estate and allows its use, without remuneration, to shelter people during a public health emergency; (2) a private person, firm, or corporation (or employee or agent thereof) that provides assistance or advice at the request of the state or a local government during a public health emergency.²²⁸

c. Hawaii. The state's Director of Health is statutorily empowered to contract with health care entities and providers for purposes of controlling a dangerous disease epidemic that requires facilities, materials, or personnel in excess of those available.²²⁹ Absent willful misconduct, health care providers and facilities acting pursuant to such an agreement are not liable for injuries or property damage resulting from their actions.²³⁰

d. New Jersey. Public entities and their agents, employees, or representatives, including volunteers, are granted civil immunity for injuries caused in connection with a public health emergency or preparation for such an emergency.²³¹ The same is true for persons or private entities that own or control property that is used in response to a public health emergency, perform a contract with a public entity, or provide a public entity with assistance or advice during a public health emergency.²³² Although no individual or private entity is liable for injuries caused by an act or omission authorized by law in the context of a public health emergency, immunity is not available for conduct that is not authorized by the act or that constitutes a crime, fraud, actual malice, gross

225. See Tarik Abdel-Monem & Denise Bulling, *Liability of Professional and Volunteer Mental Health Practitioners in the Wake of Disasters: A Framework for Further Considerations*, 23 BEHAV. SCI. & L. 573, 578 (2005) (stating that "[i]mmunity typically extends to both state agents and volunteer responders working within the scope of their duties and in furtherance of disaster response for actions resulting in property damage or personal injury including death, with the exception of acts or omissions that constitute gross negligence or willful misconduct").

226. ARIZ. REV. STAT. ANN. § 36-790(B) (2003).

227. *Id.*

228. DEL. CODE ANN. tit. 20, § 3144 (2004).

229. HAW. REV. STAT. § 325-20(a) (2005).

230. *Id.* § 325-20(e).

231. N.J. STAT. ANN. § 26:13-19(b)(1) (West 2007).

232. *Id.* § 26:13-19(c)(1).

negligence, or willful misconduct.²³³

e. Wisconsin. Persons who provide “equipment, materials, facilities, labor, or services” are not liable for death, injury, or property damage so long as they acted under the direction of governmental authorities and in response to enemy action, natural or manmade disasters, or an emergency declared by the state or federal government.²³⁴ No immunity is available for “reckless, wanton, or intentional misconduct.”²³⁵

f. Wyoming. Health care providers and other individuals who follow the instructions of a state health officer during a public health emergency will not be liable for any activities relating to compliance with those instructions, so long as they do not constitute “gross negligence or willful or wanton misconduct.”²³⁶

2. Broader Immunity Provisions in Public Health Emergency Statutes

a. Louisiana. The law’s liability section mirrors MSEHPA, but it adds another notable provision: “During a state of public health emergency, any health care providers shall not be civilly liable for causing the death of, or, injury to, any person or damage to any property except in the event of gross negligence or willful misconduct.”²³⁷

b. Maine. The statute offers immunity from civil liability to private institutions and their employees and agents to the extent immunity is available to state agencies and employees for acts relating to reporting, confining individuals, and providing prescribed care during a declared extreme public health emergency.²³⁸ During such an emergency, private institutions are also immune from liability that is related to properly investigating the credentials of licensed health care workers prior to hiring, credentialing, or privileging, so long as the hiring process complied with requirements specified in the statute.²³⁹ Finally, immunity is available for participation in good faith reporting or investigative activities prescribed by the law that relate to communicable diseases.²⁴⁰

233. *Id.* § 26:13-19(c)(2).

234. WIS. STAT. § 166.03(10)(a) (2006).

235. *Id.* § 166.03(10)(2)(b).

236. WYO. STAT. ANN. § 35-4-114 (2007).

237. LA. REV. STAT. ANN. § 29:771(B)(2)(c) (2007). A “health care provider” is defined as a “a clinic, person, corporation, facility, or institution which provides health care or professional services by a physician, dentist, registered or licensed practical nurse, pharmacist, optometrist, podiatrist, chiropractor, physical therapist, psychologist, or psychiatrist, and any officer, employee, or agent thereof acting in the course and scope of his service or employment.” *Id.* § 29:762(4) (2007).

238. ME. REV. STAT. ANN. tit. 22, § 816(1) (2004). An “extreme public health emergency” is defined as “the occurrence or imminent threat of widespread exposure to a highly infectious or toxic agent that poses an imminent threat of substantial harm to the population of the State.” *Id.* § 801(4-A).

239. *Id.* § 816 (1-A) (Supp. 2007).

240. *Id.* § 816(2) (2004).

3. Provisions in General Emergency Statutes

a. California. The statute provides immunity for the state, its political subdivisions, employees, and volunteers, and other states or their officers or employees rendering aid in California.²⁴¹ In addition, the law establishes liability protection for physicians and surgeons (including those licensed in a different state), hospitals, pharmacists, nurses, or dentists who render services during a state of emergency with the exception of willful acts or omissions.²⁴²

b. Michigan. The law provides that disaster relief force personnel who are not employees of the state or local government are entitled to the same immunity that is available to state employees.²⁴³ State and local governmental agencies and their employees or agents are not liable for personal injury or property damage sustained by disaster-relief-force personnel or any other person.²⁴⁴ Immunity is also extended to all those engaged in disaster relief work, including private persons and volunteers and those gratuitously allowing use of their premises for purposes of sheltering people, so long as they disclose any known safety hazards on the property.²⁴⁵ Finally, licensed hospitals, physicians, and certain listed clinicians who provide services during a declared emergency at “the express or implied request of a state official or agency or county or local coordinator or executive body” are not liable for injuries unless they result from willful or gross negligence.²⁴⁶ The caregivers need not be licensed in Michigan to be covered.²⁴⁷ Notably, they may also perform a variety of procedures for which they are not licensed so long as they do so under the supervision of a medical staff member of a licensed Michigan hospital.²⁴⁸

c. Minnesota. The statute establishes that while an emergency executive order is in effect, “a responder in any impacted region acting consistent with emergency plans is not liable for any civil damages or administrative sanctions as a

241. CAL. GOV'T CODE § 8655, 8657(a)–(b) (West 2005).

242. *Id.* § 8659.

243. MICH. COMP. LAWS ANN. § 30.411(1) (West 2004 & Supp. 2007). Disaster relief forces are defined as “all agencies of state, county, and municipal government, private and volunteer personnel, public officers and employees, and all other persons or groups of persons having duties or responsibilities under this act or pursuant to a lawful order or directive authorized by this act.” *Id.* § 30.402(f) (West 2004).

244. *Id.* § 30.411(2) (West 2004 & Supp. 2007).

245. *Id.* §§ 30.41(3), (7)–(8).

246. *Id.* § 30.411(4).

247. *Id.*

248. *Id.* § 30.411(5). The clinicians covered by subsections 4 and 5 are registered nurses, practical nurses, nursing students acting under the supervision of a licensed nurse, dentists, veterinarians, pharmacists, pharmacist interns supervised by licensed pharmacists, paramedics, and medical residents being trained in a licensed hospital. *Id.* § 30.411(6). These individuals may perform “administration of anesthetics, minor surgery, intravenous, subcutaneous, or intramuscular procedure; or oral and topical medication; or a combination of these under the supervision of a member of the medical staff of a licensed hospital of this state, and may assist the staff member in other medical and surgical proceedings.” *Id.* § 30.411(5).

result of good faith acts or omissions . . . in rendering emergency care, advice, or assistance.”²⁴⁹ Coverage does not extend to malfeasance in office or willful or wanton misconduct.²⁵⁰

IV. THE BOTTOM LINE: WHO AND WHAT IS ELIGIBLE FOR IMMUNITY

This Part will synthesize and analyze the contemporary immunity scheme for public health emergency responders. American law creates a patchwork of liability protections for various actors responding to public health emergencies.²⁵¹ No source, however, addresses liability and immunity issues in a comprehensive way, and many existing statutes leave important gaps and uncertainties.

