Law and the Public's Health

STATE LAWS EXTENDING COMPREHENSIVE LEGAL LIABILITY PROTECTIONS FOR PROFESSIONAL HEALTH-CARE VOLUNTEERS DURING PUBLIC HEALTH EMERGENCIES

Sara Rosenbaum, JD
Mary-Beth Harty, MPH candidate
Jennifer Sheer, JD candidate

This issue of *Law and the Public's Health* examines state laws that extend comprehensive legal liability protections for professional health-care volunteers during public health emergencies. The findings in this article were produced by researchers at The George Washington University School of Public Health and Health Services, Department of Health Policy, as part of a broader policy analysis of federal and state public health emergency response capabilities published by Trust for America's Health.[1]

BACKGROUND AND OVERVIEW

A predictable consequence both during and in the short-term aftermath of a significant natural disaster, terrorist attack, or public health emergency is that hospitals and other health-care facilities will experience a surge in patients requiring treatment and stabilization. Depending on the nature, duration, and scope of the emergency, this influx can seriously overwhelm any community's local medical response system. In such catastrophic situations, volunteer health-care professionals provide invaluable expertise and personnel support to bolster and broaden the emergency response effort. However, as with any health-care intervention, the question arises of how to address the potential for legal liability that may arise in the event that the responder performs in a negligent fashion and thus causes personal injury. The absence of legal protections against liability in such circumstances may seriously impede efforts to encourage private health professionals to volunteer their services.

The Good Samaritan doctrine and its limitations

The challenge of incentivizing volunteerism during times of emergency is hardly new. For this reason, the law has long recognized the Good Samaritan doctrine, a basic concept in American law—indeed a part of the common law on which the entire American legal system rests.[2] The doctrine essentially allows a medical professional who is sued for medical malpractice to claim that he or she was acting as a Good Samaritan and thus should be shielded from liability. The doctrine is invoked during a medical negligence trial and is essentially an after-the-fact means of protecting Good Samaritans who are sued.

The Good Samaritan doctrine exists in all states as a common law (i.e., judicial law) concept; by 2007, all states and the District of Columbia also had codified this judicial doctrine in their legal statutes. While these statutes vary in certain respects, they tend to contain several critical elements: a law that creates an affirmative defense; a restriction on the defense to aid at the scene of an emergency; a level and type of assistance that can be considered emergency (rather than post-emergency stabilization) care; and the absence of gross negligence or willful and wanton conduct.

In the context of modern notions of emergency public health response, most Good Samaritan laws are limited in two fundamental respects. First, they generally provide a very specific shield that focuses on emergency assistance rendered at the scene of an emergency. As a result, once assistance passes beyond the immediate emergency stage or the scene of assistance moves outside an emergency location, the shield may end.[3] Therefore, a Good Samaritan statute may not be comprehensive enough to cover individuals during declared public health emergencies, where assistance may be needed not only at the immediate scene of an emergency but also in the aftermath, as normal conditions slowly return. The California wildfires in the fall of 2007 offer a recent example of a situation in which the period of immediate post-emergency recovery may last for weeks or months beyond the last extinguished wildfire, as the state deals with the long-term economic, social, and physical and mental health needs of victims. Furthermore, because the number of uninsured Americans is at an all-time high, the need to continue volunteer health-care assistance beyond the end of the emergency's acute phase may be particularly pressing in the case of health care.

Second, as noted, Good Samaritan laws provide an affirmative defense to a liability claim by permitting the defendant to show that his or her conduct merits a shield because of the emergency nature of the intervention; (typically) the absence of any expectation of compensation; the absence of objection to the treat-

ment; and the absence of gross negligence, willful and wanton conduct, or intentional injury.[4] That is, one's status as a Good Samaritan must be proved by the person who claims the shield as part of a defense to a negligence claim. Thus, rather than being prospective, Good Samaritan laws are retrospective in nature. This means that the volunteer responder has no guarantee at the outset that the statute will cover his action. However, given the typical emergency scenario (a car accident, for example), the responder would only provide very basic care before ambulance crews arrive. Therefore, even if an individual cannot prove he or she is a Good Samaritan, the responder's liability should be at a minimum because the rescue team quickly assumes the responsibility for—and liability of—the victim's care. In contrast, during a declared public emergency, the responder may have to provide extensive health care in the event that rescue crews are too overloaded with other victims to respond. Under these extraordinary circumstances, the provider is exposed to greater liability simply because his or her care may have to be greater as the situation demands. Understandably, before undertaking to aid a victim during a public emergency, the responder may want greater assurance of liability protection.

