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# ***Altered Standards of Care: A Primer on Virginia Law***

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## I. Overview

Most experts, scholars and healthcare providers agree that during a disaster or emergency in which there are mass casualties, hospitals will not be able to provide the level of care to which they are accustomed. Instead, hospitals will be forced to implement “altered” standards of care as a way of dealing with shortages of personnel, equipment and time. While the term “altered” standards of care has not been defined, it is a recognized concept in the emergency response and preparedness field. The Agency for Healthcare Research and Quality (“AHRQ”) has issued a report entitled *Altered Standards of Care in Mass Casualty Events* in which they assume “altered” standards to mean “a shift to providing care and allocating scarce equipment, supplies, and personnel in a way that saves the largest number of lives in contrast to the traditional focus on saving individuals.”<sup>1</sup> Like AHRQ, the Homeland Security Council chose not to define an “altered” standard of care in the Implementation Plan for the National Strategy for Pandemic Influenza, opting instead to conclude that “the standard of care will be met [during a pandemic] if resources are fairly distributed and are utilized to achieve the greatest benefit.”<sup>2</sup>

The nebulous nature of “altered” standards of care understandably causes unease within the health care community as such standards are inextricably tied to liability. This discomfort, in turn, paralyzes some aspects of hospitals’ emergency preparedness planning.<sup>3</sup> To help hospitals understand the legal aspects of “altered” standards of care and resolve any remaining anxiety related to this issue, the Virginia Hospital and Healthcare Association (“VHHA”) has engaged Troutman Sanders LLP to draft this paper, which will serve to educate all member institutions on the current status of standard of care laws in Virginia, the potential liability exposure that can result from implementation of “altered” standards of care and the various ways in which existing unease can be addressed.

## **II. Significance of Standards of Care**

In our litigious society, healthcare providers are understandably concerned about potential legal liability for the care they render on a daily basis. If a patient is injured during the course of her care and she believes that this injury was the result of the healthcare provider's negligent actions, the patient can bring suit against the provider seeking to recover damages. The patient's claim will rest on the theory of negligence that the provider owed a duty of care to the patient, the provider breached that duty and, as a result of that breach, the patient was injured. The provider's duty to the patient is to provide treatment in accordance with the *standard of care* associated with the patient's given condition. Failure to meet that standard is negligence, which is referred to as medical malpractice when a healthcare provider is involved.<sup>4</sup> Thus, the standard of care is of the utmost importance to providers because it is the benchmark by which all actions are judged.

## **III. Standard of Care under Virginia Law**

In Virginia, standard of care is statutorily defined as “that degree of skill and diligence practiced by a reasonably prudent practitioner in the field or specialty<sup>5</sup> in this Commonwealth.”<sup>6</sup> While as a general rule a statewide standard of care is appropriate and applicable,<sup>7</sup> a local standard of care may be applied if a party can prove by a preponderance of the evidence that the health care<sup>8</sup> services and health care facilities available in the locality and the customary practices in such locality make the statewide standard of care inapplicable.<sup>9</sup>

It is customary for juries to serve as finder of fact in professional liability cases, including medical malpractice. To help explain the statutory standard of care law to the jury deciding a malpractice case, judges give “jury instructions.” For many types of cases, including medical malpractice, model jury instructions exist and are used by many courts. For medical malpractice

cases where a statewide standard of care is appropriate, the Virginia Model Jury Instructions state that a doctor is negligent if he fails to perform his duty “to use the degree of skill and diligence in the care and treatment of his patient that a reasonably prudent doctor<sup>10</sup> in the same<sup>11</sup> field of practice or specialty in this State would have used *under the circumstances of this case.*”<sup>12</sup>

When there is evidence that a local standard should apply, the following instruction is recommended:

[I]f you find that the doctor [patient] has proved by the greater weight of the evidence that *the health care services, health care facilities, and customary practices in the locality where the treatment took place make a local standard of care more appropriate* than a statewide standard, then the local standard applies and a doctor has a duty to use the degree of skill and diligence in the care and treatment of his patient that a reasonably prudent doctor in the same field of practice or specialty in the same [or a similar] locality would have used *under the circumstances of this case.*<sup>13</sup>

The jury, as the finder of fact (or the court trying the case without a jury), ultimately decides whether to use a statewide or a local standard if there is a dispute.<sup>14</sup>

Because in most cases lay juries cannot be expected to know how “reasonably prudent” doctors would have treated the plaintiff, expert testimony<sup>15</sup> is required to educate and assist the jury in its decision-making.<sup>16</sup> When the conduct in question is clearly negligent, as in a case where the defendant doctor left a hypodermic needle in the plaintiff’s neck at the close of surgery and it was not discovered until twenty months later, the Supreme Court of Virginia does not require expert testimony to establish a standard of care.<sup>17</sup> In the absence of such egregious conduct, however, expert testimony<sup>18</sup> is typically presented by the plaintiff to establish the appropriate standard of care, a deviation from that standard, and that such deviation was the

proximate cause of the plaintiff's injury and damages.<sup>19</sup> The defendant, of course, presents his own experts to rebut those experts presented by the plaintiff.

While there is case law in Virginia that suggests that the standard of care requires a physician to make use of all available diagnostic aids,<sup>20</sup> he is not an insurer, nor is he held to the highest standard of care of his profession.<sup>21</sup> Rather, in Virginia, all that is required is that he exhibit only that degree of skill and diligence employed by the ordinary, prudent practitioner in his field and community, or in similar communities, at the time and under the existing circumstances.<sup>22</sup>

#### **IV. Application of Current Virginia Law to “Altered” Standard of Care**

The most efficient and accurate method for determining how courts will apply a statute to a future issue is to understand how they have analyzed and applied the statute to similar cases in the past. Employing this principal, a thorough search of case law was conducted to find previous medical malpractice cases which arose out of emergency or disaster circumstances like the Oklahoma City bombing in 1995, September 11<sup>th</sup>, the series of hurricanes that devastated Florida in 2004, and most recently Hurricanes Katrina and Rita. Not surprisingly, the search returned no reported cases in Virginia or the remainder of the United States. Although there are anecdotal reports that malpractice claims have been filed in the wake of Hurricane Katrina, the results of the search are telling. It is possible that disaster victims and their family members are not inclined to sue for care rendered because they realize that under the circumstances, medical professionals are doing the very best that they can.

While this theory may reassure some, most in the medical field remain wary. Since there is no case law to guide our analysis of the application of the current standard of care statutes to an “altered” standard, we must use the tools available – the statutes and the jury instructions.

When looking at these two documents, one finds an interesting discrepancy. The jury instructions contain a final qualifying clause which is noticeably absent from the statute. The clause “would have used under the circumstances of this case”<sup>23</sup> requires the jury to account for the unique circumstances of the case before them when deciding whether the physician complied with the applicable standard of care. This language will be of the utmost importance in an “altered” standard of care case because it is the emergency or disaster *circumstances* surrounding the care rendered that gave rise to the need to employ an “altered” standard of care.

Two conclusions result from this discrepancy. First, documenting the emergency or disaster circumstances that give rise to an “altered” standard of care will be crucial. Documentation is difficult in the best of situations; therefore, hospitals will have to develop policies, procedures and templates to help ensure that this documentation will be created even in the midst of the disaster. Second, a legislative initiative to amend the existing standard of care statute so that it more closely resembles the jury instructions may be warranted. Because such a statute would not take effect until July 1, 2007 (after the next session of the General Assembly)<sup>24</sup> and the initiative’s success is not guaranteed, hospitals should not rely solely on this course of action to protect themselves against “altered” standard of care malpractice suits.

As discussed above, current medical malpractice jurisprudence typically relies on the use of expert testimony to outline the contours of the applicable standard of care. As in these typical cases, parties in an “altered” standard of care malpractice case will also be required to present expert testimony. This requirement may present a significant problem for both the plaintiff and the defendant in an “altered” standards case as there are no real experts because these standards of care are used infrequently, if at all. To the extent “altered” standards of care are formally created and promulgated, those who take part in the creation of the standard will likely become

the experts. This is a significant issue to keep in mind when choosing the individuals who will craft the “altered” standards.

## **V. Potential Tools to Address “Altered” Standard of Care Concerns**

There are various tools that are currently available and that hospitals can use to assuage liability concerns connected to the use of “altered” standards of care. In addition to the use of policies, procedures and templates discussed above, a declaration of emergency under the Commonwealth of Virginia Emergency Services and Disaster Law or emergency regulations issued by the Board of Health may provide protection for healthcare providers who must employ an “altered” standard of care in the face of an emergency or disaster.

### **a. Use of Title 44**

The Commonwealth of Virginia Emergency Services and Disaster Law (“Title 44”)<sup>25</sup> sets forth the statutory framework for the Governor and the executive heads or governing bodies of the political subdivisions of the state to deal with emergency situations caused by major<sup>26</sup>, natural<sup>27</sup> or man-made<sup>28</sup> disasters or a local emergency.<sup>29</sup> Among its stated purposes, Title 44 confers upon the Governor and the political subdivisions of the Commonwealth specific emergency powers,<sup>30</sup> including the ability for the Governor “to proclaim and publish such rules and regulations and to issue such orders as may, in his judgment, be necessary to accomplish the purposes of [Title 44].”<sup>31</sup> Accordingly, the Virginia Attorney General has determined that “the Governor has the authority to declare an emergency and waive state law when, in the Governor’s opinion, the safety and welfare of the people of Virginia require the exercise of emergency measures.”<sup>32</sup>

More specifically, Title 44 authorizes the Governor to take those actions that “as are in his judgment required to control, restrict, allocate or regulate the use, sale, production and



distribution of food, fuel, clothing and other commodities, materials, goods, services and resources under any state or federal emergency services programs.”<sup>33</sup> While “emergency services programs” is not a defined term within Title 44, medical and health services are included within the definition of “emergency services”<sup>34</sup> and the Commonwealth of Virginia Emergency Operations Plan. If medical and health services can be considered a “state emergency services program,” then, under Title 44, the Governor has the ability to promulgate rules and regulations allocating scarce medical resources during a declared state of emergency. Because “altered” standards of care are designed to allocate scarce medical resources, it may be reasonable to think that the Governor could proclaim an “altered” standard of care through an emergency declaration.<sup>35</sup>

The content of such a declaration will be uncertain until it is actually issued in the midst of an emergency. Despite this fact, two types of declarations can be imagined. The first type of declaration could be a generic statement that, as a result of the emergency conditions and resulting scarcity of resources, “altered” standards of care will be implemented in affected jurisdictions. Hospitals within affected jurisdictions would then be responsible for devising the content of “altered” standards. The second type of declaration could be much more specific and actually announce the “altered” standard of care. For instance, experts predict that during a pandemic influenza event, there will be a scarcity of ventilators. In a declaration of emergency, the Governor could proclaim that, as a result of the scarcity of ventilators, patients must meet certain enumerated criteria before being put on a ventilator. Healthcare providers would then be expected to render care in accordance with the specific “altered” standard established in the Governor’s declaration.

The content of the Governor's emergency declaration will impact its legal significance. The first type of declaration will probably be too general to have any significant legal effect other than providing hospitals with the authority to implement "altered" standards of care. The second type of declaration, however, may have a multi-tiered legal effect.

- First, it would definitively establish an "altered" standard of care for healthcare providers within the area of the declared emergency, negating the need for expert testimony on this subject during a malpractice case. Experts would still be needed to opine on whether the physician's actions complied with the established "altered" standard.
- Second, it may cloak healthcare providers complying with the "altered" standard with a shield of immunity. Under Title 44, no "...public or private employees ... engaged in any emergency services activities,<sup>36</sup> while complying with or attempting to comply with this chapter or any rule, regulation, or executive order promulgated pursuant to the provisions of this chapter, shall be liable for the death of, or any injury to, persons or damage to property as a result of such activities."<sup>37</sup> Healthcare providers within the affected areas who comply with the "altered" standard of care issued by the Governor through a declaration of emergency would presumably be able to take advantage of this Title 44 immunity.
- Finally, it would ensure that health care providers across affected areas were all providing the same care to similar patients. Since theoretically no patient will receive less care than any other patient, it may be difficult for individual patients to prove negligence.

Importantly, there is no existing legal precedence for such an action on the part of the Governor. If this would be a desirable resolution to the “altered” standard of care issue, we should embark on discussions with the Governor’s office as to the exact content of such a declaration and create template declarations that can be quickly completed in the midst of an emergency.

**b. Use of Emergency Regulations Issued by the Board of Health**

Although not as broad as the Title 44 powers granted to the Governor, administrative bodies of the government, like the Board of Health, have the ability to issue emergency regulations when necessitated by an “emergency situation.”<sup>38</sup> An “emergency situation” is defined as “a situation involving an imminent threat to public health or safety.”<sup>39</sup> The emergency and disaster situations that would warrant the use of “altered” standards of care will most assuredly satisfy these requirements; therefore, the Board of Health will have the general ability to issue emergency regulations.

Whether the Board of Health has the ability to issue emergency regulations prescribing “altered” standards of care presents an interesting question worthy of further exploration. The Board of Health is specifically empowered to “promulgate regulations and orders to meet any emergency or to prevent a potential emergency caused by a disease dangerous to public health, including, but not limited to, procedures specifically responding to ... any communicable disease of public health threat that is involved in an order of quarantine or isolation.”<sup>40</sup> It is foreseeable that such regulations and/or orders will include “procedures” which specify, in detail, “altered” standards of care or a general directive to implement such standards.

The legal effect of such regulations and/or orders is unclear and will be based on the court’s interpretation of the relationship between the standard of care statute and the Board of

Health's emergency regulation regarding an "altered" standard. Rules of statutory construction dictate that "two bodies of law which pertain to the same subject matter are said to be *in pari materia*. Where possible, the two should be harmonized in order to give effect to both. If both the statute and the ordinance can stand together and be given effect, it is the duty of the courts to harmonize them and not nullify the ordinance."<sup>41</sup> To harmonize the Board's emergency declaration of an "altered" standard of care with the existing standard of care statute, courts may find that the emergency regulation provides a specific clarification to the more general statute.<sup>42</sup> The regulation would basically define what a reasonably prudent practitioner should do under the existing circumstances and would therefore be consistent with the statute.

If courts adopt this analysis, a specific Board of Health emergency regulation which delineates an "altered" standard of care may have the same impact as a gubernatorial declaration of emergency in that it may obviate the need for an expert to testify as to the nature of the "altered" standard of care. Experts will, of course, still need to testify regarding whether the physician's conduct was compliant with the defined standard. Even if courts do not adopt this analysis, health care providers may still take solace in a Board of Health emergency regulation which outlines an "altered" standard of care as they will be complying with a statewide directive.

Importantly, the Board's emergency regulations do not become effective until approved by the Governor and filed with the Registrar of Regulations.<sup>43</sup> Also, because the Board's actions are governed by the Administrative Process Act, the Board must provide a copy of the proposed regulation to anyone who requests it at least two days before the meeting at which adoption will be considered.<sup>44</sup> These requirements taken together mean that, unlike the Governor's Title 44 declaration which is immediately effective, the Board of Health's emergency regulations will

take at least two days to be enacted. In an emergency situation, however, it is unclear that this process will even be feasible.

## **VI. Other Issues to Consider with Respect to “Altered” Standards of Care**

While the focus of many “altered” standard of care conversations surrounds liability, there are related issues that are just as, if not more, important. Scope of practice requirements, reimbursement issues and the actual determination of an “altered” standard of care are all issues that should be considered in any “altered” standard of care discussion.

### **a. Scope of Practice**

One key component of a standard of care is personnel – who will provide the needed care? During an emergency or disaster, there will be a shortage of personnel at all levels. As a result, physician assistants may be required to perform procedures that are usually only done by physicians. Nurses may have to perform tasks traditionally within the bailiwick of physician assistants. Licensed practical nurses may perform as registered nurses. Having these health care providers perform tasks historically outside the scope of their practice may be necessary a part of any “altered” standard of care, but it still presents a host of concerns.