A. GOVERNMENTAL ENTITIES AND EMPLOYEES

Federal, state, and local entities and their employees or agents who are performing their official duties enjoy extensive immunity protections. Nevertheless, plaintiffs may still have several litigation vehicles at their disposal.

Governmental entities and their employees are likely to be shielded from liability for tort actions by the FTCA or equivalent state tort claims acts, as long as the challenged act or omission relates to a discretionary function.²⁵² With respect to constitutional claims, federal and state governmental entities will be entitled to sovereign immunity, but local governments are not.²⁵³ In addition, federal and state officials will be entitled to qualified immunity for discretionary functions unless they knew or should have known that their conduct would violate statutory or constitutional rights.²⁵⁴

Under EMAC, states and their officers or employees are entitled to immunity when they provide assistance in a different state, and clinicians need not be licensed in the state in which they are rendering aid, so long as they are licensed in the state in which they are employed or have been deputized.²⁵⁵ In addition, states and state employees are granted liability protections under some regional mutual aid agreements²⁵⁶ and state emergency response statutes, as are local governmental entities and their employees, so long as they do not engage in willful or reckless misconduct.²⁵⁷

All public employees might also enjoy the benefits of waivers of certain

249. MINN. STAT. ANN. § 12.61(2)(b) (West 2007).

250. *Id.*

251. *See* UNIF. EMERGENCY VOLUNTEER HEALTH PRACTITIONERS ACT 3–4 (Nat’l Conference of Comm’rs on Unif. State Laws, Current Draft for Consideration Concerning Reserved Sections 11 and 12, 2007) (on file with author) (discussing the “patchwork of protections” that may apply to specific volunteers in limited settings).

252. *See supra* section III.A.1.

253. *See supra* section III.A.2.

254. *See supra* section III.A.2.

255. *See supra* section III.A.3.

256. *See supra* section III.A.3.

257. *See supra* section III.D.

statutory requirements under § 1135 of the Social Security Act.²⁵⁸ Thus, for example, they may not be sanctioned for violations of HIPAA or EMTALA during a public health emergency.²⁵⁹ Finally, under the PREP Act, public employees handling “covered countermeasures” will be immune from liability for all but willful misconduct if the HHS Secretary makes a declaration that triggers the Act.²⁶⁰

To illustrate, federal and state entities and officials, such as CDC employees or state health department workers, should be immune from liability for tort actions and constitutional claims arising from policy decisions concerning how to triage patients or ration scarce resources so long as they act in good faith. A public worker will not be protected against tort or constitutional claims, however, if she hoards scarce vaccines and immunizes all her friends and family members without a public health rationale for doing so.

With respect to disclosure of private health information, public officials will not be responsible for violations of HIPAA if a § 1135 waiver is issued.²⁶¹ Even absent a § 1135 waiver, the HIPAA Privacy Rule contains exceptions that allow certain disclosures for the purpose of public health activities.²⁶² However, plaintiffs may be able to assert successful tort claims for invasion of privacy and breach of confidentiality that are allowable under the FTCA and state law.²⁶³ Likewise, if government officials discriminate against or do not adequately accommodate individuals with disabilities, such individuals could sue state and local governmental entities under Title II of the ADA²⁶⁴ and sue federal executive agencies under § 504 of the Rehabilitation Act,²⁶⁵ though proving statutory violations in the context of a public health emergency might be difficult.²⁶⁶

B. UNCOMPENSATED VOLUNTEERS

Individual unpaid volunteers who respond to an emergency will benefit from

258. 42 U.S.C. § 1320b-5 (Supp. IV 2004). For a discussion of this provision, see *supra* notes 39–44 and accompanying text.

259. 42 U.S.C. § 1320b-5(b).

260. See *supra* section III.C.1.

261. 42 U.S.C. § 1320b-5(b).

262. 45 C.F.R. § 164.512(b) (2007) (allowing disclosure of protected health information without patient authorization to public health authorities that are “authorized by law to collect or receive . . . information for the purpose of preventing or controlling disease, injury, or disability”).

263. See *Black v. Sheraton Corp. of Am.*, 564 F.2d 531, 539 (D.C. Cir. 1977) (finding that the claim of invasion of privacy is not barred by governmental immunity); Eve Klindera, *Qualified Immunity for Cops (and Other Public Officials) with Cameras: Let Common Law Remedies Ensure Press Responsibility*, 67 GEO. WASH. L. REV. 399, 429 n.289 (1999) (“It is unclear . . . whether the government could successfully assert that the FTCA’s discretionary function exception should preclude liability in cases where plaintiffs claim an invasion of privacy due to the presence of the media during official activities.”).

264. See 42 U.S.C. § 12132 (2000).

265. See 29 U.S.C. § 794 (2000 & Supp. II 2002).

266. See *supra* section II.C.

several sources of immunity, though these too are subject to limitations. Good Samaritan statutes enacted at the state level are one important source of this protection.²⁶⁷ The Federal Volunteer Protection Act of 1997 also provides limited immunity from many lawsuits to properly licensed volunteers for non-profit organizations and governmental entities, as do some state volunteer protection acts.²⁶⁸ Finally, volunteers are protected by some state laws that specifically address general and public health emergencies.²⁶⁹

Although it appears that volunteers typically should not be concerned about liability, volunteer immunity raises several complex questions. First, volunteers are generally covered only if they are not compensated for their work.²⁷⁰ Thus, an individual whose regular employer continues to pay her salary while she participates in relief efforts in another state would not seem to be covered by most relevant statutes. A model state law, the Uniform Emergency Volunteer Health Practitioners Act,²⁷¹ aims to address this limitation. Section 2(15) of the model act, which would provide volunteers with liability protection, defines “volunteer health practitioner” as “a health practitioner who provides health or veterinary services, whether or not the practitioner receives compensation for those services.”²⁷² The Act, however, excludes practitioners who have a preexisting employment relationship with the entity for which they are working.²⁷³ Thus, hospital employees who continue to work at the hospital during a public health emergency would not be covered as volunteers under the Act.

Another limitation of the term “volunteer” is that it generally refers only to individual rescuers and does not cover hospitals, businesses, and other entities that might participate in emergency response operations without charge.²⁷⁴ The Volunteer Protection Act explicitly states that it does not affect “the liability of

267. See *supra* section III.B.1.

268. See *supra* section III.B.2. Volunteers can, however, be sued by the nonprofit organization or governmental entity for which they work. Likewise, volunteers may be responsible for certain amounts of non-economic damages. See *supra* note 203 and accompanying text.

269. See *supra* section III.D; see also, e.g., 20 ILL. COMP. STAT. 3305/10(k) (2006); MO. REV. STAT. § 44.023(5) (2000 & Supp. 2006); OHIO REV. CODE ANN. §§ 121.404, 5502.30 (West 2006).

270. See *supra* section III.B.1 (discussing Good Samaritan statutes); see also Volunteer Protection Act, 42 U.S.C. § 14505(6) (2000) (defining a “volunteer” as an “individual performing services for a nonprofit organization or a governmental entity who does not receive” compensation other than compensation for incurred expenses or any gift that is valued at over \$500 per year in return for the assistance provided); UNIF. EMERGENCY VOLUNTEER HEALTH PRACTITIONERS ACT § 2 cmt. 15 (Nat’l Conference of Comm’rs on Unif. State Laws 2006), available at <http://www.uevhpa.org/Uploads/uevhpafinal.pdf> (stating that “many legal definitions of ‘volunteer’ . . . characterize a volunteer as an individual who does not receive compensation for services”).