The limited nature of Good Samaritan statutes has prompted public health law experts to recommend enactment of more expansive shield laws that both create a prospective system for extending liability shields in advance of necessary health-care services and protect organized volunteer actions more broadly than does the restrictive coverage that is available under a Good Samaritan doctrine.

SURVEY OF PUBLIC HEALTH EMERGENCY LAWS

Methods

Trust for America's Health commissioned a rapid survey and analysis of state laws relating to medical volunteers and public health emergencies. The George Washington University study was designed to ascertain the extent to which states have modernized their laws to take current approaches to public health emergency management into account.

A research design was developed to stratify states in relation to the structure of their statutory emergency protections for health-care volunteers. Researchers, including an experienced attorney with extensive experience in legal analysis and statutory and legal interpretation, used standard legal research techniques and tools to identify all state statutes governing the subject of volunteer health professional services during emergencies. An electronic file was created for each state to permit both in-state and cross-state comparisons. The search identified states whose statutory codes clearly and unambiguously established comprehensive emergency-related legal protections for health-care volunteers that surpassed the protections available under the Good Samaritan doctrine.

In view of the doctrine's limitations, the search focused on two critical elements that would serve to separate state statutes from longstanding Good Samaritan doctrine: (*1*) a liability shield that is tied to the scope and time period of a declared emergency rather than operating as an aftermath defense to a liability action and (*2*) in lieu of an after-the-fact affirmative defense, the existence of a prospective and authorized process that allows medical and other health professionals to become designated as voluntary health-care workers acting under specific emergency response protocols.

FINDINGS

While most states recognize some form of additional liability protection beyond generic Good Samaritan protections during periods of public emergency, the statutes vary considerably. Seventeen states—Colorado, Connecticut, Iowa, Kansas, Kentucky, Maine, Michigan, Minnesota, Missouri, Nebraska, New Hampshire, New Jersey, New York, North Carolina, Oregon, South Carolina, Tennessee—and the District of Columbia maintain statutes that meet both key criteria. That is, the laws in these states both provide for immunity of health-care volunteers for the duration of declared public emergencies and anticipate the establishment of a formal prospective designation process.

An additional 12 states—Alabama, California, Georgia, Hawaii, Illinois, Indiana, Louisiana, Pennsylvania, South Dakota, Utah, Virginia, and West Virginia—meet the second prong of our test. That is, these state laws allow for the extension of immunity for health-care professionals during emergencies. However, nothing in these laws indicates the existence of a prospective designation system. Such a system would need to be specified in regulation or through an authoritative state ruling. The final group of 21 states—Alaska, Arizona, Arkansas, Delaware, Florida, Idaho, Maryland, Massachusetts, Mississippi, Montana, Nevada, New Mexico, North Dakota, Ohio, Oklahoma, Rhode Island, Texas, Vermont, Washington, Wisconsin, and Wyoming—maintain statutory schemes that either are silent on the issue of protections for voluntary health-care workers during emergencies or are sufficiently ambiguous so that no such prospective immunity arrangement can be inferred in the absence of

comprehensive implementing regulations or a ruling from an authoritative state official.

Further examination of the states whose laws extend prospective and comprehensive protections for health-care volunteers during periods of declared emergencies reveals that these laws vary significantly in statutory scope and clarity. Some statutes are relatively prescriptive, while others provide public officials with discretion to determine the types of health-care professionals and emergency workers that will receive qualified immunity, set the conditions that must be met to qualify for a voluntary worker designation, and offer considerable latitude over the duration of the period of the immunity.