Liability is of course a concern for these health professionals. The protection tools previously discussed with respect to physicians can also be used to protect other types of health care providers who are forced to practice under an “altered” standard of care. In addition to this concern, health care providers who render care outside the scope of their practice can be subject to disciplinary proceedings through their respective Boards. To avoid this situation, the Governor can waive the statutory and regulatory requirements related to the licensure of health professionals during a state of emergency or declared disaster.<sup>45</sup> Similarly, the Attorney General found that the health boards (or the Commissioner acting when the Board is not in session) can

issue emergency regulations to suspend the license requirements for health professionals.<sup>46</sup>

Along these same lines, the health boards may be able to expand the scope of practice to encompass new tasks necessitated by the “altered” standards of care. If any of these courses of action will be undertaken during an emergency or disaster situation, it is important that the details be discussed now, before the “altered” standard of care is necessary.

#### **b. Reimbursement**

Hospitals are understandably concerned about liability for health care providers practicing outside of their traditional scope of practice, but they are also concerned about the resulting reimbursement issues. For some procedures, hospitals can obtain reimbursement from insurers, including Medicare and Medicaid, only if the procedure was performed by a physician. Where this is not feasible in the midst of a disaster and a nurse or physician assistant performs the task instead, the hospital may not be reimbursed. If this happens for the duration of the disaster, the hospital could find itself in serious financial trouble. Resolution of this issue will likely require federal intervention.

Hospitals also understand that documentation of care rendered is critical when seeking payment from insurers. Proper documentation is difficult to maintain during the best of times in a hospital. It will be infinitely more difficult to maintain this during an emergency or disaster. Understandably, health care providers will be most concerned with providing the best care to the greatest number of individuals, not with documenting this care. For this reason, it is crucial that hospital institute policies, procedures and practices that will help providers document care while not detracting from their ability to render it.

### **c. Determining the Content of an “Altered” Standard of Care**

While it is commonly recognized within the health care industry that “altered” standards of care will have to be employed during a disaster, the exact nature of those standards is far from understood. Because there is a standard of care for each medical procedure from a blood draw to brain surgery and because each disaster situation will be unique, it is difficult, if not impossible, to formulate “altered” standards of care in advance. Instead, some are suggesting that it will be most beneficial to design a *process* for identifying the content of such standards. That process can then be utilized to develop “altered” standards as the need arises. Constructing such a process will be time intensive and require input and cooperation from numerous stakeholders, but may be a very worthwhile venture.

## **VII. Conclusion**

Ultimately, the way in which “altered” standards of care will be evaluated for liability purposes is a matter of state law. Currently, Virginia law does not provide a definitive method for addressing healthcare provider concerns regarding “altered” standards of care. Instead, it contains a mixture of laws that may provide liability protections. This remains a multifaceted, complex issue that deserves greater attention.

Notes

<sup>1</sup> *Altered Standards of Care in Mass Casualty Events*. Prepared by Health Systems Research Inc. under Contract No. 290-04-0010. AHRQ Publication No. 05-0043. Rockville, MD: Agency for Healthcare Research and Quality. April 2005. (“AHRQ Report”)

<sup>2</sup> *National Strategy for Pandemic Influenza: Implementation Plan*. Homeland Security Council (May 2006) at 110.

<sup>3</sup> AHRQ Report at 23.

<sup>4</sup> “Health care provider” as defined in Virginia Code section 8.01-581.1 is a person, corporation, facility or institution licensed by the Commonwealth to provide health care or professional services as a physician or hospital, dentist, pharmacist, registered or licensed practical nurse or person who holds a multistate privilege to practice nursing under the Nurse Licensure Compact, optometrist, podiatrist, chiropractor, physical therapist, physical therapy assistant, clinical psychologist, clinical social worker, professional counselor, licensed dental hygienist, health maintenance organization, or emergency medical care attendant or technician who provides fee-based services, nursing homes, or any one of those organized as a business, or an officer, agent, or employee thereof.

<sup>5</sup> “Field of practice” and “specialty” are presented in the statute as two different things. These terms are not otherwise defined and have been the subject of vigorous litigation when an expert witness from one specialty is offered to testify about the standard of care for a different specialty. The Supreme Court of Virginia, after applying a two-pronged test to determine if an expert was in a related field, has held that an expert may give expert testimony on a procedure in his clinical practice that is common to another specialty where the standard of care for the procedure is the same in both specialties. See *Sami v. Varn*, 260 Va. 280, 535 S.E.2d 172 (2000) (expert allowed to give testimony on procedures which are common to both emergency medicine and the field of obstetrics-gynecology and are performed according to the same standard of care, despite lack of knowledge regarding certain procedures of emergency medicine).

<sup>6</sup> Virginia Code § 8.01-581.20.

<sup>7</sup> A national standard of care was expressly rejected in *Black v. Bladergroen*, 258 Va. 438, 512 S.E.2d 168 (1999).

<sup>8</sup> “Health care” is defined in Virginia Code section 8.01-581.1 as “any act, or treatment performed or furnished, or which should have been performed or furnished, by any health care provider for, to, or on behalf of a patient during the patient’s medical diagnosis, care, treatment or confinement.”

<sup>9</sup> See Va. Code § 8.01-581.20(A); see also *Rhoades v. Painter*, 234 Va. 20, 360 S.E.2d 174 (1987).

<sup>10</sup> The instructions are drafted as if the suit were against a doctor because physician malpractice is more frequently litigated than other types of malpractice. If the action is not against a doctor, the appropriate term or the name of the applicable medical specialty may be substituted for “doctor” in the instruction. Further, in a case involving multiple defendants with different specialties, the instruction will have to be repeated for each specialty or defendants as clarity demands.

<sup>11</sup> Although “same” is not taken from the express language of the Virginia Code section 8.01-581.20, the drafters of the Instruction state that “it is clearly implied by the other language of the statute.” Virginia Model Jury Instructions - Civil, Chapter 35 Professional Liability, Inst. No. 35.000, Caveat. But see *Sami v. Varn*, *supra*.

<sup>12</sup> Civil Instruction No. 35.000 (emphasis added).

<sup>13</sup> Civil Instruction No. 35.010 (emphasis added).

<sup>14</sup> See Va. Code § 8.01-581.20(B).

<sup>15</sup> The overwhelming majority of medical malpractice cases in Virginia involve disputes over whether an expert is qualified to opine on the standard of care, rather than the actual application of the standard of care to the set of facts.

<sup>16</sup> See *Beverly Enterprises-Virginia, Inc. t/a, ETC. v. Nichols*, 247 Va. 264, 267, 441 S.E.2d 1, 3 (1994).

<sup>17</sup> See *Dickerson v. Fatehi*, 253 Va. 324, 484 S.E.2d 880 (1997).

<sup>18</sup> Qualifications for experts are set out in Virginia Code section 8.01-581.20(A). Any person who is licensed to practice in Virginia and any physician who is licensed in some other state of the United States and meets the education and examination requirements for licensure in Virginia, shall be presumed to know the statewide standard of care in the specialty or field of medicine in which he is qualified and certified. Once the presumption is established, the burden shifts to the other party to overcome the presumption. See *Black v. Bladergroen*, 258 Va. 438, 521 S.E.2d 168 (1999). A witness is qualified to testify as an expert on the standard of care if he demonstrates expert knowledge of the standards of the defendant’s specialty and he has had an active clinical practice in either the defendant’s specialty or a related field of medicine within one year of the alleged act or omission forming the basis of the action. See Va. Code § 8.01-581.20. Note that the presumption is expressly limited to physicians, and thus, an expert in another discipline may not benefit from the presumption.

<sup>19</sup> *Id.* (internal citations omitted); see also *Bryan v. Burt*, 254 Va. 28, 486 S.E.2d 536 (1997).



<sup>20</sup> See *Hicks v. United States*, 368 F.2d 626 (4<sup>th</sup> Cir. 1966) and *Sawyer v. United States*, 465 F. Supp. 282 (E.D. Va. 1978).

<sup>21</sup> Another recommended jury instruction reinforces the fact that the standard of care does not require medical perfection. Civil Instruction No. 35.040 provides that “[t]he fact that a doctor’s efforts on behalf of his patient were unsuccessful does not, by itself, establish negligence.”

<sup>22</sup> See *Murray v. United States*, 36 F. Supp. 2d 713 (E.D. Va. 1999); see also *Raines v. Lutz*, 231 Va. 110, 341 S.E.2d 194 (1986) (health care providers are required by law to possess and exercise only that degree of skill and diligence practiced by a reasonably prudent practitioner in the same field of practice or specialty in Virginia).

<sup>23</sup> See Instructions No. 35.000 and 35.010.

<sup>24</sup> The Virginia legislative process provides for emergency legislation, which takes effect upon signature by the Governor. If the General Assembly attached an emergency clause to the legislation, it could take effect sooner than July 1, 2007.

<sup>25</sup> Va. Code § 44-146 et seq.

<sup>26</sup> A “major disaster” is “any natural catastrophe, including any: hurricane, tornado, storm, high water, wind-driven water, tidal wave, tsunami, earthquake, volcanic eruption, landslide, mudslide, snowstorm or drought, or regardless of cause, any fire, flood, or explosion, in any part of the United States, which, in the determination of the President of the United States is, or thereafter determined to be, of sufficient severity and magnitude to warrant major disaster assistance under the Stafford Act to supplement the first and available resources of states, local governments, and disaster relief organizations in alleviating the damage, loss, hardship, or suffering caused thereby and is so declared by him[.]” Va. Code § 44-146.16.

<sup>27</sup> A “natural disaster” means “any hurricane, tornado, storm, flood, high water, wind-driven water, tidal wave, earthquake, drought, fire or other natural catastrophe resulting in damage, hardship, suffering or possible loss of life.” Va. Code § 44-146.16. A natural disaster differs from a major disaster in that it does not require a Presidential declaration; rather, it requires a gubernatorial determination that a natural catastrophe resulted “in damage, hardship, suffering or possible loss of life.” Va. Code § 44-146.16.

<sup>28</sup> A “man-made disaster” means “any condition following an attack by any enemy or foreign nation upon the United States resulting in substantial damage of property or injury to persons in the United States.” Va. Code § 44-146.16. It also includes any industrial, nuclear or transportation accident, explosion, or other condition that threatens or causes damage to property, human suffering, hardship or loss of life. *Id.*

<sup>29</sup> A “local emergency” is a “condition declared by the local governing body when in its judgment the threat or actual occurrence of an emergency or disaster is or threatens to be of sufficient severity and magnitude to warrant coordinated local government action to prevent or alleviate the damage, loss, hardship or suffering threatened or caused thereby.” Va. Code § 44-146.16.

<sup>30</sup> Va. Code § 44-146.14(a)(2).

<sup>31</sup> Va. Code § 44-146.17.

<sup>32</sup> See opinion of Attorney General to The Honorable John M. O’Bannon, III, Member, House of Delegates, 02-069 (November 13, 2002).

<sup>33</sup> Va. Code § 44-146.17(1).

<sup>34</sup> Va. Code § 44-146.16(3).

<sup>35</sup> This course of action was presented in the article *Concept of Operations for Triage of Mechanical Ventilation in an Epidemic*, by John L. Hick, MD and Daniel T. O’Laughlin, MD, published in the *Academy of Emergency Medicine’s Journal*, Volume 13, No. 2 at 223-229.

<sup>36</sup> “Emergency services activities” is not a defined term; however, medical and health services are within the definition of “emergency services.”

<sup>37</sup> Va. Code § 44-146.23(A).

<sup>38</sup> Va. Code § 2.2-4011(A).

<sup>39</sup> Va. Code § 2.2-4011(A).

<sup>40</sup> Va. Code § 32.1-42.

<sup>41</sup> Opinion of Attorney General to The Honorable Martin E. Williams Member, Senate of Virginia, 01-117 (November 19, 2001) at 2 (internal citations omitted). Courts will treat emergency regulations in the same manner as ordinances for purposes of statutory construction.

<sup>42</sup> “An equally fundamental rule of construction is that a specific or special statute supersedes a general statute insofar as there is a conflict.” See Opinion of Attorney General to Mr. Edwin N. Wilmot City Attorney for the City of Hopewell, 99-080 (March 8, 2000) at 2.

<sup>43</sup> Va. Code § 2.2-4011(A).

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<sup>44</sup> Va. Code § 2.2-4006(C).

<sup>45</sup> See Opinion of Attorney General to The Honorable John M. O'Bannon, III, Member, House of Delegates, 02-069, (November 13, 2002).

<sup>46</sup> *Id.* at \*8.

## INDEX OF ATTACHMENTS

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24. Virginia Code §2.2-4011
25. Virginia Code §32.1-42
26. Opinion of Attorney General to The Honorable Martin E. Williams, Member, Senate of Virginia, 01-117 (November 19, 2001)
27. Opinion of Attorney General to Mr. Edwin N. Wilmot, City Attorney for the City of Hopewell, 99-080 (March 8, 2000)
28. Virginia Code §2.2-4006

## ***Bioterrorism and Other Public Health Emergencies***

# **Altered Standards of Care in Mass Casualty Events**

**Prepared for:**

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# **Executive Summary**

## **Background and Purpose**

The events of September 11, 2001 and subsequent anthrax attacks underscored the need for U.S. health care organizations and public health agencies to be prepared to respond to acts of bioterrorism and other public health emergencies. Much has been accomplished in the past several years to improve health system preparedness. Many States and health care organizations and systems have developed preparedness plans that include enhancing surge capacity to respond to such events.

Many of these plans assume that even in large-scale emergencies, health care will be delivered according to established standards of care and that health systems will have the resources and facilities needed to support the delivery of medical care at the required level. However, it is possible that a mass casualty event—defined, for the purpose of this paper, as an act of bioterrorism or other public health or medical emergency involving thousands, or even tens of thousands, of victims—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. Therefore, it is critically important to identify, plan, and prepare for making the necessary adjustments in current health and medical care standards to ensure that the care provided in response to a mass casualty event results in as many lives being saved as possible.

To address this extremely important issue, in August 2004, a meeting of a number of the foremost experts in the fields of bioethics, emergency medicine, emergency management, health administration, health law and policy, and public health was convened by the Agency for Healthcare Research and Quality (AHRQ) and the Office of the Assistant Secretary for Public Health Emergency Preparedness (OASPHEP) within the U.S. Department of Health and Human Services (DHHS). These experts were joined by highly knowledgeable representatives from key Federal agencies and professional and other health organizations (see Appendix A for a complete list of participants). The purposes of this meeting were to:

- Examine how current standards of care might need to be altered in response to a mass casualty event in order to save as many lives as possible.
- Identify what planning, guidance, and tools are needed and what related issues need to be addressed to ensure an effective health and medical care response to a mass casualty event.
- Recommend specific action that will begin to address the needs of Federal, State, regional, community, and health systems planners on this critically important subject.



Consistent with these purposes, the panel of experts was asked to address the following questions:

- What do planners need to know to develop plans that provide an effective health and medical care response to a mass casualty event?
- What key principles should guide the planning for a health and medical response to a mass casualty event?
- What important issues must be considered and addressed in planning for the provision of health and medical care in a mass casualty event?
- What information, tools, models, and other resources are available to address the needs of planners?
- What other steps might be undertaken to move toward effective planning for such an event?

This paper summarizes the deliberations and recommendations of the expert panel.

## **Key Findings**

The key findings that emerged from the experts' discussion of the provision of health and medical care in a mass casualty event are summarized below. These findings are discussed in greater detail in Chapters 2 and 3.

- The goal of an organized and coordinated response to a mass casualty event should be to maximize the number of lives saved.
- Changes in the usual standards of health and medical care in the affected locality or region will be required to achieve the goal of saving the most lives in a mass casualty event. Rather than doing everything possible to save every life, it will be necessary to allocate scarce resources in a different manner to save as many lives as possible.
- Many health system preparedness efforts do not provide sufficient planning and guidance concerning the altered standards of care that would be required to respond to a mass casualty event.
- The basis for allocating health and medical resources in a mass casualty event must be fair and clinically sound. The process for making these decisions should be transparent and judged by the public to be fair.
- Protocols for triage (i.e., the sorting of victims into groups according to their need and resources available) need to be flexible enough to change as the size of a mass casualty event grows and will depend on both the nature of the event and the speed with which it occurs.