271. UNIF. EMERGENCY VOLUNTEER HEALTH PRACTITIONERS ACT (Nat’l Conference of Comm’rs on Unif. State Laws 2006), available at <http://www.uevhpa.org/Uploads/uevhpafinal.pdf>.

272. *Id.* § 2(15).

273. *Id.*; see also *id.* § 2(9) (defining “host entity”).

274. See generally *ESAR-VHP*, *supra* note 45, at app. D (summarizing state Good Samaritan statutes). But see Corporate Good Samaritan Act of 2008, 2007 GA H.B. 89 (extending liability protection to corporate entities providing goods or services without compensation under supervision of state authorities, in preparation for, anticipation of, or during a declared emergency).

any nonprofit organization or governmental entity with respect to harm caused to any person.”²⁷⁵ The proposed Uniform Emergency Volunteer Health Practitioners Act also defines a volunteer as an individual health practitioner,²⁷⁶ though it would establish that “[s]ource, coordinating, and host entities are not vicariously liable for the acts or omissions of volunteer health practitioners.”²⁷⁷ A few initiatives have been undertaken at the state level to expand the scope of coverage for volunteers so that it extends beyond individual persons. For example, in May of 2008, the governor of Georgia signed into law the “Corporate Good Samaritan Act of 2008.”²⁷⁸ The Act extends to “any association, . . . private for profit entity, not for profit entity, religious organization, or charitable organization,” among other parties.²⁷⁹ Without such statutes, however, hospitals, hotels, stadiums, and other entities that donate their time, space, supplies, and resources to emergency response efforts, will not enjoy the benefit of laws that establish immunity for volunteers.

C. PAID RESPONDERS AND ENTITIES

The actors who are often left entirely out of the immunity picture are private-sector employees who are paid for their work, such as clinicians in an affected state who continue doing their regular jobs but must operate under public health emergency conditions. Non-governmental entities, such as private hospitals or clinics, are also often excluded from immunity coverage, whether they charge for their services or donate them. These exclusions are startling because health care entities and paid workers are likely to bear the brunt of the burden during a public health emergency, as hundreds or thousands of patients seek medical care.

Entities and non-volunteers who manufacture, distribute, administer, or dispense countermeasures or unapproved products pursuant to a declaration by the HHS Secretary may be covered by the PREP Act or the Project BioShield Act.²⁸⁰ If the Secretary issues a waiver under section 1135 of the Social Security Act, entities and non-volunteers may also be shielded from administrative sanctions for certain HIPAA and EMTALA violations, and may be excused

275. 42 U.S.C. § 14503(c) (2000).

276. UNIF. EMERGENCY VOLUNTEER HEALTH PRACTITIONERS ACT § 2 cmt. 15 (Nat’l Conference of Comm’rs on Unif. State Laws 2006), available at <http://www.uevhpa.org/Uploads/uevhpafinal.pdf>.

277. UNIF. EMERGENCY VOLUNTEER HEALTH PRACTITIONERS ACT § 11(d) (Nat’l Conference of Comm’rs on Unif. State Laws, Current Draft for Consideration Concerning Reserved Sections 11 and 12, 2007) (on file with author).

278. UNC Sch. of Public Health, *Georgia Enacts Corporate Good Samaritan Act*, May 19, 2008, http://nciph.sph.unc.edu/law/ud_051908.htm.

279. 2007 GA H.B. 89; see also An Act Relating to Civil Emergency Preparedness; Providing Limited Liability to a Person who Voluntarily Provides Goods or Services to Another Person for an Emergency Situation Declared by the Governor; Repealing the Emergency Licensing Act, S. 16, 48th Leg., 1st Sess. § 1(b) (N.M. 2007) (offering liability protection to any volunteer who is a “person, including the person’s officers, directors, employees and agents.”)

280. See *supra* section III.C.

from several other legal requirements.²⁸¹ However, individuals and organizations that are not government workers will not be entitled to sovereign immunity or Eleventh Amendment immunity.²⁸² Similarly, entities and persons who are paid for their services will not be entitled to Good Samaritan status or Federal Volunteer Protection Act coverage.²⁸³ If responders are deputized by a state to provide assistance for a particular emergency, they may or may not be covered by EMAC.²⁸⁴ The state emergency response statutes are also inconsistent in their treatment of paid responders and organizations.²⁸⁵

While private-sector employees and entities might enjoy immunity in some states or in certain circumstances, their liability protection is less comprehensive than that to which other responders are entitled. Consequently, these parties might be sued and found liable for a variety of decisions and actions that are likely to be required by a public health emergency. Liability could arise from triaging decisions, choices concerning how to ration scarce resources, confidentiality breaches, providing medical services without appropriate licensure, or providing negligent care. Health care providers are well aware of these possibilities and have indicated that the potential for litigation might influence their willingness to participate in response activities.²⁸⁶

V. RECOMMENDATIONS

This Part develops a proposal for the enactment of a comprehensive immunity provision that will extend to all health care providers who respond to a public health emergency, including governmental workers, volunteers, paid employees, and private and public entities. I attempt to fashion a balanced approach to liability and immunity that promotes participation in emergency response activities while safeguarding the primary goals of liability: effective deterrence of misconduct and compensation of victims in appropriate cases. This proposed provision is a necessary response to health care providers' concerns about liability. In addition, it will not leave those who do respond, perhaps at great risk to themselves, vulnerable to lawsuits for simple negligence and thus punishable for their good-faith conduct in exigent circumstances. The provision, therefore, could be critical to achieving effective emergency response initiatives, providing needed guidance to decision-makers and promoting justice.

281. *See supra* section I.A.1.

282. *See supra* sections III.A.1–2.

283. *See supra* section III.B.

284. *See supra* section III.A.3.

285. *See supra* section III.D.

286. *See supra* notes 5–6 and accompanying text.

A. MATTERS TO CONSIDER IN CRAFTING LEGISLATION

1. Encouraging Participation in Response Activities

Legislators and policymakers designing laws and regulations for public health emergencies must be particularly sensitive to the incentives and disincentives they establish through the assignment of liability and immunity. Concern about litigation might hinder an effective response by discouraging health care professionals or entities from offering assistance under circumstances that could give rise to liability because they do not enable the provision of optimal care. Some might hesitate to volunteer their services. Others who are expected to respond in the ordinary course of their work might be so concerned about liability that they choose to be absent from their jobs or, in the case of hospitals and clinics, close their doors once they have reached ordinary capacity. In addition, hospitals may refuse to accept the assistance of volunteers for fear that they will be held liable for injuries caused by volunteers,²⁸⁷ even though the uncompensated providers will themselves be immune from liability.²⁸⁸

Concern about liability is so profound and pervasive that, according to many, it has led to the common practice of “defensive medicine.”²⁸⁹ A survey of 824 Philadelphia physicians specializing in areas with a high risk of litigation found that ninety-three percent of respondents acknowledged that they sometimes or often engage in at least one form of defensive medicine, including over-ordering diagnostic tests, referring patients to other specialists unnecessarily, and avoiding high-risk patients.²⁹⁰ The frequency of these activities did not correlate with objective measures of “physicians’ liability experience and exposure,” but rather, stemmed from deep anxiety, however exaggerated.²⁹¹ Physicians’ concern about liability is likely to be particularly acute during an emergency, when resources are scarce and optimal care cannot be provided.²⁹² Indeed, a survey conducted by the American Public Health Association found that the majority of clinicians indicated that liability concerns would impact their decisions concerning participation in emergency response efforts.²⁹³

Other analysts confirm that malpractice liability concerns lead physicians to

287. For discussion of vicarious liability and ostensible agency theories, see *supra* notes 71–76 and accompanying text.