Statutes also vary with respect to the scope of the immunity granted (i.e., covering all conduct or only conduct that is not grossly negligent, willful and wanton, or intentionally injurious). Because the immunity shield may be limited in scope, these statutes are not absolute. That is, an injured person could allege liability on the ground that the worker's conduct fell below the level of care necessary to qualify for the immunity shield. The most comprehensive of these laws would also provide for the defense of volunteers as employees of the state in the event that conduct falls below the immunity threshold.

DISCUSSION

This review of state statutes suggests that approximately one-third of all states have enacted immunity protections for health-care volunteers that are prospective in nature and linked to formal emergencies. These state laws contemplate some sort of prospective designation process to clarify the immunized status of health-care workers rather than requiring workers to raise an affirmative defense at trial. An additional 20% of all states have statutes that specify emergency immunity, but the presence of a prospective designation system cannot be inferred from the statute itself. Finally, about 40% of all states either have not addressed the issue or else have done so in an ambiguous fashion that requires further regulatory and interpretive clarification.

Of course, even the clearest emergency health-care volunteer immunity statutes would require additional guidance, as creating a prospective designation process and developing emergency operational protocols present complex implementation challenges. Further study of the implementation experiences in states with comprehensive statutes would be warranted, as would further study in those states that have not enacted such laws. Such a study might shed light on the implementation challenges that arise, the response rates among private health professionals, and the actual or anticipated operation of states' qualified immunity statutes. Additional research might also reveal whether or not, in the event of lawsuits against designated volunteers alleging *ultra vires* conduct, additional state tort claims act protections also might apply.

The events of 9/11, Hurricane Katrina, and the wildfire disaster in California are vivid reminders of the unexpected, unpredictable, and, unfortunately, inevitable nature of public health emergencies. What is also inevitable is the need for volunteer health professionals to meet the community's needs when disaster strikes. During the events that followed Hurricane Katrina, thousands of health-care professionals streamed to the Gulf Coast to offer emergency health services.[5] Likewise, an estimated 8,000 medical provider volunteers responded to emergency situations in the first few hours following the 9/11 terrorist attacks in New York.[6]

Given the importance of health-care volunteerism, it is perhaps surprising that relatively few jurisdictions have enacted comprehensive shield laws. In the absence of unambiguous protection, health-care providers who desire to volunteer in times of disaster essentially are left to speculate as to their risk of liability exposure. Scholar James G. Hodge, Jr. has identified two negative consequences of such guesswork: "First, some responders will act without significant regard for the legal ramifications, which can lead to communal and individual harms. Second, others will fail to act because of their legal concerns, which can stymie some public health interventions."[7]

One potential way that lawmakers can address these issues is by adopting the legislative language found in the Uniform Emergency Volunteer Health Practitioners Act. Developed by the National Conference of Commissioners on Uniform State Laws, this model act provides a uniform legislative framework to "facilitate organized response efforts among volunteer health practitioners."[4] To date, Colorado, Kentucky, and Tennessee have enacted this legislation; five additional states initiated legislation in 2006–2007, but were unable to pass the provisions.[8] Passage by all states would provide consistent and relatively uniform protection against emergency-related liability other than, of course, liability for conduct that is viewed as being outside of the protections because it is intentionally harmful, willful and wanton, or grossly negligent.

Sara Rosenbaum is the Hirsh Professor and Chair of the Department of Health Policy at The George Washington University Medical Center School of Public Health and Health Services. Mary-Beth Harty is a JD candidate at The George Washington University Law School. Jennifer Sheer is an MPH candidate at

The George Washington University School of Public Health and Health Services. All are in Washington.

Address correspondence and requests for the full report and accompanying tables to: Sara Rosenbaum, JD, Department of Health Policy, The George Washington University Medical Center School of Public Health and Health Services, 2021 K St. NW, Ste. 800, Washington, DC 20006.

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