- An effective plan for delivering health and medical care in a mass casualty event should take into account factors common to all hazards (e.g., the need to have an adequate supply of qualified providers available), as well as factors that are hazard-specific (e.g., guidelines for making isolation and quarantine decisions to contain an infectious disease).
- Plans should ensure an adequate supply of qualified providers who are trained specifically for a mass casualty event. This includes providing protection to providers and their families (e.g., personal protective equipment, prophylaxis, staff rotation to prevent burnout, and stress management programs).
- A number of important nonmedical issues that affect the delivery of health and medical care need to be addressed to ensure an effective response to a mass casualty event. They include:
  - The authority to activate or sanction the use of altered standards of care under certain conditions.
  - Legal issues related to liability, licensing, and intergovernmental or regional mutual aid agreements.
  - Financial issues related to reimbursement and other ways of covering medical care costs.
  - Issues related to effective communication with the public.
  - Issues related to populations with special needs.
  - Issues related to transportation of patients.
- Guidelines and companion tools related to the development of altered standards of care in a mass casualty event are needed by, and would be extremely useful to, preparedness planners at the Federal, State, regional, community, and health systems levels.

## **Recommended Action**

The expert panel offered recommendations for action that could be undertaken to support planning an effective response to a mass casualty event. The list of recommendations is not meant to be comprehensive, but it provides a starting point for further discussion. These ideas suggest that a collaborative approach should be taken when developing next steps. Both government and private organizations have unique roles and important contributions to make in moving forward. The panel's recommendations include:

- Develop general and event-specific guidance for allocating scarce health and medical care resources during a mass casualty event.

- Develop and implement a process to address nonmedical (i.e., finance, communication, etc.) issues related to the delivery of health and medical care during a mass casualty event.
- Develop a comprehensive strategy for risk communication with the public before, during, and after a mass casualty event.
- Identify, analyze, and consider modification of Federal, State, and local laws and regulations that affect the delivery of health and medical care during a mass casualty event.
- Develop practical tools, such as searchable databases, for verifying credentials of medical and other health personnel prior to and onsite during a mass casualty event.
- Create strategies to ensure health and medical leadership and coordination for the health and medical aspects of system response during a mass casualty event.
- Continue and expand efforts to train providers and others to respond effectively in a mass casualty event.
- Develop and support a research agenda specific to health and medical care standards for a mass casualty event.
- Develop a *Community-Based Planning Guide for Mass Casualty Care* to assist preparedness planners in their efforts.
- Identify and support States, health systems, communities, and regions to develop mass casualty health and medical care response plans based on the *Planning Guide*; share their results widely.

# Chapter 1. Introduction

## Overview

The events of September 11, 2001 and subsequent anthrax attacks underscored the need for U.S. health care organizations and public health agencies to be prepared to respond to acts of bioterrorism and other public health emergencies. Much has been accomplished in the past several years to improve health system preparedness. Many States and health care organizations and systems have developed preparedness plans that include enhancing surge capacity to respond to such events.

Most of these plans assume that even in large-scale emergencies, health care will be delivered according to established standards of care and that health systems will have the resources and facilities needed to support the delivery of medical care at the required level. However, it is possible that a mass casualty event—defined, for the purpose of this paper, as an act of bioterrorism or other public health or medical emergency involving thousands, or even tens of thousands, of victims—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. Therefore, it is critically important to identify, plan, and prepare for making the necessary adjustments in current health and medical care standards to ensure that the care provided in response to a mass casualty event results in as many lives being saved as possible.

To address this extremely important issue, in August 2004, a meeting of a number of the foremost experts in the fields of bioethics, emergency medicine, emergency management, health administration, health law and policy, and public health was convened by the Agency for Healthcare Research and Quality (AHRQ) and the Office of the Assistant Secretary for Public Health Emergency Preparedness (OASPHEP) within the U.S. Department of Health and Human Services (DHHS). These experts were joined by highly knowledgeable representatives from key Federal agencies and professional and other health organizations (see Appendix A for a complete list of participants). The purposes of this meeting were to:

- Examine how current standards of care might need to be altered in response to a mass casualty event in order to save as many lives as possible.
- Identify what planning, guidance, and tools are needed and what related issues need to be addressed to ensure an effective health and medical care response to a mass casualty event.
- Recommend specific action that will begin to address the needs of Federal, State, regional, community, and health systems planners on this critically important subject.

Consistent with these purposes, participants were asked to address the following questions:

- What do planners need to know to develop plans that provide an effective health and medical care response to a mass casualty event?
- What key principles should guide the planning for a health and medical response to a mass casualty event?
- What important issues must be considered and addressed in planning for the provision of health and medical care in a mass casualty event?
- What information, tools, models, and other resources are available to address the needs of planners?
- What other steps might be undertaken to move toward effective planning for such an event?

This White Paper summarizes the deliberations and recommendations of this group of experts. Chapter 2 provides these experts' assessment of the need to develop and plan for the possible implementation of altered standards of care in response to a mass casualty event. Chapter 3 then outlines a framework and set of principles that can guide the development of strategies for adjusting the manner in which health and medical care is delivered in a mass casualty event to maximize the number of lives saved. Chapter 4 identifies an important set of related issues that must be addressed if these strategies are to be as effective as possible in achieving their goal. And, finally, Chapter 5 presents the experts' recommendations concerning the action steps to be taken to help States, communities, health systems, and providers to be prepared to respond to a mass casualty event in ways that save as many lives as possible.

## Chapter 2. Health and Medical Care Delivery in a Mass Casualty Event

### Health and Medical Care Standards in the Context of a Mass Casualty Event

Substantial work has already been done and continues to be undertaken throughout the country to improve the ability of health systems to respond to acts of terrorism or other public health emergencies. Much of the planning in this area focuses on increasing the surge capacity of affected delivery systems through the rapid mobilization and deployment of additional resources from the community, State, regional, or national levels to the affected area. However, few of these plans specifically address a situation in which the delivery system is unable to respond (even if only temporarily) according to established standards of care due to the scope and magnitude of a mass casualty event.

A key issue upon which the experts agreed is that the goal of the health and medical response to a mass casualty event is to save as many lives as possible. There is consensus that, to achieve this goal, health and medical care will have to be delivered in a manner that differs from the standards of care that apply under normal circumstances. This issue is not addressed in a comprehensive manner in many preparedness plans.<sup>1</sup> Finally, the experts also agreed that for health and medical care delivered under these altered standards to be as effective as possible in saving lives, it is critically important that current preparedness planning be expanded to explicitly address this issue and to provide guidance, education, and training concerning these altered care standards.

Standards of health and medical care, broadly defined, address not only what care is given, but to whom, when, by whom, and under what circumstances or in what places. A comprehensive set of standards for health and medical care specifies the following:

**What**—what types of interventions, clinical protocols, standing orders, and other specifications should be used in providing health and medical care?

**To whom**—which individuals should receive health and medical care according to their condition or likelihood of response?

**When**—with what urgency should health and medical care be provided?

**By whom**—which individuals are certified and/or licensed to provide care within a defined scope of practice and other regulations?

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<sup>1</sup> In preparation for the expert meeting, information and a sample of existing triage protocols and preparedness models were collected and reviewed. A brief summary of that review is provided in Appendix B.

**Where**—what facility and system standards (pre-hospital, hospital, alternate care site, etc.) should be in place for the provision of health and medical care?

Under normal conditions, current standards of care might be interpreted as calling for the allocation of all appropriate health and medical resources to improve the health status and/or save the life of each individual patient. However, should a mass casualty event occur, the demand for care provided in accordance with current standards would exceed system resources. In a small rural hospital, 10 victims from a local manufacturing accident might be considered a mass casualty event. In a metropolitan area, several hundred victims would be manageable within system resources. In an event involving thousands of victims, preserving a functioning health care system will require a move to altered standards of care. It may also be necessary to create both pre-hospital operations and alternate care sites to supplement hospital care.

The term “altered standards” has not been defined, but generally is assumed to mean a shift to providing care and allocating scarce equipment, supplies, and personnel in a way that saves the largest number of lives in contrast to the traditional focus on saving individuals. For example, it could mean applying principles of field triage<sup>2</sup> to determine who gets what kind of care. It could mean changing infection control standards to permit group isolation rather than single person isolation units. It could mean limiting the use of ventilators to surgical situations. It could mean creating alternate care sites from facilities never designed to provide medical care, such as schools, churches, or hotels. It could also mean changing who provides various kinds of care or changing privacy and confidentiality protections temporarily.

## **Hypothetical Scenarios Illustrating Changes in the Delivery of Care in Response to a Mass Casualty Event**

Two hypothetical mass casualty scenarios were developed by the panel of experts to help illustrate specific ways in which care standards would have to change in response to a mass casualty event (see Exhibit 1). The first scenario involves the simultaneous explosion of multiple dirty bombs in a metropolitan area. The second scenario involves the release of a biological agent. The use of these two scenarios facilitates the examination of the impacts and implications of two serious events that differ in nature and occur at different velocities. For example, the explosive scenario would produce a large number of casualties upon detonation and place an immediate demand on all aspects of the health care system. The biological scenario would develop more slowly, with its peak impact occurring at the end of an unknown incubation period.

The examination of these scenarios revealed that the explosive and biological terrorism mass casualty scenarios are likely to share common elements, but also raise issues that are specific to the nature of each event and the speed with which the event places demands on the health care system. The following discussion highlights these common elements. Event-specific issues for each scenario appear in Exhibits 2 and 3 and are organized by setting (scene [or pre-hospital], hospital, and alternate care sites).

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<sup>2</sup> The term triage refers to the process of sorting victims according to their need for treatment and the resources available.

# Changes in Care Delivery Common to Two Scenarios

At their peaks, both the explosive and biological mass casualty scenarios are likely to involve the following:

## Exhibit 1. Two Mass Casualty Scenarios Used to Identify Anticipated Changes to Care Delivery

Two mass casualty scenarios were developed by the panel of experts to help identify how care delivered at the event scene or pre-hospital setting, hospital, and alternate care sites would vary from care provided under normal circumstances.

### **Scenario 1. Multiple, simultaneous explosions**

A series of multiple dirty bombs have been set off simultaneously throughout a large metropolitan subway system. The city's hospitals also have been targeted and approximately 40 percent of the hospitals are no longer operational. There are an estimated 10,000 victims.

### **Scenario 2. Biological agent release**

A highly lethal communicable biological agent with a set but initially unknown incubation period has been released in a heavily populated area. Diagnosis is dependent on laboratory tests. Medical staffs are required to use personal protection equipment. Treatment requirements include patient isolation and the use of ventilators; however, the impact and effectiveness of treatment is unknown.

- *Triage efforts that will need to focus on maximizing the number of lives saved.* Instead of treating the sickest or the most injured first, triage would focus on identifying and reserving immediate treatment for individuals who have a critical need for treatment and are likely to survive. The goal would be to allocate resources in order to maximize the number of lives saved. Complicating conditions, such as underlying chronic disease, may have an impact on an individual's ability to survive.
- *Triage decisions that will affect the allocation of all available resources across the spectrum of care:* from the scene to hospitals to alternate care sites. For example, emergency department access may be reserved for immediate-need patients; ambulatory patients may be diverted to alternate care sites (including nonmedical space, such as cafeterias within hospitals, or other nonmedical facilities) where "lower level" hospital ward care or quarantine can be provided. Intensive or critical care units may become surgical suites and regular medical care wards may become isolation or other specialized response units.
- *Needs of current patients, such as those recovering from surgery or in critical or intensive care units; the resources they use will become part of overall resource allocation.* Elective procedures may have to be cancelled, and current inpatients may



have to be discharged early or transferred to another setting. In addition, certain lifesaving efforts may have to be discontinued.

- *Usual scope of practice standards that will not apply.* Nurses may function as physicians, and physicians may function outside their specialties. Credentialing of providers may be granted on an emergency or temporary basis.
- *Equipment and supplies that will be rationed and used in ways consistent with achieving the ultimate goal of saving the most lives* (e.g., disposable supplies may be reused).
- *Not enough trained staff.* Staff will be scared to leave home and/or may find it difficult to travel to work. Burnout from stress and long hours will occur, and replacement staff will be needed. Some scarce and valuable equipment, such as ventilators, may not be used without staff available who are trained to operate them.
- *Delays in hospital care due to backlogs of patients.* Patients will be waiting for scarce resources, such as operating rooms, radiological suites, and laboratories.
- *Providers that may need to make treatment decisions based on clinical judgment.* For example, if laboratory resources for testing or radiology resources for x-rays are exhausted, treatment based on physical exam, history, and clinical judgment will occur.
- *The psychological impact of the event on providers.* Short- and long-term stress management measures (e.g., Critical Incident Stress Management programs) are essential for providers and their families.
- *Current documentation standards that will be impossible to maintain.* Providers may not have time to obtain informed consent or have access to the usual support systems to fully document the care provided, especially if the health care setting is damaged by the event.
- *Backlog in processing fatalities.* It may not be possible to accommodate cultural sensitivities and attitudes toward death and handling bodies. Numbers of fatalities may make it difficult to find and notify next of kin quickly. Burial and cremation services may be overwhelmed. Standards for completeness and timeliness of death certificates may need to be lifted temporarily.

## Exhibit 2. Changes Specific to Care Delivery in a Multiple Explosion (Scenario 1)

**Scenario 1:** *A series of multiple dirty bombs have been set off simultaneously throughout a large metropolitan subway system. The city's hospitals also have been targeted and approximately 40 percent of the hospitals are no longer operational. There are an estimated 10,000 victims.*

In addition to the changes common to both scenarios described in this report, the following additional changes in medical care delivery may occur under this scenario.

### **Pre-hospital**

- Physicians most likely will not be at the scene. Emergency medical services and other first responders will perform triage.
- Anyone at the scene who can help may need to act as "medical staff."
- Triage protocols currently used (e.g., START, JumpSTART) may not apply, given magnitude of the event.
- Buses and other forms of nonmedical transportation may have to be used to supplement emergency transport systems.
- With an insufficient number of usual pre-hospital treatments and supplies, such as spineboards and immobilization equipment or the need to respond quickly, ambulatory victims may have to walk or self-transport to the nearest facility or hospital.

### **Hospital**

- Even if a hospital is among those still functioning, it may experience water, heating and cooling, electricity shortages, and communication problems.
- Reserved medical supplies and equipment may not arrive quickly enough from national and regional resources, such as the Strategic National Stockpile, given the velocity of the event.
- The provider-patient relationship may be interrupted. Providers may have service-specific assignments rather than patient group assignments (e.g., they would perform all intravenous infusions rather than provide all aspects of care for a group of patients).
- The hospital may need to exercise strict control of access to and from the hospital and diversion of ambulatory victims to alternate care sites. The emergency department should be protected in order to care for more critically injured victims (i.e., those who cannot walk to the hospital) who will arrive later.
- Decontamination practices will change, so that only gross decontamination (e.g., removal of clothes) is performed.
- Only lifesaving surgeries will be performed, and initial surgical care will aim to stabilize the patient. When more resources become available, additional surgery to fully treat injuries can occur.
- The practice of ordering only the supplies needed for immediate use means that limited supplies will run out quickly. This situation will be compounded by same vendor/resource dependence. It will also be compounded by an event requiring large amounts of specialized supplies or care. Examples include mass casualty events involving mostly children (substantial pediatric supplies needed) or demand for burn beds and related care.

### **Alternate Care Sites**

- Ambulatory patients will be redirected to alternate care sites within or outside of the hospital, such as the hospital cafeteria or a nearby school, to be re-triaged and receive care for minor injuries.

### Exhibit 3. Changes Specific to Care Delivery in a Biological Event (Scenario 2)

**Scenario 2:** *A highly lethal communicable biological agent with a set but initially unknown incubation period has been released in a heavily populated area. Diagnosis is dependent on laboratory tests. Medical staff are required to use personal protection equipment. Treatment requirements include patient isolation and the use of ventilators; however, the impact and effectiveness of treatment is unknown.*

In addition to the changes common to both scenarios described in this report, the following additional changes in medical care delivery may occur under this scenario.

