

**The Joint Subcommittee Studying
the Feasibility of Offering Liability
Protections to Health Care Providers
Rendering Aid During a State or
Local Emergency
HJR701/SJR390 (2007)
Richmond, Virginia**

The Joint Subcommittee to Study the Feasibility of Offering Liability Protections to Health Care Providers Rendering Aid During a State or Local Emergency was established pursuant to House Joint Resolution 701 (patron: Hamilton) and Senate Joint Resolution 390 (patron: Newman). The joint subcommittee held its first meeting in Richmond, Virginia, on August 30, 2007. Delegate Phillip A. Hamilton was elected chairman and Senator Stephen D. Newman was elected vice-chairman. Delegate Hamilton gave brief opening remarks explaining the genesis of the study resolutions, noting that they arose out of legal exercises conducted by the Attorney General's office in conjunction with the health care community.

Overview

Staff presented a brief overview of the study's directives. The resolutions note that health care providers who respond to a disaster or declared emergency often do not have access to the same level of resources that would be available under normal circumstances, and that during such an emergency health care providers must make decisions as to what level of care can be rendered based upon the resources actually available. The resolutions further note that health care providers in such situations may be required to render aid that is outside their scope of practice. The resolutions charged the joint subcommittee with examining "the estimated benefits to the citizens of the Commonwealth of enhanced liability protections for health care providers as well as determining how many other states provide these kinds of liability protections."

Presentations

I. Health Care Provider Liability in Disasters

Mr. Steven D. Gravely, J.D., M.H.A., a member of the joint subcommittee and an attorney with Troutman Sanders, made a presentation, via teleconference, concerning health care provider liability protections in disasters and the protections currently available under Virginia law. Mr. Gravely has also been appointed as a special counsel to the Attorney General's office and assigned to work with the Virginia Department of Health on health care provider liability issues. A CD-ROM containing his earlier work in this capacity was distributed to the members of the subcommittee. He was assisted in his presentation by his associate Erin S. Whaley, J.D., M.A., who attended the subcommittee's meeting.

Mr. Gravely described a health care system that is under significant stress, where staff shortages exist and the industry has migrated to a "just in time" model of care. Mr. Gravely explained that a disaster or emergency would cause substantial disruptions to such a health care system. He stated that health care providers have three liability concerns in a disaster: (1) failure to prepare, (2) failure to respond, and (3) liability associated with "altered" standards of care. He gave examples of failures to prepare or respond including the failure to use infection control measures in response to the SARS outbreak in Canada and the failure to evacuate in a timely manner in response to Hurricane Katrina. He noted that there were multiple suits in Canada against health care providers and the government stemming from such failures during the SARS outbreak as well as suits against health care providers in Louisiana as a result of Hurricane Katrina.

In regards to liability associated with "altered" standards of care, Mr. Gravely related that the term has no accepted definition, but has become shorthand for describing the allocation of scarce critical resources during a disaster. He further noted that making such an allocation is difficult to do in a legal vacuum. He explained that the current statutory definition of standard of care makes no provision for the circumstances under which the care was rendered, although he also noted that Virginia's Model Jury Instructions do include such a provision. He stated that there was no Virginia case law dealing with "altered" standards of care and, as a result, the discrepancy between the statutory definition and the Model Jury Instructions may lead to uncertainty among health care providers as the instructions are not mandatory.

Mr. Gravely also reviewed current Virginia law providing liability protections for health care providers, expressing that there are three primary sources of such liability protections. He stated that in recent years Virginia has focused its attention on providing protections for individual health care providers, specifically volunteers.

The first of these three laws is the Good Samaritan statute located at Va. Code § 8.01-225. Mr. Gravely explained that the Good Samaritan statute only applied to individuals who provide emergency care without compensation and only if such care is provided at the scene of an accident or emergency. He further explained that the Good Samaritan statute does not apply to institutional health care providers or provide liability protections for individual providers who render such care as part of their job, i.e., for compensation, or who provide care at hospitals or other nonemergency settings. The statute also does not protect providers who render preventative care during an emergency.

The second of these three laws is volunteer immunity which is available under the Federal Volunteer Protection Act, located at 42 U.S.C. § 14501 et seq., or the Virginia State Government Volunteers Act, located at Va. Code § 2.2-3600 et seq. Mr. Gravely stated that both of these Acts only apply to volunteer health care providers and likewise did not apply to institutional health care providers.

The third law described by Mr. Gravely is the Commonwealth of Virginia Emergency Services and Disaster Law located at Va. Code § 44-146.13 et seq. Mr. Gravely explained that this law gave the Governor the power to declare a state of

emergency, and that consistent with such a declaration the Governor could promulgate a rule for the allocation of scarce medical resources during the emergency. Mr. Gravely noted further that the law also expressly provides immunity under certain situations, described as Section A Immunity and Section C Immunity. Section A Immunity provides liability protections for certain entities engaged in emergency services activities; however, Mr. Gravely stated that it was unclear whether the rendition of care in a hospital setting during an emergency would qualify for this protection. Section C Immunity provides liability protections for providers who gratuitously render aid during a disaster. Mr. Gravely noted that both Section A and Section C Immunity only applies after a state of emergency is declared and provides no pre-declaration protection. He also expressed his belief that basing liability protection on an emergency declaration that has yet to be drafted leaves significant uncertainty as to the scope of protection.

Mr. Gravely ended his presentation with the following three conclusions: (1) health care providers have a reasonable basis for concern about their liability for care rendered during a disaster, (2) health care providers are a vital component in an effective response framework, and (3) current Virginia law does not clearly provide liability protections for health care providers who render care during a disaster.