288. For discussion of immunity for uncompensated volunteers, see *supra* notes 267–79 and accompanying text.

289. David M. Studdert et al., *Defensive Medicine Among High-Risk Specialist Physicians in a Volatile Malpractice Environment*, 293 JAMA 2609, 2609 (2005) (discussing defensive medicine).

290. *Id.* at 2612, 2615.

291. *Id.* at 2615 (stating that “[p]ersonal anxiety may . . . overshadow actual experience”).

292. Kipnis, *supra* note 126, at 88 (“In a disaster, there may not be enough to go around. The number of patients who present at a hospital can significantly exceed its carrying capacity”); Press Release, Am. Med. Ass’n, Justice Served for Dr. Pou (July 24, 2007), available at <http://www.ama-assn.org/ama/pub/category/print/17849.html> (“The AMA continues to be very concerned about criminalizing decisions about patient care, especially those made during the chaotic aftermath of a disaster, when medical personnel and supplies are severely compromised.”).

293. See *supra* note 5 and accompanying text.

practice defensive medicine.²⁹⁴ They further find that legislative reforms that reduce malpractice pressures diminish the use of defensive medicine and “treatment intensity.”²⁹⁵ Consequently, according to these commentators, such reforms improve physician productivity, and notably, do not compromise patient welfare and health outcomes.²⁹⁶

In addition, damages caps have been found to generate small increases in the supply of physicians.²⁹⁷ This phenomenon is particularly relevant to public health emergencies. It reinforces this Article’s contention that diminished concerns about liability are associated with greater willingness on the part of individuals to serve as health care providers.

The U.S. Congress, in formulating the Volunteer Protection Act, recognized the importance of liability protection in encouraging altruistic behavior. In § 14501(a), Congress explained that:

- (1) the willingness of volunteers to offer their services is deterred by the potential for liability actions against them;
- (2) as a result, many nonprofit public and private organizations and governmental entities . . . have been adversely affected by the withdrawal of volunteers from boards of directors and service in other capacities.²⁹⁸

The purpose of the Act, consequently, is to promote social welfare “by reforming the laws to provide certain protections from liability abuses related to volunteers serving nonprofit organizations and governmental entities.”²⁹⁹

2. Controlling Court Dockets and Insurance Costs

In addition to encouraging participation in response activities, immunity can serve important economic and efficiency functions by significantly reducing the volume of litigation that stems from public health emergencies. Because it is unlikely that individuals will receive the same level of care that they would enjoy under ordinary circumstances, health care providers might be inundated with lawsuits filed by disappointed patients absent clear alteration of liability standards. Such litigation could significantly raise malpractice insurance costs for health care providers. In light of substantial increases in insurance premium

294. See Daniel P. Kessler & Mark B. McClellan, *How Liability Law Affects Medical Productivity*, 21 J. HEALTH ECON. 931, 952 (2002).

295. *Id.*

296. *Id.*

297. Daniel P. Kessler et al., *Impact of Malpractice Reforms on the Supply of Physician Services*, 293 JAMA 2618, 2618, 2623–24 (2005) (“Three years after adoption, direct reforms increased physician supply by 3.3%, controlling for fixed differences across states, population, states’ health care market and political characteristics, and other differences in malpractice law.”); MICHELLE M. MELLO, ROBERT WOOD JOHNSON FOUND., *MEDICAL MALPRACTICE: IMPACT OF THE CRISIS AND EFFECT OF STATE TORT REFORMS* 11 (2006), http://www.rwjf.org/pr/synthesis/reports_and_briefs/pdf/no10_researchreport.pdf (“The best studies suggest that caps are associated with a small increase in physician supply.”).

298. 42 U.S.C. § 14501(a)(1), (2) (2000).

299. See *id.* § 14501(b) (2000).

costs in recent years, physicians and advocates have already expressed concern about the future of the medical profession. Some believe that many physicians will be forced to end their careers, limit their practices to low-risk procedures, or move away from certain geographic regions with particularly high malpractice insurance rates.³⁰⁰ In addition, if a multitude of claims are filed that require insurers to pay for prolonged litigation or settlements, it is possible that some insurers will find their financial viability threatened and will stop issuing malpractice policies.³⁰¹

A large number of public-health-emergency-related cases could also clog court dockets and prevent the judiciary from attending to other business. Such cases might involve particularly difficult proof questions because traumatized victims may have murky recollections of events, and chaotic conditions could impede recordkeeping and retention of evidence. The impact of public health emergencies on medical malpractice insurance costs and court dockets could be reduced by the institution of liability protection about which the public is educated so that potential plaintiffs do not pursue claims covered by immunity legislation. Although cases of gross negligence or willful misconduct should still be actionable, and some cases will involve disputes as to whether conduct constituted ordinary or gross negligence, lawyers presumably would refuse to accept clients whose complaints clearly relate to no more than ordinary negligence.

3. Volunteer Oversight

An important policy question is whether volunteers should receive immunity coverage if they are not working under the direction of a governmental entity or nonprofit organization coordinating emergency response activities. Is it desirable to protect spontaneous volunteers who independently appear on the scene and begin dispensing medication or providing treatment? Might encouraging

300. Alec Shelby Bayer, *Looking Beyond the Easy Fix and Delving into the Roots of the Real Medical Malpractice Crisis*, 5 HOUS. J. HEALTH L. & POL'Y 111, 125 (2005) (reporting that California experienced a medical malpractice insurance crisis in the 1970s that caused doctors to leave the state or limit their practices); Mary Margaret Penrose & Dace A. Caldwell, *A Short and Plain Solution to the Medical Malpractice Crisis: Why Charles E. Clark Remains Prophetically Correct About Special Pleading and the Big Case*, 39 GA. L. REV. 971, 975 (2005) ("Essentially, doctors and their advocates assert that without stiff and immediate limitations on medical malpractice litigation, doctors will be unable to afford the escalating costs of medical malpractice insurance coverage and will eventually be 'run out of town' or at least out of business, leaving many of us without the aid of a physician when we need medical care.").

301. *Barme v. Wood*, 689 P.2d 446, 448 (Cal. 1984) (discussing the high cost of medical malpractice insurance coverage in California, which caused some malpractice insurers to stop selling policies and others to raise premium charges to a level that led many doctors to leave California, limit their practices, or practice without any insurance coverage); *Hurricane Katrina Insurance Issues: Hearing Before the Subcomm. on Oversight and Investigations of the H. Comm. on Financial Services*, 110th Cong. (2007) (statement of Rep. Bobby Jindal) (stating that insurance companies are refusing to issue new insurance policies in Louisiana because they claim they cannot afford to do so, but noting that insurance companies had a record \$44.8 billion in profits in 2006).

individualized interventions hinder or conflict with the efforts of relief organizations?

Existing and proposed laws adopt different approaches. Good Samaritan statutes generally apply to all volunteers and do not distinguish between those acting independently and those acting with oversight by the government or a relief organization.³⁰² State emergency response statutes are inconsistent in their treatment of volunteers, some being more liberal than others in terms of which volunteers are covered.³⁰³ The federal Volunteer Protection Act applies only to volunteers of “a nonprofit organization or governmental entity.”³⁰⁴ The Uniform Emergency Volunteer Health Practitioners Act would apply only to “volunteer health practitioners registered with a [valid] registration system . . . who provide health or veterinary services in this state for a host entity.”³⁰⁵ Another proposed statute, the Hurricane Katrina Emergency Health Workforce Act of 2005,³⁰⁶ similarly called for the establishment of a National Emergency Health Professionals Volunteer Corps “to provide for an adequate supply of health professionals in the case of a Federal, State or local emergency.”³⁰⁷ Legislators drafting statutes that address volunteer immunity and liability, therefore, must determine whether to establish disincentives for volunteers to act independently and whether to exclude those without oversight from coverage.