#### Pre-hospital

- There will be no initial "scene" in a biological event. Pre-hospital activity related to triage, diagnosis, and case identification, will be done at physicians' offices, community health centers, emergency departments, and even pharmacies.
- Communication among providers will be important in order to develop a coordinated understanding of the symptoms and a systematic approach to treatment that is consistent with coordinated planning.
- Public health/epidemiological surveillance, including data mining from disparate sources (such as over-the-counter medication purchases, work/school absenteeism, etc.) may be useful in outbreak analysis and epidemiological projection.
- Emergency medical services may be used to transport victims to specific quarantine or isolation locations and other alternate care sites.

#### Hospital

- The emphasis will be on prevention and contagion control, as well as treatment, depending on staff and resources available. Victims who are conclusively diagnosed as infected will be isolated. Group isolation may be necessary.
- "Suspected" exposure patients will be quarantined. If laboratory tests and other diagnostic tools are not available, these patients may be treated based on histories reported and physician clinical judgment.
- Staff shortages are likely at all hospitals due to concerns about exposure to the infection. A recent survey suggests that as many as 50 percent of hospital workers may not show up for work during a bioterrorism event.
- Protection of all staff and their families, such as prophylaxis, will be needed to help ensure adequate staffing (including nonmedical staff such as housekeeping and dietary staff).
- "Early treaters/responders" will have to be quarantined and treated as if they have been exposed to the biological agent. Their quarantine will have a negative impact on provider supply.
- Demand for pharmaceuticals is likely to outstrip the supply. Both experimental and expired drugs may have to be used.
- Initially, standards of care initially may improve for the first wave of patients, but as the number of victims increases, standards could degrade.

#### Alternate Care Sites

- Alternate care sites will be used for triage and distribution of vaccines or other prophylactic measures, as well as for quarantine, minimum care, and hospice care.

Based on a review of the health and medical care issues presented by these two scenarios, the panel of experts identified a need for more guidelines to ensure a systematic approach to decisionmaking in mass casualty events. Guidelines should take into account and be scaleable to the size, nature, and speed of the event, so that they can guide the following decisions:

- How to ensure and protect an adequate supply of trained providers and support staff.
- How to triage patients into groups by the nature of their condition, probability of success of interventions/treatment, and consideration of resources available.
- How to maintain infection control and a safe care environment.
- How to use and reuse common supplies and equipment, such as gloves, gowns, and masks.
- How to allocate scarce clinical resources of a general nature, such as beds, surgery capability, and laboratory and other diagnostic services.
- How to allocate scarce and highly specialized clinical resources, such as decontamination units, isolation units, ventilators, burn beds, and intensive and critical care units.
- How to treat specific conditions, including how to make best use of available pharmaceuticals.
- How to protect health care providers and support staff and their families.
- How to modify documentation standards to ensure enough information to support care and obtain reimbursement without posing an undue administrative burden.
- How to manage excessive fatalities.

As illustrated in these scenarios, the occurrence of a mass casualty event will require significant changes in the way in which health and medical care is delivered under extraordinary circumstances. The panel of experts was quite clear in its view that if the health care system is to be successful in saving as many lives as possible, planning, education, and training efforts should be focused on the development and implementation of appropriate altered standards of care in response to a mass casualty event. A framework and set of principles to guide work in this area were developed by the panel and are presented in the next chapter.

# **Chapter 3. Framework and Guiding Principles When Planning for Health and Medical Care in a Mass Casualty Event**

## **Framework**

The expert panel suggested that a framework for planning should take into account the ways in which response to a mass casualty event is both similar to and different from responses to current surge capacity issues in health care facilities. The goal is to devise a framework that is applicable to both ordinary (“daily routine”) and extraordinary situations. To this end, they recommended that plans for a medical care response to a mass casualty event should:

- Be compatible with or capable of being integrated with day-to-day operations.
- Be applicable to a broad spectrum of event types and severities.
- Be flexible, to permit graded responses based on changing circumstances.
- Be tested, to determine where gaps in the framework exist.

A model reflecting the concept of a graded response that is sensitive to changing circumstances was shared with the panel and is depicted in Exhibit 4. This matrix illustrates how the release of a biological agent resulting in mass casualties would require that health and medical care standards be altered over time as the disease progresses within the population and demands on the health system grow. The disease progresses from a pre-release state (upper left) through death, at each stage placing greater demands on the system, and thus requiring increasing alterations in standards. This staged model approach allows for the development of care guidelines for each stage that are consistent with the overall goal of maximizing the number of lives saved.

Although Exhibit 4 is based on a disease model, this graded response could be adapted easily to other types of mass casualty events (e.g., chemical releases or explosions) by compressing the stages according to the magnitude and velocity of the event. High magnitude, high velocity events will require the system to adopt altered standards more quickly than smaller or slower-developing events. However, it is also important to recognize that as the impact of the event wanes and resources become more available, it may be possible to return to established standards of care used in normal situations.

**Exhibit 4. How Health and Medical Care Standards May Have to Be Modified in a Mass Casualty Event by Stage of Disease in the Population**

<div> Level of Standards →   Stage of Disease in the Population </div>	Normal Medical Care Standards	Near Normal Medical Care Standards	Focus on Key Lifesaving Care	Total System/ Standards Alteration
		(alternate sites of care, use of atypical devices, expanded scope of practice)	(cannot offer everyone highest level of care but can offer key lifesaving care)	(questions asked about who gets access to what resources)
<i>Pre-release of agent</i>	✓			
<i>Release responses</i>	✓	✓		
<i>Symptomatic</i>		✓	✓	
<i>Illness</i>			✓	✓
<i>Death</i>			✓	✓

Source: Dr. Michael Allswede, University of Pittsburgh, UPMC Health System

## Guiding Principles for Developing Altered Standards of Care to Respond to a Mass Casualty Event

In addition to offering suggestions for a framework for the development of plans to respond to a mass casualty event, the expert panel also articulated five principles that should steer the development of such guidelines. Incorporating these five principles will ensure that standards of care are altered sufficiently to respond to issues arising from a mass casualty event.

**Principle 1: In planning for a mass casualty event, the aim should be to keep the health care system functioning and to deliver acceptable quality of care to preserve as many lives as possible.**

Adhering to this principle will involve:

- Allocating scarce resources in order to save the most lives.

- Developing a basis for the allocation of resources that is fair, open, transparent, accountable, and well understood by both professionals and the public.
- Ensuring, to the possible extent, a safe environment for the provision of care, and placing a high priority on infection control measures, and other containment processes.

**Principle 2: Planning a health and medical response to a mass casualty event must be comprehensive, community-based, and coordinated at the regional level.**

Effective planning should:

- Be done at the facility level. However, facility-level planning alone is not sufficient.
- Integrate facility-level planning into a regional systems approach.
- Involve a broad array of public and private community stakeholders.<sup>3</sup>
- Begin with the agreement on shared responsibility among all partners in the planning process. It is not adequate for individual institutions and systems to have emergency response plans unless those plans are coordinated into a single unified response system.
- Be consistent. Planning also should be integrated with Federal, State and local emergency plans.

**Principle 3: There must be an adequate legal framework for providing health and medical care in a mass casualty event.**

An adequate legal framework for providing health and medical care in a mass casualty event would do the following:

- Include a designation of the authority to declare an emergency and implement temporary alterations in standards of care.
- Define the conditions for temporary modification of laws and regulations that govern medical care under normal conditions.
- Be simple, clear, and easy to communicate to providers and the public.

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<sup>3</sup> These stakeholders include: emergency management agencies, police and fire departments, emergency medical services, ambulance and other transport providers, health departments and community health centers, hospitals, ambulatory care centers, private physician offices, medical examiners, nursing homes, health centers, mental health services, morticians, and others. They also may include schools, churches, hotels, businesses, and other organizations that can provide space for alternate care facilities and cooperate in the preplanning required to activate such sites.

- Be flexible enough to accommodate the demands of events that vary in size and velocity, such as an explosive or biological event.

**Principle 4: The rights of individuals must be protected to the extent possible and reasonable under the circumstances.**

The rights of individuals must be protected to the extent possible and reasonable:

- In establishing and operationalizing an adequate legal framework for the delivery of care.
- In determining the basis on which scarce resources will be allocated.
- When considering limiting personal freedom through quarantine or isolation as well as the conditions for release.
- When privacy and confidentiality may have to be breached.

**Principle 5: Clear communication with the public is essential before, during, and after a mass casualty event.**

To manage expectations and educate the public about the impact of an event, whom to call for information, where to go for care, and what to expect, the following points should be kept in mind:

- The public should be brought into the discussion during the early stages of planning so that citizens develop a clear understanding of concepts such as rationing of resources.
- Public understanding and acceptance of plans are essential to success.
- Messages should be consistent and timely at all stages.
- Official health and medical care messages should be delivered through public media by a local physician whom the public perceives to have knowledge of the event and the area, a representative of the Centers for Disease Control and Prevention (CDC), or the Surgeon General, depending on the level of communication necessary.
- Spokespersons at all levels—local, State, regional, and Federal—should coordinate their messages.
- It may be necessary to vary the modes of communication according to the type of information to be communicated, the target audience for which it is intended, and the operating condition of media outlets, which may be directly affected. Variations that illustrate this point but that do not reflect expert discussion include the need to use languages other than English and the need to use alternatives to usual media outlets in the affected area. Also, national audience messages would be less detailed and specific than messages to the affected area.



## **Chapter 4. The Larger Context: Important Related Issues**

The expert panel emphasized that, for health systems and providers to respond effectively to a mass casualty event, a number of important legal, policy, and ethical issues related to altered standards of care must be addressed before such an event occurs. These issues are discussed below.

### **The Authority to Activate the Use of Altered Standards of Health and Medical Care**

It is important to establish clear authority to activate the use of altered standards of health and medical care. The following questions pertain:

- What circumstances will trigger a call for altered standards of care?
- Who is authorized to make that call, and at what level (site, community, region, State, or Federal) should the call be made?
- Under what legal statutory authority, should the call be made?
- Once the call is made, who assumes responsibility for directing emergency actions?
- What is the relationship of otherwise autonomous institutions to the incident management system?

Generally, when a decision exceeds the authority of a particular organization or region, responsibility for the decision moves to the next level of decisionmaking and authority. Nonetheless, it is advisable that State and local jurisdictions empower local decisionmakers to act before Federal or other outside assistance arrives. Some decisions may emanate from public officials at higher levels of authority, such as the mayor, governor, or president, whereas clinical decisions will need to come from health and medical professionals closer to the event.

While decisions made by those closer to the event may trigger a move to altered standards of care, policies that support the move to altered standards must be put in place by the highest levels of authority necessary. For example, during a mass casualty event, a hospital may decide that the demand for medical care has exceeded the hospital's ability to provide care under normal standards. This decision will require a move to expanded functions for staff (e.g., nurses may perform some physician duties). In this case the decision to move to altered standards of care emanates from the clinical level. However, it is important that the appropriate higher level of authority has put in place the policies, such as provisions allowing the modification of State

scope of practice laws that support the decision and empower the hospital's nurses or other health care staff to provide an expanded level of care.

Examples of existing resources that offer starting points for addressing questions of authority are described in the accompanying exhibits. One is a draft checklist developed by the American Bar Association for State and local government attorneys to prepare for possible disasters (Exhibit 5). Another is the Model State Emergency Health Powers Act (Exhibit 6). A third is draft executive orders developed in Colorado that create a legal framework for an emergency and address a variety of legal issues (Exhibit 7).

**Exhibit 5. Draft Checklist for State and Local Government Attorneys to Prepare for Possible Disasters**

Questions of authority are addressed by the "Draft Checklist for State and Local Government Attorneys To Prepare for Possible Disasters" prepared by the Task Force on Emergency Management and Homeland Security of the State and Local Government Law Section, American Bar Association (March 2003).

The checklist includes lists of questions pertaining to authority in general, authority for surveillance, and intergovernmental joint powers agreements. It also addresses public information, administrative and fiscal issues, contracting, personnel, and liability.

For more information, see <http://www.abanet.org/statelocal/disaster.pdf>

## Exhibit 6. Model State Emergency Health Powers Act

The Model State Emergency Health Powers Act (Model Act) grants specific emergency powers to State governors and public health authorities in the event of a large public health emergency. The Model Act was developed for the Centers for Disease Control by The Center for Law and the Public's Health at Georgetown and Johns Hopkins Universities to ensure an effective response to large-scale emergency health threats while protecting the rights of individuals. It provides a broad set of powers for an entity called the Public Health Authority.

As it may relate to altered standards of care, the Model Act provides that a declaration of an emergency activates the disaster response and recovery aspects of State, local, and interjurisdictional disaster emergency plans. There is no mention of local-level involvement. The Public Health Authority is empowered to take control over facilities (health care and other) and "materials," such as food, fuel, clothing and other commodities, and roads. It may control health care supplies by rationing resources; establishing priority distribution to health care providers, disaster response personnel and mortuary staff; and establishing a general distribution to all others. It may establish and enforce quarantine and other infection control measures.

The following provisions of the Model Act have provoked considerable discussion among public health scholars and practitioners:

- *Quarantine.* "Special Powers" of the Public Health Authority apply to: performing physical examinations, necessary tests, and/or vaccination. Any person refusing examination, tests, or vaccination may be isolated or quarantined. These sections (601, 603) have been subject to media and public scrutiny. States have designed widely differing solutions. However, the Model act has helped to modernize State laws on quarantine and encourages greater consistency among State laws regarding quarantine provisions.
- *Liability.* Health care providers are not held liable for any civil damages, except in cases where they are found to be negligent in treating or in failing to provide treatment. This includes out-of-State health care providers for whom relevant permits to practice have been waived by the Public Health Authority. The Model Act also explicitly states that except in cases of gross negligence or willful misconduct, the State (and the State and local officials specified in the act) is not liable for any property damage, death, or injury incurred as a result of complying with the Act (§804(a)).
- *Compelling Provider Participation.* The Model Act states (§608 (a)) that the Public Health Authority can compel in-State health care providers to assist in vaccination, testing, treatment, or examination of an individual as a licensure condition.
- *Other Provisions.* Other provisions of the Model Act include the use of otherwise protected private medical information, public information obligations, access to mental health services and personnel, compensation for private property (calculated according to nonemergency eminent domain procedures) and reimbursement for health care supplies.

For more information, see <http://www.publichealthlaw.net/Resources/Modellaws.htm>

## Exhibit 7. Colorado's Approach to Planning for Disaster Emergencies—Executive Orders

Colorado has chosen to plan for disaster emergencies by using draft executive orders to create a legal framework for an emergency and address a variety of legal issues. These orders are summarized in this exhibit.