II. Public Health and Healthcare Emergency Preparedness and Response: Role of the Virginia Department of Health

Dr. Lisa Kaplowitz, M.D., M.S.H.A., Deputy Commissioner for Emergency Preparedness and Response, made a presentation on behalf of the Virginia Department of Health (VDH) explaining its role in emergency preparedness and response. Her presentation focused on five issues: (1) Virginia's public health emergency response; (2) hospital/health care system emergency response; (3) the public health and health system partnership; (4) the roles of health care providers; and (5) the need for liability protections for health care providers in emergencies.

In addressing these issues, Dr. Kaplowitz noted that the VDH's Emergency Preparedness and Response Programs were established in 2002 and employ an all hazards approach, preparing for both natural disasters and terrorist related emergencies. Since 2002, with funding provided by the Centers for Disease Control and Prevention and the United States Department of Health and Human Services, the VDH has enhanced the local capacity to respond to emergencies through the hiring of a planner and epidemiologist for each of Virginia's 35 District Health Departments, has established five regional teams to coordinate planning and response, has upgraded information and communications technologies and systems, and has enhanced public information in emergencies.

Dr. Kaplowitz noted that the initial response to an emergency is always local. The members inquired whether the Governor was required to wait for a local declaration of emergency before he would be able to issue his own declaration. Dr. Kaplowitz explained that she was unaware of any time where the Governor thought an emergency should be declared but officials on the local level did not. Ms. Whaley stated that under

Title 44, a local declaration must exist before a declaration by the Governor. The chairman directed staff to research this issue for the next meeting.

Dr. Kaplowitz further explained that, under the coordination of the Virginia Emergency Operations Center (VEOC), the VDH is responsible for Emergency Support Function 8: The Coordination of Public Health/Health and Medical Response. The VDH's Emergency Coordination Center operates to fulfill this function on the state and local level through coordinating the Public Health response, coordinating hospital and long-term care response, and communicating with health care provider systems and linking them to the VEOC.

Dr. Kaplowitz also emphasized the importance of partnerships with private and public health care providers. She stressed that the mission of the VDH is disease control and prevention, not the provision of health care. As most health care is provided by the private sector, the VDH has partnered with the Virginia Hospital and Healthcare Association to manage and coordinate the use of federal funds for health system preparedness. Dr. Kaplowitz noted that the VDH collaborates with the health care community, including hospitals as well as individual physicians, on issues of preparedness. The VDH also helps to coordinate volunteer health care providers, such as those in Medical Reserve Corps, and is developing a statewide system for registering and identifying such volunteers. Through this collaboration with health care providers, Dr. Kaplowitz stated that one of the primary concerns raised by the providers is their potential liability during an emergency when the practice environment is suboptimal.

Dr. Kaplowitz concluded her presentation by using the VDH's planning for a pandemic influenza outbreak as an example of the VDH's role in emergency preparedness as well as challenges that will be faced by health care providers during such an outbreak.

III. Medical Society of Virginia

Gerald C. Canaan, II, Esq., of Hancock, Daniel, Johnson & Nagle, P.C., briefly spoke on behalf of the Medical Society of Virginia (MSV). Mr. Canaan explained that the MSV was more focused on health care provider liability from the standpoint of the individual physicians, and not that of institutional health care providers such as hospitals. Mr. Canaan indicated that from an individual physician standpoint, the MSV does not perceive that there is a large problem with the liability protections already afforded individual physicians under current Virginia law, although he acknowledged the concerns of institutional health care providers.

Mr. Canaan represented that the primary concern of the MSV regarding health care provider liability protections is the issue of compensation. Mr. Canaan noted that current Virginia law, such as the Good Samaritan statute or the Emergency Services and Disaster Law, only provide for liability protections when the physician's services are not rendered for compensation. Mr. Canaan stressed that physicians who respond to disasters and emergencies are typically not looking for compensation; however, they would like to be able to recover their expenses without losing their liability protections. Mr. Canaan

stated that physicians who accept reimbursement from charitable organizations or other entities for expenses such as travel costs or the cost of supplies may be no longer able to invoke liability protections if such reimbursement is considered to constitute compensation.

Mr. Canaan also cited several examples of small "tweaks" that could be made to current Virginia law. First, he noted a potential discrepancy between the Good Samaritan statute, which uses the term "without compensation," and the Emergency Services and Disaster Law, which uses the term "gratuitously." Mr. Canaan also cited an omission from Va. Code § 8.01-225.01 which provides liability protections for health care providers who abandon a patient in order to respond to a man-made disaster. Mr. Canaan noted that the protections of this statute do not apply to physicians responding to a natural disaster.

Other Business

The chairman opened the floor for public comments; no one took advantage of the opportunity. The chairman then asked the members for their comments. The members requested, in preparation for the next meeting, that staff research several issues: (1) how the federal government handles health care provider liability that may arise in emergency situations such as accidents on military bases which involve multiple casualties; (2) the potential criminalization of physicians' actions in response to emergencies as illustrated by the case of Dr. Anna Pou in Louisiana; (3) the process in Virginia for the declaration of a state of emergency on the local, state and federal levels, as well as whether different types of declarations are applicable to different types of disaster, i.e., pandemics as compared to hurricanes; (4) the liability protections available prior to the declaration of an emergency, focusing on issues such as negligent planning; and (5) whether other states offer liability protections to health care providers who render aid during emergencies. Finally, draft legislation prepared by staff was distributed to the members of the subcommittee for their review and for discussion at future meetings.

Future Meetings

The joint subcommittee is authorized to hold three more meetings and plans to hold at least one more meeting. For the three potential future meetings, the House Clerk's Office will be polling the subcommittee members' availability for the last week of September, the last two weeks of October, and after the elections in November.