4. Professional Licensure Requirements

A further matter of concern is whether caregivers should enjoy immunity if they provide services that require licensing that the individual does not possess. In extreme emergencies, it may be better to have unlicensed individuals performing tasks for which they are not credentialed than to withhold care from disaster victims altogether. Nevertheless, laxity about licensing standards can also lead to irresponsible and unnecessarily deficient medical care. Various statutes address this question differently. The Volunteer Protection Act, for example, extends immunity only to those who are properly licensed or certified.³⁰⁸ By contrast, Michigan’s emergency response statute allows individuals to perform medical tasks without proper licensing so long as they are overseen by a

302. See generally *ESAR-VHP*, *supra* note 45, at app. D (summarizing state Good Samaritan statutes).

303. See, e.g., 20 ILL. COMP. STAT. 3305/10(k) (2006) (covering volunteers who work under the direction of local emergency services and accredited disaster agencies); MICH. COMP. LAWS ANN. § 30.411(3) (West 2004 & Supp. 2007) (covering volunteer members of disaster relief forces or other “private or volunteer personnel engaged in disaster relief activity”); MINN. STAT. ANN. § 12.61(1)(c), (2)(b) (West 2005 & Supp. 2008) (covering volunteers who provide health-related services and act in a manner that is consistent with emergency plans).

304. 42 U.S.C. § 14503(a) (2000).

305. UNIF. EMERGENCY VOLUNTEER HEALTH PRACTITIONERS ACT § 3 (Nat’l Conference of Comm’rs on Unif. State Laws 2006), available at <http://www.uevhpa.org/Uploads/uevhpafinal.pdf>.

306. Hurricane Katrina Emergency Health Workforce Act of 2005, S. 1638, 109th Cong.

307. *Id.* § 3(a).

308. 42 U.S.C. § 14503(a)(2) (2000).

licensed hospital worker.³⁰⁹ Thus, precedent exists for both approaches.

B. PROPOSED LEGISLATIVE SOLUTIONS: A COMPREHENSIVE IMMUNITY PROVISION

The most appropriate remedy for the existing gaps in the public health emergency immunity scheme is a comprehensive immunity provision that addresses liability for all health care providers, whether they be paid or unpaid, private or public sector workers, individuals, or entities. Such a provision should be incorporated into the Public Health Service Act³¹⁰ and state public health emergency statutes so that it applies when either the HHS Secretary or a governor declares a public health emergency.³¹¹ States that do not currently have a statute that specifically addresses public health emergencies would be urged to enact such a law, incorporating a comprehensive emergency provision.

1. The Details of the Suggested Provision

The provision should establish that health care providers will not be liable for injuries or harm caused by good-faith actions undertaken in order to respond to a public health emergency so long as they are acting in their capacity as employers or employees in the affected area or volunteering under the direction of governmental authorities or nonprofit organizations, and are not engaged in willful misconduct, gross negligence, or criminal activity.

The term “health care provider” should be defined as a “provider of services” or a “provider of medical and other health services,” as those terms are defined in the HIPAA legislation.³¹² HIPAA defines “provider of services” in relevant part as “a hospital, critical access hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency, [or] hospice program.”³¹³ “Medical and other health services” are defined by describing various hospital, diagnostic, clinical, ambulance, and other services, which are too numerous to list here.³¹⁴ Thus, if hotels were turned into hospitals in an emergency or unlicensed individuals were trained to provide certain covered services,³¹⁵ they would be considered health care providers and eligible for protection under the proposed provision.

The law should also address oversight and licensure issues. Following precedent established in the Volunteer Protection Act, volunteers should be protected

309. MICH. COMP. LAWS ANN. § 30.411(4), (5) (West 2004 & Supp. 2007).

310. 42 U.S.C. § 247d(a) (2000 & Supp. II 2002). On February 7, 2007, Representative Paul Gillmor in fact introduced a bill “[t]o amend the Public Health Service Act to provide liability protections for employees and contractors of health centers under section 330 of such Act who provide health services in emergency areas.” H.R. 870, 110th Cong. (2007). Thus, some lawmakers are already contemplating revisions of the Public Health Service Act to include an immunity provision.

311. For discussion of emergency declarations by various authorities, see *supra* section I.A.

312. See 42 U.S.C.A. § 1395x(s), (u) (West Supp. 2007).

313. *Id.* § 1395x(u).

314. *Id.* § 1395x(s). The HIPAA Privacy Rule defines “health care provider” by reference to these statutory provisions. See 45 C.F.R. § 160.103 (2007).

315. See *infra* notes 321–22 and accompanying text.

only if they are working with oversight from a governmental entity or nonprofit organization.³¹⁶ Thus, volunteers will not be protected if they appear on the scene independently and operate without direction from coordinating agencies. Such conduct is undesirable because it could hinder and conflict with, rather than advance, response operations.

While particular organizations might choose to call only upon volunteers who are listed on a registry,³¹⁷ the provision should cover all volunteers who are appropriately licensed³¹⁸ and supervised, regardless of whether they are members of a registry. In an emergency, it is possible that computer and communication systems will fail, thus hindering the use of registries, or that many of those who registered with the hopes of serving as responders will be unavailable because of their personal circumstances. It seems imprudent to turn away qualified volunteers because of their registry status when there is desperate need for assistance.

Ordinarily, responders should be required to hold appropriate licenses, certificates, or permits to perform the tasks they are undertaking. The proposed immunity provision, however, should incorporate the principle of licensure reciprocity established in EMAC.³¹⁹ Thus, during a public health emergency, individuals licensed in one state would be able to provide assistance in another state in which they are not licensed.³²⁰

It is possible, however, that at the height of the crisis, demand for care will be so great that there will not be enough personnel with licenses from any state to provide all needed services. At that point, a choice will have to be made between foregoing care altogether and utilizing individuals with a strong medical background who are not specifically credentialed to perform the tasks at issue. Consequently, the law should enable the HHS Secretary or a governor to make a specific finding during a public health emergency that the supply of licensed health care professionals is insufficient to meet demand and to issue an order allowing health care providers to perform tasks for which they are not licensed as long as they do so under the supervision of properly credentialed health care providers. This determination would be separate from the determination that a public health emergency exists, and the authorization would not *require* health care entities to utilize unlicensed providers. Rather, it would empower them to choose to do so and would extend immunity for all but willful misconduct, gross negligence, and criminal activity to the unlicensed workers,

316. 42 U.S.C. § 14503(a) (2000).

317. For discussion of volunteer registries, see *supra* notes 57–58 and accompanying text. The Uniform Emergency Volunteer Health Practitioners Act of 2007 would protect only individuals who are registered with a registration system. UNIF. EMERGENCY VOLUNTEER HEALTH PRACTITIONERS ACT § 3 (Nat'l Conference of Comm'rs on Unif. State Laws 2006), *available at* <http://www.uevhpa.org/Uploads/uevhpafinal.pdf>. A covered registration system is defined in section 5 of the Act. *Id.* § 5.

318. For discussion of licensure requirements, see *infra* notes 319–22 and accompanying text.

319. For discussion of EMAC, see *supra* section III.A.3.

320. See 110 Stat. 3877, 3880; *supra* section III.A.3.

their supervisors, and the health care entities using their services while operating under such authorization.