- *Executive Order 0.0 Declaring a State of Disaster Emergency Due to Criminal Acts of Biological Terrorism.* This executive order declares a disaster emergency of an epidemic type. The Governor's Expert Emergency Epidemic Response Committee would meet and advise the governor that an emergency exists. The governor would then issue this order, which is good for 30 days and sets the stage for other orders directing specific actions to meet the emergency.
- *Executive Order 1.1 Ordering Hospitals to Transfer or Cease the Admission of Patients to Respond to the Current Disaster Emergency.* In directly authorizing hospitals to cease admissions and transfer patients, this order permits hospitals to determine on their own without central guidance whether they have reached their capacity to examine and treat patients. It further grants immunity from civil or criminal liability to those hospitals, physicians, and emergency service providers who act in good faith to comply with the executive order. The order takes the position that the Emergency Medical Treatment and Labor Act (EMTALA) requirements do not preempt this order.
- *Executive Order 2.0 Concerning the Procurement and Taking of Certain Medicines and Vaccines Required to Respond to the Current Disaster Emergency.* This order authorizes the seizure of certain named drugs from public and private outlets listed in the State's pharmacy statutes, and embargoes the supply of those drugs. At the same time, it exempts from seizure those supplies that certain facilities are required to keep on hand for the chemoprophylaxis of their employees. It provides for keeping records of drugs embargoed and for compensating the outlets at the cessation of the emergency.
- *Executive Order 3.0 Concerning the Suspension of Certain Statutes and Regulations to Provide for the Rapid Distribution of Medication in Response to the Current Disaster Emergency.* This order implements Colorado's Strategic National Stockpile Plan and suspends certain pharmacy statutes to facilitate the rapid distribution of medicines and vaccines in response to an emergency epidemic. The order further authorizes named officials to direct listed health care providers to participate in this effort and explicitly permits the limited participation in that effort by nonmedical personnel. The order is not intended for application in response to a chemical event.
- *Executive Order 4.0 Concerning the Suspension of Physician and Nurse Licensure Statutes to Respond to the Current Disaster Emergency.* This order permits physicians and nurses who hold a license in good standing in another State, or who hold an unrestricted but inactive Colorado license, to practice under the supervision of a Colorado-licensed physician during the emergency, provided they do so without charge to the State or any individual patient or victim. This order would permit more physicians and nurses to be available to treat infected persons during the emergency.
- *Executive Order 5.0 Concerning the Suspension of Certain Licensure Statutes to Enable More Colorado Licensed Physician Assistants and Emergency Medical Technicians to Assist in Responding to the Current Disaster Emergency.* Under normal conditions, physician assistants (PAs) and emergency medical technicians (EMTs) licensed in Colorado can practice only in association with or under the supervision of physicians by prior agreement. This order permits PAs and EMTs to practice under the supervision of any licensed physicians in order to afford treatment to the greatest number of infected individuals. The PAs, EMTs, and physicians involved are granted immunity from civil or criminal liability if they act in good faith to meet the terms of the order.
- *Executive Order 6.0 Concerning the Isolation and Quarantining of Individuals and Property in Response to the Current Disaster Emergency Epidemic.* This order empowers the Colorado Department of Public Health and Environment to establish, maintain, and enforce isolation (of infected individuals) and quarantine of (exposed individuals) as needed to protect the public health in an epidemic situation. It further grants similar powers to local boards of health to combat infectious disease epidemics.
- *Executive Order 7.0 Ordering Facilities to Transfer or Receive Patients with Mental Illness and Suspending Certain Statutory Provisions to Respond to the Current Disaster Emergency.* This order permits the transfer of mentally ill persons from a designated facility to some other facility as necessary to treat them for the infectious disease causing the epidemic. It further specifies requirements related to required services and use of identifying personal information, and provides for immunity from civil or criminal liability for any facility acting in good faith under the order.
- *Executive Order 8.0 Concerning Suspension of Certain Statutes Pertaining to Death Certificates and Burial Practices in Response to the Current Disaster Emergency.* This order suspends the statutory timing requirements for filing death certificates and authorizes the executive director of the Colorado Department of Public Health and Environment to direct the disposition of dead bodies in a manner that will protect the public health.

## Legal and Regulatory Issues

The organization and delivery of health care is highly regulated. In a mass casualty event, it is likely that some provisions for temporary modification of regulatory requirements at all levels of government will be necessary. At the present time, uncertainty about legal issues, particularly liability, may be creating a reluctance to anticipate and plan for a mass casualty event that would require altered health and medical care standards. As mentioned earlier, it is important to establish clear authority to activate altered standards of medical care. Alternatives may include enhancing or modifying a number of laws and regulations pertaining to the delivery of health and medical care in normal conditions. The level of authority necessary to modify laws and regulations during a mass casualty event will correspond with whether they are Federal, State, regional, or local laws. However, in all cases, it is important to make all providers and institutions aware of the established legal framework and authority to modify laws and regulations, so that responders to a mass casualty event will know which laws do and do not apply in a given situation.

To the extent possible, existing laws and other mechanisms should be used to the fullest and should not impede the process of planning for a mass casualty event. It is therefore important to examine existing State public health laws, licensing/certification laws, interstate emergency management compacts and mutual aid agreements, and other legal and regulatory arrangements to determine the extent to which they meet potential new threats. Any waivers granted are likely to be targeted to the affected area for a temporary and specified period of time. In the case of a mass casualty event involving a communicable agent that moves from region to region, it will be important to have flexibility to extend or expand such waivers.

Some of the Federal, State, and local laws and regulations that govern the delivery of health and medical care under normal conditions may need to be modified or enhanced in the case of a mass casualty event. These include laws to: ensure access to emergency medical care; protect patient privacy and confidentiality of medical information; shield medical providers and other rescuers from lawsuits; govern the development and use of health and medical facilities; and regulate the number of hours health and medical providers can work as well as the conditions in which they work. Relevant laws include but are not limited to the following:

- Emergency Medical Treatment and Active Labor Act (EMTALA).
- Health Insurance Portability and Accountability Act (HIPAA).
- Federal Volunteer Protection Act.
- Good Samaritan Law.

Additional types of laws and regulations that relate to the delivery of health and medical care include:

- 80-hour work week rule for medical residents.
- Occupational Safety and Health Administration and other workplace regulations.

- Building codes and other facility standards.
- Publicly funded health insurance laws (including Medicare, Medicaid, and the State Children’s Health Insurance Program).
- Laws pertaining to human subject research.
- Laws and regulations governing the use and licensure of drugs and devices.

In developing a comprehensive plan for the delivery of health and medical care during a mass casualty event, it is important to consider mechanisms to allow for legal, regulatory, or accreditation adjustments in the following areas:

- *Liability of providers and institutions for care provided under stress with less than a full complement of resources.* The plan may have to provide for “hold harmless” agreements or grant immunity from civil or criminal liability under certain conditions.
- *Certification and licensing.* Although it is important to ensure that providers are qualified, it is also important to have flexibility in granting temporary certification or licenses for physicians, nurses, and others who are inactive, retired, or certified or licensed in other States.
- *Scope of practice.* It may be necessary to grant permission to certain professionals on a temporary and emergency basis to function outside their legal scope of practice or above their level of training.
- *Institutional autonomy.* If organizations and institutions cede their authority in order to participate in a unified incident management system in a crisis, the plan may have to address the legal implications for those organizations.
- *Facility standards.* Standards of care that pertain to space, equipment, and physical facilities may have to be altered in both traditional medical care facilities and alternate care sites that are created in response to the event.
- *Patient privacy and confidentiality.* Provisions of HIPAA and other laws and regulations that require signed releases and other measures to ensure privacy and confidentiality of a patient’s medical information may have to be altered.
- *Documentation of care.* Minimally accepted levels of documentation of care provided to an individual may have to be established, both for purposes of patient care quality and as the basis for reimbursement from third-party payers.
- *Property seizures.* Provisions may have to be made to take over property, including facilities, supplies, and equipment, for the delivery of care or to destroy property deemed unsafe.

- *Provisions for quarantine or mass immunization.* In anticipation of a biological event, the plan will have to address the establishment and enforcement of isolation, quarantine, and mass immunization and provisions for release or exception.

## **Financial Issues**

Preparing for and providing health and medical care during a mass casualty event could result in large financial losses for all involved organizations, if issues surrounding the financing of such preparation and care are not addressed. Concern about financial resources and reimbursement for health and medical care provided during a mass casualty event applies to all providers, organizations, and sites, including governmental and nongovernmental, not for profit and for profit. It includes concern about costs of the following:

- Providing care in traditional medical settings, alternate care sites and pre-hospital care settings.
- Creating alternate care sites in settings such as schools, neighborhood centers, or hotels.
- Training providers.
- Staging drills.
- Repairing physical plant damage.

One potential source of disaster relief is the Stafford Act (Public Law 93-288). However, financing from the Federal government must be supplemented by funds from other public as well as private organizations. In preparing a comprehensive plan, it may be very valuable for planners to include financial management experts from the participating organizations, such as hospital systems. In addition formal mutual aid agreements or other contracts should be developed in advance to document relationships, expectations, and requirements related to obtaining emergency reimbursements. On the patient side, issues of financial access, such as requiring proof of insurance, apply. This concern is closely related to legal issues of documentation for reimbursement. It is not likely that providers will be able to maintain documentation practices beyond what is considered minimally adequate to support treatment; altered standards of documentation for reimbursement purposes may have to be defined.

## **Communicating with the Public**

Comprehensive plans for responding to a mass casualty event include strategies for communicating with the public before, during, and after an event, as follows:

- Prior to the occurrence of a mass casualty event, the goal should be to educate the public about:
  - Signs and symptoms of chemical, biological, radiological, and other exposures.
  - Appropriate self-care responses.
  - Appropriate use of health and medical care.
  - What to expect from the health care system in the event of a mass casualty incident.
- During a mass casualty incident, the goal should be to:
  - Provide information to the public about the status of the response.
  - Give consistent messages about when and where to seek care.
  - Manage expectations regarding the delivery of health and medical care.
  - Provide guidance on how to obtain information about the status of missing persons.
- Following a mass casualty incident, the goal should be to provide ongoing information to the public about:
  - Signs and symptoms of sequelae of exposure to toxic agents and post-traumatic stress.
  - Who to call for information.
  - Where to go for help.

Clear communication with the public is an essential part of a health and medical response to a mass casualty event. In order to deliver clear and appropriate messages before, during, and after a mass casualty event, it is important to consider a number of issues:

- Providing consistent and regular messaging, preferably through a single spokesperson with professional (medical) credibility, is highly desirable.
- Conveying clinical information requires particular care to assure that a lay audience can understand it.
- Distinguishing between political and professional messages is essential.
- Making provisions for communication in languages other than English may be necessary.



Strategies for public communication can be built from effective models of risk communication in use today for natural disasters, such as hurricanes and earthquakes. They should reflect and be tied to our long history of civil defense and other preparedness efforts dating as far back as World War II and the Cold War.

## **Ensuring an Adequate Supply of Health Care Providers**

One of the key components of an effective health and medical care response is ensuring adequate supplies of a broad array of qualified responders and providers who are available and willing to serve in a mass casualty event. This is likely to involve the following:

- Recruiting from retired or currently unemployed but qualified volunteer providers within the community and State.
- Making use of reserve military medical and nursing providers and other responders, as well as an expanded group of providers, such as veterinarians, dentists and dental auxiliary providers, pharmacists, and health professional students.
- Modifying State certification and licensing requirements to allow out-of-State providers to practice on a temporary basis.
- Modifying State regulations on a temporary basis to broaden scope of practice standards among various trained providers.
- Reallocating providers from nonemergency care and nonemergency sites to emergency response assignments and from unaffected regions to affected regions (this will involve identifying skill sets of each practitioner group [e.g., paramedics, nurse midwives, etc.], so as to optimize reassignment potential).
- Creating and training a pool of nonmedical responders to support health and medical care operations.
- Making adequate provisions to protect providers (and their families) who serve in mass casualty event situations to ensure their willingness to respond.
- Developing systems for the advance registration and credentialing of clinicians to augment health care personnel needs during a mass casualty event.

## **Provider Training and Education Programs**

Adopting altered standards of care, even temporarily, will have a significant impact on health care delivery operations and therefore on the needs of providers for training and education to

serve in those circumstances. Planners should not assume that individual providers will know how to deliver appropriate care in a mass casualty event, but rather should develop or identify training programs to ensure a knowledgeable and systematic, coordinated response effort.

A wide array of preparedness training has been designed and is being delivered throughout the country. Some of the training has been evaluated for effectiveness. In the absence of a national clearinghouse for training for all providers and conditions, it is not possible to provide a complete picture of what is available and effective. General principles that might guide the development and identification of effective training include the following:

- Training should be competency based.
- Training should be ongoing.
- Training should be provided to all responders, including nonmedical personnel and potential community volunteer responders, as well as primary care providers in office and clinic settings.
- Training should be based on the doctrine of daily routine, which assumes that providers will do best what they do most often, but anticipate extension and expansion of provider roles.
- Training should be provided on a just-in-time basis only where appropriate, especially if it differs from daily routine.
- Training should be specific to the role a person is likely to play in a mass casualty event (e.g., clinic nurses and nurse aides may need training in burn care).
- Training should be specific to the conditions of performance (type of hazard, type of site) and involve opportunities to practice new skills through simulation and other mechanisms.
- Training should be effective, as demonstrated by evaluations and trainee performance.
- Training should be made available to all potential traditional and non-traditional providers, including veterinarians, dentists and dental auxiliary providers, pharmacists and health professional students.

A beginning list of the types of training needed by all responders and providers in pre-hospital, hospital, and alternate care sites includes but is not limited to the following:

- General disaster response, including an introduction to altered standards of care and how the move to such standards may affect triage and treatment decisions as well as facility conditions.
- Legal and ethical basis for allocating scarce resources in a mass casualty event.

- Orientation on how an incident management system would work in a mass casualty event.
- How to treat populations with special needs (e.g., children and elderly persons).
- How to recognize the signs and symptoms of specific hazards and a trend of similar types of signs and symptoms.
- How to treat specific conditions.
- How to recognize and manage the effects of stress on themselves and their patients.

Finally, as components of preparedness training are defined, they should be incorporated into the original training for each provider group. For example, if paramedics are expected to participate in mass immunizations or assist in emergency departments, it would be desirable that they get basics on immunization and sterile technique in their original training.

## **Protection of Health Care Providers and Facilities**

It is important for planners to consider the following to ensure the protection of health care providers:

- Personal protective equipment, prophylaxis, and other protections that enable them to work safely.
- Training specific to provider responsibilities and to the nature of the event.
- Adequate rotation of staff to prevent burnout and errors due to fatigue.
- Freedom from threats of malpractice (see earlier discussion of legal issues).
- Mental health support during and following stressful situations (e.g., Critical Incident Stress Management).
- Care and support for health care providers' families.

A related concern is to protect the integrity and safety of existing health care facilities (e.g., hospitals, the providers who work there, and the patients who are already under care) at the time a mass casualty event occurs. The protection of alternate care sites created in response to a mass casualty event would also be important. A plan to protect health care facilities might include steps to ensure the following:

- Current patients and facility staff do not become secondary victims.

- Contaminated victims are not permitted to enter “clean” treatment areas.
- Facilities may utilize temporary security procedures, such as lockdowns, to enforce safety.
- Decontamination processes in all care settings are adequate.
- Noncritically ill patients are safely relocated to other facilities, if needed.

## **Caring for Populations with Special Needs**

It is essential that plans for the delivery of health and medical care in a mass casualty event address how the special needs of several groups within the general population can be met. These needs may vary from providing for alternate means of decontamination for babies and other nonambulatory persons, to having translators available at intake centers, to providing mental health assessment resources within the health care setting. Involving organizations and services designed to serve groups with special needs under normal conditions may be a successful approach. As mentioned earlier, a victim’s underlying medical condition may affect their survivability, and therefore may be considered negatively in triage. In some cases resources may be diverted away from adults to children because of their greater life expectancy.

Populations recognized as having special needs in a mass casualty event include but may not be limited to the following:

- *Children.* The unique physiology and wide variation in physical and cognitive development by age within childhood requires that triage personnel be trained in pediatric triage standards and other pediatric assessment protocols (e.g., JumpSTART); family care and adult care be available in pediatric settings; appropriately-sized supplies, equipment, and medication doses be available; and safe use of decontamination procedures be ensured. Provisions for treating children whose parents are not present and for treating parents who will not leave their children are important considerations.
- *Persons with physical or cognitive disabilities.* As under normal standards of care, provisions to accommodate the special disability-related needs of some persons are important aspects of the organization of care. These are likely to include issues of physical access to and within care sites, alternative and safe decontamination procedures, enhanced communication, and issues involving informed consent.
- *Persons with preexisting mental health and/or substance abuse problems.* Preexisting mental health and substance abuse conditions are known to exacerbate an individual’s ability to cope with physical and emotional trauma. Provisions should be made for screening and direction to appropriate services as part of triage or other assessment protocols.

- *Frail or immunocompromised adults and children.* Individuals in these groups who are victims may require adjustments in treatment regimens and special monitoring, but these adjustments will be made within the context of any overriding goal to maximize lives saved.
- *Non-English speakers.* Local and regional planning may have to take into account the need for communication tools in languages other than English. Although printed materials of a general nature may be prepared in advance, printed materials and signs will not be an adequate response for those who cannot read any language. An additional challenge may be present if undocumented individuals fear discovery and reprisal if they come forward for health care in a mass casualty event. Involvement of formal and informal networks, organizations, and media outlets that serve non-English speaking groups is essential.

## **Transportation of Patients**

Addressing issues related to the transportation of patients during a mass casualty event is also important. Roads may be blocked and the emergency transport system will not be adequate to meet the need. Issues to consider include the following:

- Who will accompany patients, since health and medical personnel may be needed elsewhere?
- How should all available public and private transport, including public and school buses, taxis, and limousines, be mobilized?
- What kind of prior agreements can be established to ensure this mobilization can occur?



## Chapter 5. Recommended Action Steps

Several recommendations for action related to planning a health and medical care response to a mass casualty event are identified below. The list of recommendations is not meant to be comprehensive, but it provides a starting point for discussion. These ideas suggest that a collaborative approach should be taken when developing next steps; both government and private organizations have unique roles and important contributions to make in moving forward.

### **Step 1: Develop general and event-specific guidance for allocating scarce health and medical care resources during a mass casualty event.**

Public and private organizations, including professional societies, should develop guidance in specific areas related to allocating scarce clinical resources. Examples include but are not limited to the following:

- Triage guidelines and measures for specific types of events.
- Allocation guidelines for scarce resources, such as ventilators, burn beds, or surgical suites.
- Guidance for the triaging and treatment of children, specifically the ways in which altered standards of care might differ for a pediatric population.

### **Step 2: Develop and implement a process to address nonclinical issues related to the delivery of health and medical care during a mass casualty event.**

Examples of nonclinical issues include but are not limited to the following:

- Alternative ways to establish authority to move to altered standards of health and medical care in a mass casualty situation.
- Alternative ways to ensure an adequate legal framework, including liability, certification and licensing, and mutual aid agreements for the provision of health and medical care in a mass casualty event.
- Alternative ways to resolve issues of finance and reimbursement issues related to the provision of health and medical care in a mass casualty event.

### **Step 3: Develop a comprehensive strategy for risk communication with the public before, during, and after a mass casualty event.**

Experts agreed that a unified strategy and tools for public communication around mass casualty risk and health and medical care response are indicated. Part of the challenge is to craft credible messages that the public will perceive as immediately relevant and important to their daily lives without causing undue alarm. Such a strategy should take the form of anticipatory guidance. Messages should be developed collaboratively with various stakeholders (such as the American Hospital Association, the Joint Commission on the Accreditation of Health Care Organizations, and others), that should also participate in their dissemination.

Specific ideas and suggestions made regarding public communication include but are not limited to the following:

- Continue and expand CDC training of journalists to cover health events as a means to partner effectively with the media in reaching the public.
- Find effective ways to communicate clinical information to lay audiences.
- Utilize primary care providers and local public health departments, especially nurses, in getting out agreed-upon messages in local communities on a one to one basis.
- Provide a communications capability at the level of the individual facility as well as through joint information centers.
- Include communications internal to health care facilities and among system components, such as hospitals and alternate care sites, in communications strategies.
- Build on the HANS (Health Alert Network System), part of CDC's emergency alert system, to develop an overall communication strategy.

### **Step 4: Identify, analyze, and consider modification of Federal, State, and local laws and regulations that may affect the delivery of health and medical care during a mass casualty event.**

As part of an effort to develop a legal framework for providing health and medical care in a mass casualty situation, an effort should be made to create a compendium of laws and regulations at the Federal, State and local levels that affect the delivery of health and medical care. This compendium of laws and regulations would facilitate the creation of an adequate legal framework for moving to altered standards of care when necessary. It would identify the following:

- The responsible parties for each law or regulation (local, State or Federal government).



- Circumstances when each law or regulation can be modified.
- Specific ways each law or regulation could be modified on a temporary basis.

**Step 5: Develop means for verifying credentials of medical and other health personnel prior to and on-site during a mass casualty event.**

In disaster situations, individuals who claim to be qualified providers and who want to volunteer their services typically approach health care facilities. In order to be able to make use of such resources, facility and incident managers need to have tools and methods, such as searchable databases, for verifying credentials. Efforts are underway at both the State and Federal levels to address this need. Emergency Systems for Advance Registration of Volunteer Health Care Personnel (ESAR-VHP), as outlined in the Public Health Security and Bioterrorism Preparedness and Response Act of 2002 (Public Law 107-188), as well as the Medical Reserve Corps credentialing efforts, and other State-developed systems are examples of tools that could be useful in this regard.

**Step 6: Create strategies to ensure health and medical leadership and coordination for the health and medical aspects of system response during a mass casualty event.**

Experience in developing preparedness strategies suggests there is a need to assure high-level health and medical leadership at the system and regional levels. For some systems and regions, this may involve creating a designated Medical Disaster Specialist or a role with comparable responsibilities to coordinate the health and medical aspects of system response. The expertise required ensuring appropriate health and medical leadership in a mass casualty event includes the following:

- Knowledge about how and when to initiate altered standards of care.
- Knowledge and skill to facilitate communication and provide the link between the medical care system and overall incident response.
- Knowledge and skill to provide disaster-related medical leadership in a system of community or region, including all aspects of medical preparedness and response.
- Knowledge and skill to provide leadership for training.
- Knowledge of and the ability to match hospital and system-specific resources to interventions in a crisis.
- Knowledge of surge plans, resources, and techniques for that particular region/city.

- Knowledge and skill in developing resource-sharing agreements, such as regional travel teams and memoranda of understanding, with adjacent areas.

## **Step 7: Continue and expand efforts to train providers and others to respond effectively in a mass casualty event.**

A wide range of provider training is needed to ensure an effective health and medical response to a mass casualty event. Training needs include, but are not limited to:

- General disaster response, including an introduction to altered standards of care and how the move to such standards may affect triage and treatment decisions as well as facility conditions.
- Legal and ethical basis for allocating scarce resources in a mass casualty event.
- Orientation to how an incident management system would work in a mass casualty event.
- How to treat children and other groups who may need special equipment or modified approaches to care.
- How to recognize the signs and symptoms of specific hazards.
- How to treat specific conditions.
- How to recognize and manage the effects of stress on themselves and their patients.

General principles to guide the design of effective training programs are included in Chapter 4.

## **Step 8: Develop and support a research agenda specific to health and medical care standards for mass casualty events.**

Ideas for research related to health and medical care standards for mass casualty events are listed below. The focus of these suggested studies should be on practical application, testing, and sharing of promising practices.

- Examine how different combinations of resources, signs/symptoms, and response to treatment may affect the numbers of lives that can be saved. A better understanding of survivability is especially important in developing criteria for the allocation of scarce treatment resources.
- Analyze or develop models to predict how much injury or illness can be prevented under different kinds of mass casualty scenarios. A better understanding of achievable reductions in injury and illness is important to setting goals for a system under stress.

- Examine international models and other real-world experiences of health and medical care delivery for evidence of what happens when “usual” rules are suspended or impossible to maintain. Other models and experiences may include specific disaster experiences (e.g., the Madrid train bombing and suicide bombings in Israel), as well as countries whose health systems operate daily with mildly, moderately, or severely constrained resources compared with the U.S. health care system. The focus of the research might be on methods for and outcomes of rationing scarce resources under different conditions.
- Evaluate all aspects of demonstrations and mock mass casualty events, such as “TOPOFF 3” and other drills, to find and address weak points in the system.
- Conduct research on effective risk communication with the public.
- Identify ways to share promising and tested practices in resource sharing (e.g., mutual aid agreements in St. Louis, Louisiana, New York City, and New Jersey).

## **Step 9: Develop a Community-Based Planning Guide for Mass Casualty Care.**

Experts agree that local and regional planners need a resource to assist them in enhancing surge capacity plans so that they include situations involving mass casualty events. A *Community-Based Planning Guide for Mass Casualty Care* could be developed that includes guidelines, principles, templates, and examples of promising or tested practices for addressing the many and varied aspects of this task, whether the focus is site-specific, local, regional, or statewide. Although some tools and resources exist that could be incorporated into a *Planning Guide*, others—including guidelines for the allocation of scarce resources during a mass casualty event—have yet to be fully developed or evaluated. It is important that the *Planning Guide* not be prescriptive, but rather offer suggestions and identify tools and resources that may be useful in guiding triage and the allocation of scarce resources.

## **Step 10: Identify and support States, health systems, and regions to develop mass casualty and health and medical care response plans based on the Planning Guide and to share their results widely.**

A number of practice-oriented “centers of excellence” could be supported in their efforts to build on surge capacity planning to prepare for a health and medical response to mass casualty events. The goal would be to move beyond specific elements of a plan limited to facilities, such as hospitals, to create a health and medical care response plan that is coordinated among its participants and with the overall emergency response system for the system or region. A central expectation of this approach is that the supported centers would develop and implement plans based on the *Planning Guide* and serve as demonstrations whose results would be widely shared with peers around the country.

## **Appendixes**

## Appendix A. Expert Meeting on Mass Casualty Medical Care Participant List

### Final Participant List: Expert Meeting on Mass Casualty Medical Care, August 3-4, 2004, The Hotel George, Washington, DC

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## **Preliminary Review of Selected Emergency Response Protocols and Models**

A preliminary review of a number of triage protocols and preparedness models was conducted prior to the expert meeting to assess the extent to which these documents provided explicit guidance on the issue of altered standards of care in the context of a mass casualty event. Brief summaries of the review of several field triage protocols and the Modular Emergency Medical System (MEMS) are presented below.

### **Field Triage Protocols**

One category of altered standards of care focuses on specific methods for field triage. In a mass casualty situation of any magnitude, methods of triage, or sorting victims according to their condition and resources available, are used to identify and, if possible, move to immediate treatment those who are most likely to survive or can benefit the most from treatment. Thus, triage standards address who receives care and when care is provided or the urgency with which it is provided. Triage is performed most often by first responders.

Triage begins in the field if there is a fixed event site; however, it also occurs within care settings, such as hospitals and alternate care sites, where individual victims may present themselves for care independent of organized responses. Secondary triage also may be necessary within a facility, such as a hospital, as demands on the system grow.

Several well-established standards for triage are currently in use.<sup>1-5</sup> Triage systems include START; JumpSTART (a pediatric modification to START); START, then SAVE; MASS; and others. Each system seeks to establish a small number of categories among victims that indicate the urgency with which they should be treated. Colors are often used to represent the categories—for example, red (immediate care); yellow (delayed); green (ambulatory and minor injuries); and black (dead and/or “expectant”).

The adequacy of the triage system used depends on the nature of the event and the population affected. For example, systems such as START and JumpSTART are trauma-oriented and may be effective in an explosive event. Traditional epidemic approaches to triage, considered more appropriate for biological events, sort infected patients into three categories: susceptible individuals, infected individuals, and removed individuals (by successful immunization, recovery, or death).

These standards have the impact of allocating resources for patient care. The standards are relevant to pre-hospital, hospital, and alternate care sites and to a situation where resources are constrained and demand is so great that rationing is required. While most systems offer detailed clinical measurements of status for triage purposes, they do not, by definition, provide actual clinical protocols for the treatment that would follow.



## **Modular Emergency Medical System**

Another type of standard that is pertinent to this discussion is one that addresses the organization of care and provides a context in which triage and medical care guidelines would be used. The Modular Emergency Medical System (MEMS) offers a comprehensive plan of operations and standards for responding to a mass casualty event of such size that alternate care delivery sites would be required.

MEMS emerged in response to Title IV of The Defense against Weapons of Mass Destruction Act of 1996 (Public Law 104-201). The law required that the Secretary of Defense develop and carry out a program to improve the responses of Federal, State, and local agencies to emergencies involving biological and chemical weapons. In response, the U.S. Department of Defense (DOD) created the Biological Warfare Improved Response Program. DOD then invited the Departments of Health and Human Services (DHHS), Energy (DOE), and Agriculture (USDA), and the Federal Emergency Management Agency (FEMA), the Federal Bureau of Investigation (FBI) and the Environmental Protection Agency (EPA), as well as emergency responders and managers from multiple States and local communities, to participate.

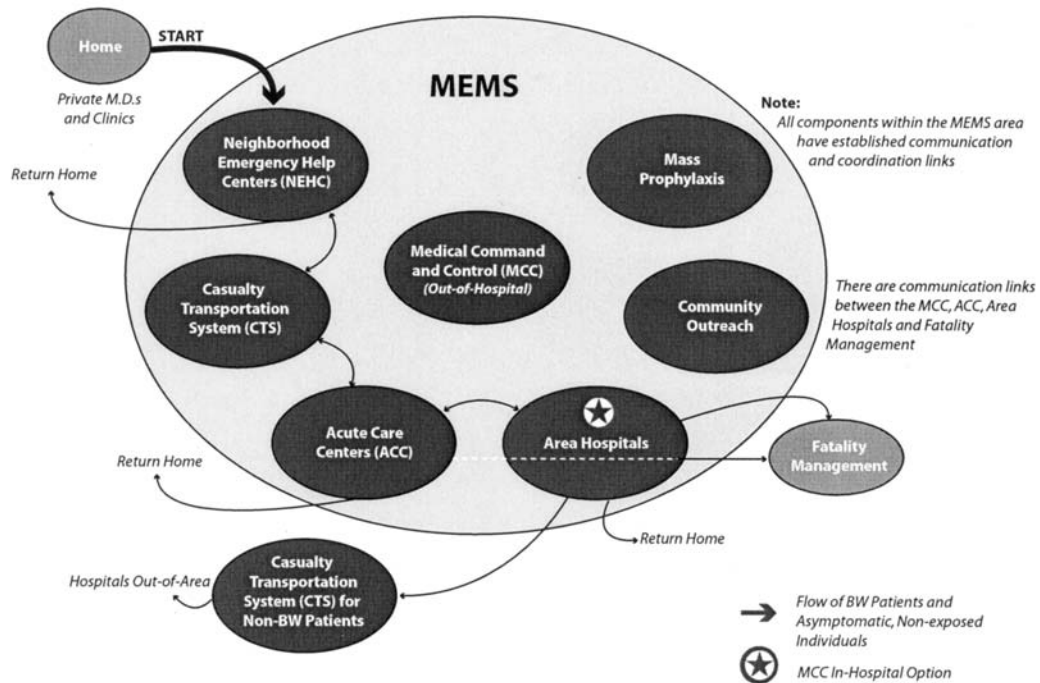
MEMS offers detailed standards for a system of care that can be expanded and contracted in modular units as the need arises. It provides a framework for the organization of care, particularly for setting up predetermined, special-use alternate care sites. Thus, MEMS answers the questions of what general kinds of care are provided and where (alternate site standards). In specifying the staffing required for alternate care sites, MEMS also addresses who will provide care. One of the underlying assumptions in MEMS is that resources will be brought in or created within the area most affected by the mass casualty event. Exhibit B-1 on the following page graphically depicts the operation of MEMS.

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## Appendix B. Preliminary Review of Selected Emergency Response Protocols and Models (continued)

Exhibit B1. Operation of the Modular Emergency Medical System (MEMS)



SOURCE: U.S. Army Soldier and Biological Chemical Command. Modular Emergency Medical System: Expanding Local Healthcare Structure in a Mass Casualty Incident. June 2002. Retrieved Aug. 17, 2004, from [http://accem.org/pdf/mems\\_copper\\_book.pdf](http://accem.org/pdf/mems_copper_book.pdf)

NATIONAL STRATEGY FOR  
PANDEMIC  
INFLUENZA

IMPLEMENTATION PLAN



HOMELAND SECURITY COUNCIL

MAY 2006



THE WHITE HOUSE

WASHINGTON

My fellow Americans,

On November 1, 2005, I announced the *National Strategy for Pandemic Influenza*, a comprehensive approach to addressing the threat of pandemic influenza. Our *Strategy* outlines how we are preparing for, and how we will detect and respond to, a potential pandemic.

Since then, our Nation has taken a series of historic steps to address the pandemic threat. In December, the Congress appropriated \$3.8 billion. The International Partnership for Avian and Pandemic Influenza, which we launched at the United Nations in September 2005, has encouraged openness and coordinated action by the international community. Here at home, we have made major investments in vaccine and antiviral development, research into the influenza virus, surveillance for disease in animals and humans, and the local, State, and Federal infrastructure necessary to respond to a pandemic. By making these critical investments, the Federal Government has begun strengthening our ability to safeguard the American people in the event of a devastating global pandemic and helping to prepare the Nation's public health and medical infrastructure.