A similar approach has already been adopted by the state of Michigan.³²¹ Michigan specifies the categories of individuals who may perform particular services for which they are not licensed, with appropriate oversight. These include registered nurses, practical nurses, nursing students supervised by licensed nurses, dentists, veterinarians, pharmacists, pharmacist interns supervised by licensed pharmacists, paramedics, and medical residents being trained in a licensed hospital in any state.³²² The proposed statutory amendment should similarly specify the categories of professionals and professionals-in-training who have a sufficiently strong medical background to be eligible to perform services under this provision. It should also specify the tasks that they should be authorized to perform under appropriate supervision. Legislators might consider including, in the list of eligible individuals, clinicians who became inactive or retired in good standing and are still physically and mentally able to work.

Telemedicine may offer another resource for public health emergency response efforts. Telemedicine is "the delivery of health care at a distance, increasingly but not exclusively by means of the Internet."³²³ According to some, India has been extremely active in providing telemedicine to the United States, having captured as much as two percent of the U.S. health care market through outsourcing and earning hundreds of millions of dollars.³²⁴ While some states have erected legislative barriers to the employment of foreign providers for purposes of telemedicine,³²⁵ health care providers outside the United States with experience serving American physicians and patients might be an invaluable resource during an emergency. States that have statutorily rejected this approach might need to incorporate waivers of the telemedicine practice restrictions into their public health emergency response laws.

The proposed immunity provision is designed to create a comfort level that will encourage entities and individuals to participate in response operations and

321. MICH. COMP. LAWS ANN. § 30.411(5)–(6) (West 2004 & Supp. 2007).

322. *Id.* § 30.411(6)(a). The services that can be performed by such individuals are "administration of anesthetics; minor surgery; intravenous, subcutaneous, or intramuscular procedure; or oral and topical medication; or a combination of these." *Id.* § 30.411(5).

323. BIOMEDICAL INFORMATICS: COMPUTER APPLICATIONS IN HEALTH CARE AND BIOMEDICINE 991 (Edward H. Shortliffe & James J. Cimino eds., 3d ed. 2006).

324. Thomas R. McLean, *The Future of Telemedicine & Its Faustian Reliance on Regulatory Trade Barriers for Protection*, 16 HEALTH MATRIX 443, 443 (2006) (citing India Office, World Health Org., Country Report for Mode 1: Cross-Border Trade in Health Services 65 (July 2003) (draft working paper, available at http://www.whoindia.org/en/section2/section233_538.htm)).

325. See IND. CODE ANN. § 25-22.5-1-1.1(a)(4) (West 2006) (deeming medical consultation transmitted through electronic communications on a regular and non-episodic basis to constitute the practice of medicine in Indiana and thus to require Indiana licensure); TEX. OCC. CODE ANN. § 151.056(a) (Vernon 2004) (establishing that a "person who is physically located in another jurisdiction but who, through the use of any medium, including an electronic medium, performs an act that is part of a patient care service initiated in this state . . . that would affect the diagnosis or treatment of the patient, is considered to be engaged in the practice of medicine in this state and is subject to appropriate regulation by the board," including licensure requirements).

make unavoidable, difficult decisions, such as those concerning triaging and allocation of scarce resources, without excessive concern about litigation. Nevertheless, it requires individuals and organizations to do their best under the circumstances and deters intentional misconduct. For this reason, a “good faith” requirement is incorporated into the law and willful misconduct, gross negligence, and criminal activity are excluded from immunity. There is, however, a high standard of proof for establishing these categories of wrongdoing. Gross negligence is “[a]n intentional failure to perform a manifest duty in reckless disregard of the consequences as affecting the life or property of another.”³²⁶ The standard for willful misconduct is also high, requiring conscious intent to undertake the injurious activity with a realization of the likelihood of harm.³²⁷ Criminal liability must be proved “beyond a reasonable doubt.”³²⁸

Thus, for example, if a doctor missed a hairline fracture on an x-ray at a time when the emergency room was inundated with hundreds of patients, she would enjoy immunity. However, a doctor who amputated a leg on the wrong patient would most likely be found guilty of gross negligence and would not be entitled to immunity. Similarly, a doctor who made good-faith decisions concerning which critically ill patients would and would not receive the small number of available respirators would be entitled to immunity even if some patients who were not treated with a respirator died. By contrast, a health care provider who removed a respirator from an elderly patient in order to give it to a younger patient would not be entitled to immunity because he would essentially be killing the older individual.

A variety of organizations, such as the American Nursing Association and the Agency for Healthcare Research and Quality are developing guidelines for appropriate treatment protocols during public health emergencies.³²⁹ Such guidance may assist clinicians in providing adequate care and could be useful in litigation for the purpose of determining whether health professionals acted appropriately and are entitled to immunity. If standard operating procedures for emergencies have been developed and widely disseminated to health care professionals, it is more likely that parties that adhered to the guidelines would be deemed entitled to immunity. Conversely, those who deviated from well-established emergency procedures will be found to have engaged in gross

326. *Marriott Corp. v. Chesapeake & Potomac Tel. Co. of Md.*, 723 A.2d 454, 462 (Md. 1988) (internal quotations omitted); *see also* Karen J. Kruger, *Governmental Immunity in Maryland: A Practitioner's Guide to Making and Defending Tort Claims*, 36 U. BALT. L. REV. 37, 53 (2007) (discussing the high standard for proving gross negligence).

327. *Equal Employment Opportunity Comm'n v. GLC Restaurants, Inc.*, No. CV 05-0618 PCT-DGC, 2006 WL 3052224, at *7 (D. Ariz. Oct. 26, 2006) (noting that “willful misconduct” is a high standard); *Martin v. Pan Am. World Airways, Inc.*, 563 F. Supp. 135, 141 (D.D.C. 1983) (defining willful misconduct restrictively and stating that it exists only if the defendant recognized the probable harm that would result from his actions).

328. *In re Winship*, 397 U.S. 358, 364 (1970) (stating that “the reasonable-doubt standard is indispensable” to convincing the fact-finder of a person's guilt).

329. *See supra* note 64 and accompanying text.

negligence or willful misconduct.

2. When and to Whom Should the Proposed Provision Apply?

The immunity provision should be triggered by a declaration of a public health emergency and should apply only to activities that took place in response to the emergency and during the emergency's duration.³³⁰ The provision should have its own termination mechanism so that the HHS Secretary and the state governors could terminate liability protection before the termination of the public health emergency, if appropriate. It is possible that in some circumstances there will be reason to maintain a state of emergency, but the workload of health care providers will abate to the point where immunity protection is no longer justified. Because of the significant liability implications, authorities should be careful to terminate the immunity provision—if not the public health emergency itself—as soon as reasonably possible. If the public health emergency or the immunity provision has not been terminated, the provision should automatically expire thirty days after the public health emergency was declared, unless it is renewed by the Secretary or governor for a specific length of time.³³¹ The automatic termination will ensure that health care providers do not escape liability for extended periods of time when they are not actually working under exigent circumstances.

Because I propose extensive immunity protections, the recommended provisions should apply only in very limited circumstances that involve large-scale health threats and require the treatment of hundreds or thousands of patients. Emergencies such as tornadoes, earthquakes, and the Murrah Federal Building bombing often do not rise to this level in public health terms because injuries are suffered only in a small area and local hospitals can either process patients effectively themselves or transfer them to hospitals outside the impacted location. In some cases, a general emergency, such as a natural disaster, may ultimately lead to a serious disease outbreak, but at that point, a public health emergency should be declared. Absent such a declaration, responders would enjoy many of the existing immunity provisions³³² and would be judged based on a standard of care that would take into account emergency conditions and unusual patient loads,³³³ but the proposed comprehensive immunity provision

330. See 42 U.S.C. § 1320b-5(e)(1) (Supp. IV 2004) (providing that a waiver of legal requirements pursuant to this section ends upon termination of the declared emergency or disaster). For further discussion of this provision, see *supra* notes 39–44 and accompanying text.