Building upon these efforts, the *Implementation Plan for the National Strategy for Pandemic Influenza* ensures that our efforts and resources will be brought to bear in a coordinated manner against this threat. The *Plan* describes more than 300 critical actions, many of which have already been initiated, to address the threat of pandemic influenza.

Our efforts require the participation of, and coordination by, all levels of government and segments of society. State and local governments must be prepared, and my Administration will work with them to provide the necessary guidance in order to best protect their citizens. No less important will be the actions of individual citizens, whose participation is necessary to the success of these efforts.

Our Nation will face this global threat united in purpose and united in action in order to best protect our families, our communities, our Nation, and our world from the threat of pandemic influenza.

A large, stylized handwritten signature of George W. Bush in black ink.

GEORGE W. BUSH  
THE WHITE HOUSE  
May 2006

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## PREFACE

In the last century, three influenza pandemics have swept the globe. In 1918, the first pandemic (sometimes referred to as the “Spanish Flu”) killed over 500,000 Americans and more than 20 million people worldwide. One-third of the U.S. population was infected, and average life expectancy was reduced by 13 years. Pandemics in 1957 and 1968 killed tens of thousands of Americans and millions across the world. Scientists believe that viruses from birds played a role in each of those outbreaks.

Today, we face a new threat. A new influenza strain — influenza A (H5N1) — is spreading through bird populations across Asia, Africa, and Europe, infecting domesticated birds, including ducks and chickens, and long-range migratory birds. The first recorded appearance of H5N1 in humans occurred in Hong Kong in 1997. Since then, the virus has infected over 200 people in the Eastern Hemisphere, with a mortality rate of over 50 percent.

At this time, avian influenza is primarily an animal disease. Human infections are generally limited to individuals who come into direct contact with infected birds. If the virus develops the capacity for sustained, efficient, human-to-human transmission, however, it could spread quickly around the globe. In response to this threat, the President issued the *National Strategy for Pandemic Influenza* on November 1, 2005. The *Strategy* outlines the coordinated Federal Government effort to prepare for pandemic influenza. Of equal importance, the *Strategy* underscores the critical roles that State, local, and tribal authorities, the private sector, and communities must play to address the threat of a pandemic, and the concrete steps that individuals can and should take to protect themselves and their families.

This Implementation Plan for the *National Strategy for Pandemic Influenza* further clarifies the roles and responsibilities of governmental and non-governmental entities, including Federal, State, local, and tribal authorities and regional, national, and international stakeholders, and provides preparedness guidance for all segments of society. The Plan addresses the following topics:

- **Chapters 2 and 3 (U.S. Government Planning and Response)** describe the unique threat posed by a pandemic that would spread across the globe over a period of many months; the specific and coordinated actions to be taken by the Federal Government as well as its capabilities and limitations in responding to the sustained and distributed burden of a pandemic; and the central importance of comprehensive preparation at the State, local, and community levels to address medical and non-medical impacts with available resources.
- **Chapters 4 and 5 (International Efforts and Transportation and Borders)** outline steps we will take to work with our international partners to prevent, slow, or limit the spread of infection globally and in the United States, and describe proposed measures for effective management of our borders and the transportation sector during a pandemic.
- **Chapter 6 (Protecting Human Health)** details the critical actions that public health authorities, non-governmental organizations, the private sector, and individuals should take to protect human health and reduce the morbidity and mortality caused by a pandemic.
- **Chapter 7 (Protecting Animal Health)** highlights the actions necessary to prevent and contain outbreaks in animals with the aim of reducing human exposure and the opportunity for viral mutation that could result in efficient human-to-human transmission.

- **Chapter 8 (Law Enforcement, Public Safety, and Security)** outlines the support that State and local law enforcement and public safety agencies must provide, with appropriate Federal assistance, to public health efforts and essential public safety services, and to maintain public order.
- **Chapter 9 (Institutional Considerations)** provides guidance for the preparation of essential pandemic plans by Federal, State, local, and tribal authorities, businesses, schools, and non-governmental organizations to ensure continuity of operations and maintenance of critical infrastructure. It also provides guidance for families and individuals to ensure appropriate personal protection. To address the threat of pandemic influenza, it is essential that such plans be put in place as soon as possible.

The Implementation Plan represents a comprehensive effort by the Federal Government to identify the critical steps that must be taken immediately and over the coming months and years to address the threat of an influenza pandemic. It assigns specific responsibilities to Departments and Agencies across the Federal Government, and includes measures of progress and timelines for implementation to ensure that we meet our preparedness objectives.

This Plan will be revised over time. The pandemic threat is constantly evolving, as is our level of preparedness. The actions, priorities, timelines and measures of progress will be reviewed on a continuous basis and revised as appropriate to reflect changes in our understanding of the threat and the state of relevant response capabilities and technologies. Additional details regarding the implementation of this Plan are included at the conclusion of Chapter 1.

The active engagement and full involvement of all levels of government and all segments of society, including at the community level, are critical for an effective response. Ultimately, however, the actions of individuals will be the key to our response.



### *Medical Standards of Care*

If a pandemic overwhelms the health and medical capacity of a community, it will be impossible to provide the level of medical care that would be expected under pre-pandemic circumstances. It may be necessary because of hospital overcrowding to establish pre-hospital facilities and alternate-care sites to provide supplemental capacity. In some circumstances, it may be necessary to apply triage principles in the hospital to regulate which patients gain access to intensive care units (ICUs) and ventilators, and it is likely that vaccine, pharmaceuticals, and other medical materiel will also be rationed. Non-clinical personnel and family members may be asked to assist with administrative and environmental tasks, while qualified clinicians may be asked to perform unfamiliar functions such as staffing temporary medical care facilities, visiting patients in their homes, or providing medical advice via on-line or hot-line connections.

The terms ‘altered’ and ‘degraded’ standards of care have often been applied to such situations in both government documents and the medical literature. The legal and ethical ‘standard of care,’ however, is what is reasonably expected of medical systems and providers and is determined by extant circumstances. Relevant conditions include the availability of hospital, ICU, or specialty care beds; medical equipment and materiel; and personnel who are trained and qualified to provide care. As in all situations involving the allocation of scarce medical resources, the standard of care will be met if resources are fairly distributed and are utilized to achieve the greatest benefit. In a pandemic, hospital and ICU beds, ventilators, and other medical services may be rationed. As in other situations of scarce medical resources, preference will be given to those whose medical condition suggests that they will obtain greatest benefit from them. Such rationing differs from approaches to care in which resources are provided on a first-come, first-served basis or to patients with the most severe illnesses or injuries.

Given the strain that a pandemic would place on a community’s medical system, it will be necessary for hospitals, medical providers, and oversight agencies to maximize hospital bed surge capacity, and triage and treat patients in a manner that affords each the best chance of survival and recovery within the limits of available resources. In addition, the public must be informed regarding when, how, and where to obtain medical care. In all cases, the goal should be to provide care and allocate scarce equipment, supplies, and personnel in a way that saves the largest number of lives. Planning should therefore include thresholds for altering triage algorithms and otherwise optimizing the allocation of scarce resources. Where prospective and mature data are available, changes in clinical care algorithms should be evidence-based.

In planning for a prolonged mass casualty event, it must be recognized that persons with unrelated medical conditions will continue to require emergency, acute, and chronic care. It is important to keep the health care system functioning and to deliver the best care possible to preserve as many lives as possible. Planning a health and medical response to a mass casualty event must be comprehensive, community-based, and coordinated at the regional level. In making adjustments in the delivery of care because of constrained resources, individual autonomy, privacy, and dignity should be protected to the extent possible and reasonable under the circumstances. Finally, clear communication with the public is essential before, during, and after a mass casualty event such as a pandemic.

### *Availability of Medical Materiel*

Health care facilities typically maintain limited inventories of supplies on-site and depend on just-in-time restocking programs. Replenishment of critical inventories is thus dependent upon an intact supply chain from manufacturing and distribution to transportation and receiving. During a pandemic there

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CODE OF VIRGINIA  
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\*\*\* CURRENT THROUGH THE 2005 REGULAR SESSION, Acts 2005, cc. 1 to 951 \*\*\*  
\*\*\* ANNOTATIONS CURRENT THROUGH JANUARY 1, 2006 \*\*\*

TITLE 8.01. CIVIL REMEDIES AND PROCEDURE  
CHAPTER 21.1. MEDICAL MALPRACTICE  
ARTICLE 1. MEDICAL MALPRACTICE REVIEW PANELS; ARBITRATION OF MALPRACTICE CLAIMS

**GO TO CODE OF VIRGINIA ARCHIVE DIRECTORY**

*Va. Code Ann. § 8.01-581.1 (2006)*

**STATUS: CONSULT SLIP LAWS CITED BELOW FOR RECENT CHANGES TO THIS DOCUMENT LEXSEE**  
2006 Va. ALS 638 — See section 1.

§ 8.01-581.1. Definitions

As used in this chapter:

*"Health care"* means any act, or treatment performed or furnished, or which should have been performed or furnished, by any health care provider for, to, or on behalf of a patient during the patient's medical diagnosis, care, treatment or confinement.

*"Health care provider"* means (i) a person, corporation, facility or institution licensed by this Commonwealth to provide health care or professional services as a physician or hospital, dentist, pharmacist, registered nurse or licensed practical nurse or a person who holds a multistate privilege to practice such nursing under the Nurse Licensure Compact, optometrist, podiatrist, chiropractor, physical therapist, physical therapy assistant, clinical psychologist, clinical social worker, professional counselor, licensed dental hygienist, health maintenance organization, or emergency medical care attendant or technician who provides services on a fee basis; (ii) a professional corporation, all of whose shareholders or members are so licensed; (iii) a partnership, all of whose partners are so licensed; (iv) a nursing home as defined in § 54.1-3100 except those nursing institutions conducted by and for those who rely upon treatment by spiritual means alone through prayer in accordance with a recognized church or religious denomination; (v) a professional limited liability company comprised of members as described in subdivision A 2 of § 13.1-1102; (vi) a corporation, partnership, limited liability company or any other entity, except a state-operated facility, which employs or engages a licensed health care provider and which primarily renders health care services; or (vii) a director, officer, employee, independent contractor, or agent of the persons or entities referenced herein, acting within the course and scope of his employment or engagement as related to health care or professional services.

*"Health maintenance organization"* means any person licensed pursuant to Chapter 43 (§ 38.2-4300 et seq.) of Title 38.2 who undertakes to provide or arrange for one or more health care plans.

*"Hospital"* means a public or private institution licensed pursuant to Chapter 5 (§ 32.1-123 et seq.) of Title 32.1 or Article 2 (§ 37.2-403 et seq.) of Title 37.2.

*"Impartial attorney"* means an attorney who has not represented (i) the claimant, his family, his partners, co-proprietors or his other business interests; or (ii) the health care provider, his family, his partners, co-proprietors or his other business interests.

*"Impartial health care provider"* means a health care provider who (i) has not examined, treated or been consulted regarding the claimant or his family; (ii) does not anticipate examining, treating, or being consulted regarding the claimant or his family; or (iii) has not been an employee, partner or co-proprietor of the health care provider against whom the

claim is asserted.

"*Malpractice*" means any tort action or breach of contract action for personal injuries or wrongful death, based on health care or professional services rendered, or which should have been rendered, by a health care provider, to a patient.

"*Patient*" means any natural person who receives or should have received health care from a licensed health care provider except those persons who are given health care in an emergency situation which exempts the health care provider from liability for his emergency services in accordance with § 8.01-225.

"*Physician*" means a person licensed to practice medicine or osteopathy in this Commonwealth pursuant to Chapter 29 (§ 54.1-2900 et seq.) of Title 54.1.

**HISTORY:** Code 1950, § 8-911; 1976, c. 611; 1977, c. 617; 1981, c. 305; 1986, cc. 227, 511; 1989, cc. 146, 730; 1991, cc. 455, 464; 1993, c. 268; 1994, cc. 114, 616, 651; 2001, c. 98; 2003, cc. 487, 492; 2005, cc. 482, 649, 692.

**NOTES:**

CROSS REFERENCES.—As to tort liability of hospitals, see § 8.01-38. As to limitation on recovery of punitive damages in actions, including medical malpractice actions, see § 8.01-38.1. As to notice of claims against the Commonwealth involving medical malpractice, see § 8.0-195.6. As to statute of limitations for claims against the Commonwealth involving medical malpractice, see § 8.01-195.7. As to practitioner's disclosure of information when necessary for the protection or enforcement of the practitioner's legal rights including such rights with respect to medical malpractice actions, see § 8.01-399. As to limitation on recovery in certain medical malpractice actions, see § 8.01-581.15. As to the Medical Malpractice Joint Underwriting Association, see § 38.2-2800. For the Medical Malpractice Rules of Practice, see Volume 11 of the Code of Virginia.

EDITOR'S NOTE.—Effective October 1, 2005, in the definition of "hospital," "Article 2 (§ 37.2-403 et seq.) of Chapter 4 of Title 37.2" should be substituted for "Chapter 8 (§ 37.1-179 et seq.) of Title 37.1."

THE 2001 AMENDMENTS.—The 2001 amendment by c. 98, in the paragraph defining "Health care provider," deleted "or an officer, employee or agent thereof acting in the course and scope of his employment, or" from the end of clause (v), inserted "or" at the end of clause (vi), and added clause (vii); and transferred the paragraph defining "Physician" from next-to-last paragraph to last paragraph.

THE 2003 AMENDMENTS.—The 2003 amendment by c. 487, in the paragraph defining "health care provider," substituted "or, health maintenance organization, or emergency medical care attendant or technician who provides services on a fee basis" for "or, health maintenance organization" in clause (i), and substituted "subdivision A 2 of § 13.1-1102" for "§ 13.1-1102 A. 2." in clause (v).

The 2003 amendment by c. 492, in the paragraph defining "health care provider," inserted "independent contractor" following "employee" and inserted "or engagement" following "employment" in clause (vii).

THE 2005 AMENDMENTS.—The 2005 amendment by c. 482 inserted "or a person who holds a multistate privilege to practice such nursing under the Nurse Licensure Compact" in the definition of "Health care provider" and made minor stylistic changes.

The 2005 amendments by cc. 649 and 692 are identical, and inserted "action or breach of contract action for personal injuries or wrongful death" in the definition of "Malpractice"; and made minor stylistic changes.

LAW REVIEW.—For article on Virginia's Medical Malpractice Review Panel, see 11 *U. Rich. L. Rev.* 51 (1976). For note, "Medical Malpractice Arbitration: A Comparative Analysis," see 62 *Va. L. Rev.* 1285 (1976). For survey of Virginia insurance law for the year 1975-1976, see 62 *Va. L. Rev.* 1446 (1976). For survey of Virginia tort law for the year 1975-1976, see 62 *Va. L. Rev.* 1489 (1976). For note on a constitutional analysis of Virginia's Medical Malpractice Act, see 37 *Wash. & Lee L. Rev.* 1192 (1980). For article on the limitation on recovery in medical negligence cases in Virginia, see 16 *U. Rich. L. Rev.* 799 (1982). For article, "Medical Malpractice Review Panels in Operation in Virginia," see 19 *U. Rich. L. Rev.* 273 (1985). For comment, "Scope of Permissible Pretrial Discovery of Medical Malpractice Review Panel Deliberations in Virginia: *Klarfeld v. Salisbury*," see 10 *G.M.U. L. Rev.* 577 (1988). For survey on medical malpractice in Virginia for 1989, see 23 *U. Rich. L. Rev.* 731 (1989). For article, "Recent Developments in Medical

Malpractice and Health Care Law," see 24 *U. Rich. L. Rev.* 655 (1990). For article, "Autonomy and Informed Consent in Medical Decisionmaking: Toward a New Self-Fulfilling Prophecy," see 47 *Wash. & Lee L. Rev.* 379 (1990). For a review of damages in medical malpractice in Virginia, see 33 *U. Rich. L. Rev.* 919 (1999). For a note, "Pulliam v. Coastal Emergency Services of Richmond, Inc.: Reconsidering the Standard of Review and Constitutionality of Virginia's Medical Malpractice Cap," see 8 *Geo. Mason L. Rev.* 587 (2000). For an article, "The Quiet Demise of Deference to Custom: Malpractice Law at the Millenium," see 57 *Wash. & Lee L. Rev.* 163 (2000). For annual survey article discussing the state of health care law in Virginia, see 38 *U. Rich. L. Rev.* 137(2003). For annual essay of Virginia Law: "Discovery Divide: Virginia Code Section 8.01-581's Quality Assurance Privilege and Its Protection of Healthcare Provider Policies and Incident Reports," see 39 *U. Rich. L. Rev.* 61 (2004).