331. See 42 U.S.C. § 1320b-5(e) (providing for automatic termination of the waiver after sixty days from its initial date of publication unless it is extended for a further sixty-day period or another additional period of time). For a detailed discussion of this provision, see *supra* notes 39–44 and accompanying text. Because the proposed immunity provision will have more far-reaching implications than the limited waiver at issue in § 1320b-5, a thirty-day duration is recommended instead of the sixty-day duration of § 1320b-5.

332. See *supra* Part III.

333. See *supra* note 62 and accompanying text (defining standard of care in terms of what a reasonable practitioner would do under similar circumstances).

would not apply.³³⁴

In addition, the recommended immunity provision would apply only to health care providers. It would, however, cover all such providers, including those that are governmental entities or employees, volunteers, private entities, and individuals working for compensation in the private sector. Hospitals, clinics, and physicians' offices could be inundated with an extremely high volume of very sick patients. It is unjust to exclude health care providers and other workers who are operating under intense pressure in unprecedented circumstances from liability protection simply because they are paid. Furthermore, such exclusion could lead some to close their doors or refuse to work and choose to risk termination rather than tort litigation. Although many health care providers will have medical malpractice insurance coverage, such coverage will be of little comfort to those who fear litigation itself, which may expose them to significant adverse media coverage³³⁵ and threaten the viability of their practices. Litigation can also lead to higher insurance premiums, which some health care providers would find difficult to absorb.³³⁶

While many others could be called upon to respond to a public health emergency, health care providers require licensing and very costly malpractice insurance, offer special skills, and routinely make life and death decisions. Malpractice cases against health care providers are often very difficult to prove and generate prolonged litigation involving many costly experts. These difficulties would be compounded in an emergency, when treatment is given in chaotic conditions that do not allow for thorough deliberations concerning care decisions or for extensive record-keeping. Moreover, health care providers, whose professional success depends largely upon their personal reputation and patients' trust, have much to lose from the mere fact of being sued, even if they ultimately prevail in court. In sum, health care providers are particularly vulnerable to suit, and their concern about liability is acute.

Other responders, such as law enforcement officials, transportation workers, food suppliers, and rescuers, will benefit from some of the existing immunity provisions³³⁷ and from a lenient standard of care that is associated with exigent circumstances,³³⁸ but they do not require the proposed comprehensive immunity provisions. Truck drivers who are late in delivering medical supplies, for

334. See Anthony B. Iton, *Rationing Influenza Vaccine: Legal Strategies and Considerations for Local Health Officials*, 12 J. PUB. HEALTH MANAG. & PRACT. 349, 354 (2006) (stating that "there may be a variety of political and practical reasons why politicians might not want to declare a state of emergency").

335. Miguel Bustillo, *Doctor Cleared in Katrina Case*, CHI. TRIB., July 25, 2007, at 3 (discussing the well-publicized case of Dr. Anna Pou, who was accused of hastening the deaths of four patients in New Orleans in the aftermath of Hurricane Katrina, though the grand jury ultimately declined to indict her).

336. For a discussion of rising medical malpractice insurance costs and their impact on physicians, see *supra* note 300 and accompanying text.

337. See *supra* Part III.

338. See *supra* note 62 and accompanying text (defining the "standard of care" in terms of how a reasonable practitioner would operate under the circumstances).

example, could easily prevail in court if they could prove that the delay was caused by road blocks or other unavoidable difficulties. State officials who are not health care providers and who make law enforcement or resource allocation decisions will enjoy the benefit of governmental immunity or qualified immunity, and thus should also have little concern about litigation.

C. CONCERNS AND JUSTIFICATIONS FOR THE PROPOSED APPROACH

Because the concept of standard of care already incorporates the notion that appropriate treatment will vary depending on the circumstances at issue, it is arguable that no immunity provision is needed at all for public health emergencies. Courts will decide negligence claims in light of the exigent circumstances under which clinicians were operating and will not expect them to provide the same quality of treatment that they would furnish in ordinary times. Similarly, specialty hospitals that ordinarily handle only elective surgery or orthopedic problems would not be judged as harshly as hospitals with trauma units whose emergency rooms are accustomed to handling large volumes of critically ill patients. Nevertheless, the proposed immunity provision is needed for two reasons. First, if the public is informed about its existence, the provision will discourage plaintiffs from bringing inappropriate suits and thereby clogging court dockets, diverting resources that could otherwise be spent on recovery efforts and raising malpractice insurance costs.³³⁹ Second, aggrieved individuals could bring many claims other than negligence that do not incorporate the standard of care concept.³⁴⁰ In order to provide comprehensive protection, the proposed provision is general and broad enough to address all potential civil causes of action, including those arising from breach of confidentiality, EMTALA, the ADA, and others.³⁴¹ It thus covers any injuries or harm caused by good faith actions undertaken in response to a public health emergency, excluding willful misconduct, gross negligence, or criminal activity, regardless of the theory of liability used by plaintiffs who believe that they have been wronged.

Critics might also argue that the proposed provision undermines the dual goals of liability: deterring misconduct and compensating injured parties. Potentially, added immunity might under-deter negligent behavior by reassuring clinicians that they will not be held liable for carelessness that falls short of gross negligence or willful misconduct. In addition, immunity would deprive parties injured by negligent care of compensation for the harm they have suffered. Nevertheless, I would argue that the benefits of the proposed solution far outweigh its costs.

First, it should be noted that commentators disagree about the effectiveness of tort liability as a deterrent to misconduct, and the empirical literature

339. *See supra* section V.A.2.

340. *See supra* Part II.

341. *See supra* Part II.

provides only weak evidence in this regard.³⁴² Some have argued that tort law fails to deter undesirable behavior because its sanctions are perceived as weak, it does not clearly articulate what conduct will be punished, much of the activity that is sanctioned cannot be changed through monetary incentives,³⁴³ and fear of liability discourages innovation and, therefore, actually retards social progress.³⁴⁴ In addition, filed malpractice cases often do not reflect actual instances of medical malpractice.³⁴⁵ According to several sources, many episodes of negligence are not challenged in court, and many of the cases that are filed are not brought against providers who had actually committed malpractice.³⁴⁶ Critics also claim that moral principles provide a much stronger incentive for appropriate behavior than does tort law.³⁴⁷ Furthermore, the deterrent effect of tort law is vitiated by the availability of liability insurance.³⁴⁸

Some commentators, nevertheless, point to studies indicating that the tort system influences conduct to a limited extent, reducing malpractice by somewhat less than thirty percent and negligent driving by approximately ten percent.³⁴⁹ In the words of one commentator, "tort law, while not as effective as economic models suggest, may still be somewhat successful in achieving its stated deterrence goals."³⁵⁰ Others have stressed the need for additional empirical research and propose ways to increase the deterrent effect of medical

342. PETER A. BELL & JEFFREY O'CONNELL, ACCIDENTAL JUSTICE: THE DILEMMAS OF TORT LAW 68 (1997) [hereinafter BELL & O'CONNELL] (noting that "[r]ecently, . . . scholars, 'reformers,' and even some judges have expressed skepticism about whether tort awards have any significant deterrent value"); Jerry L. Mashaw, *A Comment on Causation, Law Reform, and Guerilla Warfare*, 73 GEO. L.J. 1393, 1394 (1985) (stating that "it is extremely difficult to find any empirical evidence that the tort system produces deterrence in the sense normally talked about"); Frank A. Sloan et al., *Effects of Tort Liability and Insurance on Heavy Drinking and Drinking and Driving*, 38 J.L. & ECON. 49, 72 (1995) (asserting that "[t]here is a paucity of empirical evidence on deterrent effects of tort law").

343. This might be so because the behavior is unconscious, the threat of sanctions is too remote, or the actors have too great an interest in continuing the conduct. See BELL & O'CONNELL, *supra* note 342, at 85-87.

344. See *id.* at 77-78.

345. Cramm et al., *supra* note 7 (reporting on a study by the Harvard Medical Group that reviewed 30,195 patient records and found 306 instances of provider negligence, but of these, only three percent were challenged in court, while eighty-three percent of the forty-seven claims filed by the relevant patients were against providers who had not been negligent).

346. *Id.*; see also Paul C. Weiler, *Reforming Medical Malpractice in a Radically Moderate—and Ethical—Fashion*, 54 DEPAUL L. REV. 205, 214-16 (2005) (reporting that while there are 115,000 negligent medical injuries or deaths annually, only about 55,000 claims are filed each year, "of which just 15,000 produce any payments at all (whether through settlements or jury awards)").

347. See Gary T. Schwartz, *Reality in the Economic Analysis of Tort Law: Does Tort Law Really Deter?*, 42 UCLA L. REV. 377, 382 (1994).

348. *Id.*

349. *Id.* at 444; see also PAUL C. WEILER, MEDICAL MALPRACTICE ON TRIAL 91 (1991) (arguing that tort law has stimulated "broad-based improvements in the institutional environment and procedures through which medical care is provided").

350. Schwartz, *supra* note 347, at 443; see also Richard A. Posner, *Alternative Compensation Schemes and Tort Theory: Can Lawyers Solve the Problems of the Tort System?*, 73 CAL. L. REV. 747, 749 (1985) (referring to studies that "show that liability insurance premiums affect the decision to drive [and] that the number of automobile deaths has risen as a result of the no-fault movement (perhaps by as much as 15% in some states)").

malpractice litigation.³⁵¹

The recommended provision responds to the unique circumstances of a public health emergency. It preserves the goals of deterrence and compensation but modifies liability rules to fit the chaotic and unusual circumstances at issue. While egregious behavior will be deterred by the prospect of liability, the threat of liability will not loom so large that it deters individuals or entities from participating in emergency response activities or punishes them for their willingness to provide aid, as it will not attach to simple negligence. Likewise, victims will be compensated for intentional wrongdoing or gross negligence, but not for more minor oversights. It is likely, in fact, that some of those who suffer harm because of sub-optimal care would have been even worse off absent the negligent services because they would have received no care at all. It should also be noted that in many circumstances, disaster victims will be able to obtain compensation for property loss and injuries through FEMA³⁵² or victim relief funds, such as the one established after the events of September 11, 2001.³⁵³ Thus, even without access to the courts, individuals will not be left devoid of all financial resources.

Public policy decisions concerning the creation of immunity provisions would be facilitated by further empirical research regarding the behavioral impact of the potential for liability, particularly in emergency situations. Absent hard data, legislators must base decisions on instinct and conjecture about human psychology. The recommended provision is designed to promote both individual justice and general public welfare by deterring intentional misconduct, compensating victims when compensation is clearly due, encouraging widespread participation in response efforts, and, at the same time, addressing concerns about a potential proliferation of lawsuits that could overwhelm the courts and be extremely costly for health care providers and malpractice insurers.³⁵⁴

D. OTHER APPROACHES

Commentators have made several other suggestions for addressing liability

351. See generally Michelle M. Mello & Troyen A. Brennan, *Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform*, 80 TEX. L. REV. 1595, 1615, 1623–28 (2002) (stating that “further empirical study would be appropriate” and discussing suggestions for “[s]harpening the [d]eterrent [s]ignal”).

352. See Fed. Emergency Mgmt. Agency, What Is Disaster Assistance?, http://www.fema.gov/assistance/process/individual_assistance.shtm (“Disaster assistance is money or direct assistance to individuals, families and businesses in an area whose property has been damaged or destroyed and whose losses are not covered by insurance.”).

353. See generally M. ANN WOLFE, DOMESTIC SOC. POLICY DIV., CONG. RESEARCH SERV., HOMELAND SECURITY: 9/11 VICTIM RELIEF FUNDS (2003), <http://www.law.umaryland.edu/marshall/crsreports/crsdocuments/RL31716.pdf> (discussing the federal response to the attacks of September 11, 2001 and the status of selected victim relief funds).

354. For discussion of concerns about court dockets and insurance costs in the aftermath of a public health emergency, see *supra* notes 300–01 and accompanying text.

related to public health emergencies. One option is for providers to draft informed-consent forms that specifically apply to emergencies, thereby disclosing the risks of being treated under exigent circumstances to the extent they can be anticipated.³⁵⁵ It is unlikely, however, that such forms will be useful in many circumstances. First, prior to an actual emergency, it will be difficult if not impossible to develop forms that provide sufficient details concerning the specific emergency rather than simply a generic list of heightened risks. Also, many victims may come into the hospital in a condition that renders them incompetent to give meaningful consent. Maintaining, storing, and filing the forms might also be challenging, especially in makeshift emergency clinics without filing cabinets and administrative assistants. Finally, patients may have no other options for care in an emergency. As such, their signatures on emergency consent forms that waive litigation rights may be deemed to have been coerced, and the forms would therefore not insulate the hospital from liability.

A second option is the creation of compensation pools. As noted above, the PREP Act provides for the establishment of an emergency fund designed to compensate aggrieved individuals for covered injuries associated with countermeasures.³⁵⁶ Some legal scholars have suggested the establishment of compensation pools from which payments would be made to all parties who are wrongfully injured during emergency response activities,³⁵⁷ except perhaps in cases of gross negligence or willful misconduct. Given sufficient resources, the establishment of such funds could be a satisfactory solution to the liability problem. However, in the likely event that scarce resources must be allocated among many initiatives during a catastrophic event, the establishment of compensation funds and claims procedures should not be deemed to be of the highest priority. Rather, money and personnel should be focused on providing care and conducting rescue, recovery, and rebuilding operations.

CONCLUSION

A comprehensive immunity provision for health care providers that is incorporated into federal and state law would significantly improve upon the existing piecemeal liability scheme for public health emergency responders. The proposal described in this Article is designed to balance the needs of disaster victims with the needs of those providing aid and the best interests of society at large. The proposal aims to encourage involvement in response activities without excusing egregious misconduct, to control court dockets and insurance costs, and to address oversight of volunteers and credentialing requirements.

355. See Hodge et al., *supra* note 55, at 85.

356. 42 U.S.C.A. § 247d-6e (West Supp. 2007).

357. See Hodge et al., *supra* note 15, at 68 (suggesting the establishment of “a discrete compensation fund, modeled after Social Security Disability Insurance, workers’ compensation insurance, or the National Vaccine Injury Compensation Program, to pay claims for persons injured during emergency responses”).

This Article has argued that liability protection should be offered not only to public agencies and their employees and to volunteers, but also to paid health care workers and entities that participate in emergency operations in their ordinary course of business. The recommended provision, therefore, is more generous than many of those currently found in the law. Nevertheless, it does not sacrifice the values of deterrence and justice, but rather creates incentives and disincentives that are appropriate for the extreme and chaotic conditions of public health emergencies. Although some who receive negligent treatment in emergency conditions might not enjoy any recovery, they may still be better off than they would be without any treatment at all. Moreover, those who are injured through bad faith or intentional wrongdoing would have access to the courts under the proposed scheme.

A clear and detailed immunity provision that addresses relevant concerns for all health care providers participating in public health emergency response activities, whether they be public or private parties, individuals or corporate entities, paid or unpaid, will enhance the effectiveness of public health emergency operations and remedy the existing legislative gaps.