RESEARCH REFERENCES.—Harold L. Hirsch, *Trauma: Personal Injury, Medicine and Surgery* (Matthew Bender).  
 J.E. Schmidt, *Attorneys' Dictionary of Medicine* (Matthew Bender).  
 Lee S. Goldsmith, *Medical Malpractice: Guide to Medical Issues* (Matthew Bender).  
 Leonard J. Nelson, *Medical Malpractice Reports* (Matthew Bender).  
 Louisell and Williams, *Medical Malpractice* (Matthew Bender).  
 Marshall Houts, *Lawyer's Guide to Medical Proof* (Matthew Bender).  
 Roscoe N. Gray, *Attorneys' Textbook of Medicine* (Matthew Bender).

MICHIE'S JURISPRUDENCE REFERENCES.—For related discussion, see 14B *M.J. Physicians and Surgeons*, § 15.

#### I. DECISIONS UNDER CURRENT LAW.

##### EDITOR'S NOTE. —

Some of the cases cited below were decided under this article as it read prior to later amendments thereto.

CONSTITUTIONALITY.—Virginia Medical Malpractice Act does not violate *Va. Const., Art. IV, § 14*, which prohibits the enactment of any local, special or private law regulating the practice in or changing the rules of evidence in any judicial proceedings or inquiry before the courts or other tribunals but constitutes a valid legislative classification, since a law may apply to a small class so long as the classification is reasonable and the law applies equally to all persons within the class. *DiAntonio v. Northampton-Accomack Mem. Hosp.*, 628 F.2d 287 (4th Cir. 1980).

The Virginia Medical Malpractice Act does not violate Virginia constitutional provision vesting the judicial power in the Supreme Court and other courts established by the General Assembly, since the essence of judicial power is the final authority to render and enforce a judgment, and the Medical Malpractice Review Panel's opinion is binding upon no one. *DiAntonio v. Northampton-Accomack Mem. Hosp.*, 628 F.2d 287 (4th Cir. 1980).

The different treatment of medical malpractice plaintiffs from other tort plaintiffs is not a denial of equal protection, when the special problems posed by soaring insurance costs are considered. *DiAntonio v. Northampton-Accomack Mem. Hosp.*, 628 F.2d 287 (4th Cir. 1980).

PURPOSE OF 1994 AMENDMENTS.—The General Assembly intended the 1994 amendments adding new entities to the definition of "health care provider" to serve the same purpose as the original enactment of the medical malpractice cap, i.e., to provide a remedy for a perceived social problem, the unavailability of medical malpractice insurance at affordable rates. Thus, the Virginia Supreme Court rejected the argument that the 1994 amendment contained no statement of purpose and therefore failed the test that a statutory scheme must bear a reasonable and substantial relationship to the object sought to be accomplished by the legislation. *Pulliam v. Coastal Emergency Servs. of Richmond, Inc.*, 257 Va. 1, 509 S.E.2d 307 (1999).

ACTIONS CONSTITUTING "TORTS" UNDER THE ACT.—Assault and battery as well as intentional infliction of emotional distress are "torts," and qualify as "any" tort under the act. *Hagan v. Antonio*, 240 Va. 347, 397 S.E.2d 810 (1990).

"HEALTH CARE PROVIDER."—Corporation which provides emergency physicians to staff emergency departments of hospitals was an entity which primarily renders health care services within the meaning of the definition of "health care provider." *Pulliam v. Coastal Emergency Servs. of Richmond, Inc.*, 257 Va. 1, 509 S.E.2d 307 (1999).

In a family's suit against numerous state, county, and private defendants for separating the daughter from the mother and stepfather because of allegations of sexual abuse, a safe house, safe house employees, a foster care organization, and caseworkers were entitled to summary judgment or dismissal as to malpractice claims because they were not health care providers. *Gedrich v. Fairfax County Dep't of Family Servs.*, 282 F. Supp. 2d 439, 2003 U.S. Dist. LEXIS 16312 (E.D. Va. 2003).

Trial court erred in granting the clinical psychologist's demurrer to the patient's motion for judgment concerning the patient's medical malpractice claim; the patient and clinical psychologist had a limited physician-patient relationship arising out of the fact that the patient had impliedly agreed to an independent medical examination pursuant to Va. Sup. Ct. R. 4:10, the patient alleged sufficient facts from which it could be determined that the clinical psychologist owed her a duty not to conduct himself during the examination in such a way as to harm her and she alleged that his conduct in suggesting that she was faking her injury, when he allegedly knew that she suffered from post-traumatic stress disorder and a brain injury, proximately caused her injury. *Harris v. Kreutzer*, — Va. —, 624 S.E.2d 24, 2006 Va. LEXIS 11 (2006).

**EXISTENCE OF PHYSICIAN-PATIENT RELATIONSHIP WITH HEALTH CARE PROVIDERS.**—Parents sufficiently pled facts which, if proven at trial, would show the existence of a physician-patient relationship between them and their health care providers, when they pled that they requested the health care providers to provide all health care that a family should receive from a pediatrician and a professional corporation engaged in providing health care services relating to the practice of pediatrics and that the health care providers agreed to provide the parents with the requested services. *Didato v. Strehler*, 262 Va. 617, 554 S.E.2d 42, 2001 Va. LEXIS 119 (2001).

**ALLEGED BREACH OF DUTY OF CONFIDENTIALITY SOUNDED IN TORT** and not in contract; because the alleged breach of duty of confidentiality sounded in tort, it was "malpractice" for the reason that it was "any tort based on health care" under the act. It followed that the trial court properly sustained the motion to dismiss because notice of claim was not given before suit was filed in violation of § 8.01-581.2(A). *Pierce v. Caday*, 244 Va. 285, 422 S.E.2d 371 (1992).

**BREAST EXAMINATION WITHIN THE MEANING OF HEALTH CARE.**—A breast examination, including the touching, is an inseparable part of a typical, complete physical examination of a woman, and therefore the defendant's conduct during a breast examination was "based on health care" within the meaning of the act. *Hagan v. Antonio*, 240 Va. 347, 397 S.E.2d 810 (1990).

**AVAILABILITY OF REVIEW PROVISIONS IN FEDERAL COURT.**—Even if federal courts are required to apply the provisions of the Virginia Medical Malpractice Act under the *Erie* doctrine, the malpractice review provisions otherwise available to a defendant in state court litigation are not available when the action is commenced in federal court. *Adkins v. Commonwealth ex rel. UVA Medical Ctr.*, 154 F.R.D. 139 (W.D. Va. 1994).

**EXHAUSTION OF REMEDIES UNDER CHAPTER AS PREREQUISITE TO ACTION IN FEDERAL COURT.**—The Virginia Medical Malpractice Act is applicable in a diversity action. Thus, exhaustion of this available remedy is required before bringing a medical malpractice action in a federal court sitting in diversity in *Virginia*. *Herer v. Burns*, 577 F. Supp. 762 (W.D. Va. 1984).

However, exhaustion of state remedies is not a prerequisite to an action under 42 U.S.C. § 1983. Therefore, plaintiffs, who did not rely solely on diversity jurisdiction, were not required to avail themselves of the Virginia Medical Malpractice Act before a federal court had jurisdiction to consider constitutional and pendent wrongful death claims. *Herer v. Burns*, 577 F. Supp. 762 (W.D. Va. 1984).

**CAP APPLIES TO RECOVERIES UNDER THE EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT.**—The statutory cap of \$1,000,000 (now \$1,500,000) imposed by § 8.01-581.15 applies to medical malpractice recoveries under the Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd. *Lee ex rel. Wetzel v. Alleghany Regional Hosp. Corp.*, 778 F. Supp. 900 (W.D. Va. 1991).

Virginia's medical malpractice damages cap applied to claim under Emergency Medical Treatment and Active Labor Act (42 U.S.C. 1395dd) for failure to provide an appropriate medical screening. *Power v. Arlington Hosp. Ass'n*, 42 F.3d 851 (4th Cir. 1994).

**CHILD HAS STATUTORY CAP SEPARATE FROM CAP ON MOTHER'S CLAIMS.**—A mother and her newborn child are separate "patients," and thus, each may recover a maximum of \$1,500,000. *Lee ex rel. Wetzel v. Alleghany Regional*

*Hosp. Corp.*, 778 F. Supp. 900 (W.D. Va. 1991).

Hospital's motion to refer a patient's action to a medical malpractice review panel pursuant to the Virginia Medical Malpractice Act was denied because there was no statutory authority for the Supreme Court of Virginia to appoint a medical malpractice review panel for a case pending in federal court. *Lovelace v. Rockingham Mem'l Hosp.*, 299 F. Supp. 2d 617, 2004 U.S. Dist. LEXIS 2025 (W.D. Va. 2004).

A FATHER SEEKING DAMAGES FOR EMOTIONAL HARM and medical expenses, resulting from the malpractice to the mother and child, may not recover separately. *Lee ex rel. Wetzel v. Alleghany Regional Hosp. Corp.*, 778 F. Supp. 900 (W.D. Va. 1991).

The father's claims for emotional distress and medical expenses are derivative of the child's, and thus fall within the child's statutory cap. *Lee ex rel. Wetzel v. Alleghany Regional Hosp. Corp.*, 778 F. Supp. 900 (W.D. Va. 1991).

THE VIRGINIA MEDICAL MALPRACTICE ACT CONTAINS NO PROVISION FOR VICARIOUS LIABILITY, and the breadth of the statutory scheme suggests that none is intended; for example, because a physician, a nurse, or a hospital each may be held liable in their own right, there is no basis or reason for holding a physician liable for the conduct of another physician, a hospital nurse, or any other hospital employee. *Peck v. Tegtmeyer*, 834 F. Supp. 903 (W.D. Va. 1992), *aff'd*, 4 F.3d 985 (4th Cir. 1993).

STANDARD OF CARE FOR ASSISTED LIVING FACILITIES.—Although hospitals and nursing homes are included within the definition of "health care provider" in this section, adult homes (assisted living facilities) are not so included; the omission is significant, and adult homes (assisted living facilities), where residents are provided room and board but there are no medically-trained personnel on the staff and residents are free to come and go at will, are not held to the standard of care which applies to health care providers. Furthermore, subject to the provisions of former § 63.1-182.1 (see now § 63.2-1808), such homes do not have a duty to care for the health, welfare, and safety of their residents when such residents are absent from the home's premises. *Commercial Distribs., Inc. v. Blankenship*, 240 Va. 382, 397 S.E.2d 840 (1990).

PURPOSE OF ASSISTED LIVING FACILITIES.—Adult homes (assisted living facilities) are neither hospitals, nursing homes, nor custodial institutions; they exist pursuant to statutes intended to provide a residence for persons under disabilities, offering those persons the greatest degree of freedom and participation in normal life consistent with their conditions. *Commercial Distribs., Inc. v. Blankenship*, 240 Va. 382, 397 S.E.2d 840 (1990).

BREACH OF CONTRACT ACTION NOT MALPRACTICE.—Had the General Assembly meant to include breach of contract actions within the definition of "malpractice," surely it would have so provided. *Glisson v. Loxley*, 235 Va. 62, 366 S.E.2d 68 (1988).

The legislature was directing its attention to torts and not breaches of contract in the enactment which established the medical malpractice review system. *Glisson v. Loxley*, 235 Va. 62, 366 S.E.2d 68 (1988).

UNLICENSED PHYSICIAN NOT HEALTH CARE PROVIDER.—Since the doctor who performed the service was not licensed in the Commonwealth when he rendered the services to the deceased, he was not a health care provider within the purview of the statute. *Taylor v. Mobil Corp.*, 248 Va. 101, 444 S.E.2d 705 (1994).

CLINICAL LABORATORY NOT HEALTH CARE PROVIDER.—A clinical laboratory which provided erroneous test results to a physician was not a health care provider under the Virginia Medical Malpractice Act. *Richman v. National Health Labs., Inc.*, 235 Va. 353, 367 S.E.2d 508 (1988).

Clinical laboratory was not an agent or employee of doctors and thus was not a health care provider. Consequently, this act did not apply to the lab, and filing the notice of claim under the act did not toll the statute of limitations as to the claim of negligence against the lab. *Richman v. National Health Labs., Inc.*, 235 Va. 353, 367 S.E.2d 508 (1988).

WHEN INFANT IS OBSTETRICIAN'S PATIENT.—At the moment of live birth, and until the pediatrician assumes responsibility for the care of the newborn, the infant is the obstetrician's "patient." *Bulala v. Boyd*, 239 Va. 218, 389 S.E.2d 670 (1990).

REFUSAL TO PROVIDE VENTILATOR TREATMENT FOR INFANT WITH AN ENCEPHALY.—Where hospital

sought a declaration that its refusal to provide infant born with anencephaly with ventilator treatment did not constitute malpractice under the Virginia Medical Malpractice Act, the federal district court declined to "elbow its way" into Virginia medical malpractice standards by addressing the issue because of the significant state interest manifested by the review process as well as the Commonwealth's interest in resolving contentious and unsettled social issue for itself. *In re Baby "K"*, 832 F. Supp. 1022 (E.D. Va. 1993), aff'd, 16 F.3d 590 (4th Cir.), cert. denied, 513 U.S. 825, 115 S. Ct. 91, 130 L. Ed. 2d 42 (1994).

*Lawrence v. Wirth*, 226 Va. 408, 309 S.E.2d 315 (1983); *Edwards v. City of Portsmouth*, 237 Va. 167, 375 S.E.2d 747 (1989); *Gonzalez v. Fairfax Hosp. Sys.*, 239 Va. 307, 389 S.E.2d 458 (1990); *Turner v. Wexler*, 244 Va. 124, 418 S.E.2d 886 (1992).

## CIRCUIT COURT OPINIONS

**MEDICAL MALPRACTICE ACT CONSTITUTIONAL.**—Virginia Medical Malpractice Act, § 8.01-581.1 et seq., which provided a statutory cap on the amount of damages that could be awarded in a medical malpractice action, was constitutional since the law applied equally to all persons within the class, because the classification was reasonable, and because the medical malpractice cap was a rational means of achieving the legislative goal of securing health care services by maintaining the availability of malpractice insurance at affordable rates. *Allen v. Mid-Atlantic Health Alliance, Inc.*, 63 Va. Cir. 59, 2003 Va. Cir. LEXIS 194 (Fredericksburg 2003), rev'd in part, sub nom. *Gamache v. Allen*, 268 Va. 222, 601 S.E.2d 598 (2004).

**"PATIENT" DEFINED.**—Nothing in the statute suggested that a person examined for purely evaluational purposes should be denied the rights provided to patients as defined by statute. *Mansoor v. Favret*, 55 Va. Cir. 302, 2001 Va. Cir. LEXIS 286 (Charlottesville 2001).

**"HEALTH CARE PROVIDER."**—Demurrer of defendants, a hospital corporation and a health care corporation, to a motion for judgment by plaintiff patient in the patient's medical malpractice action was denied where the trial court disagreed with defendants to the extent that they alleged that they were not liable because they were not "health care providers"; the amended motion for judgment stated that defendants operated a hospital, and, pursuant to § 8.01-581.1, a corporation that provides health care or professional services as a hospital is a health care provider. *Elliott v. Cook*, 60 Va. Cir. 1, 2002 Va. Cir. LEXIS 121 (Loudoun County 2002).

There was nothing in the Uniform Commercial Code as adopted by Virginia, § 8.1A-101 et seq., or the Medical Malpractice Act, which stated that supplying a patient with a device for a fee was not a sale and that a health care provider could not be liable on a products liability theory under such circumstances; and had the General Assembly intended health care providers to be treated as "merchants," such a provision would have been covered in the Medical Malpractice Act, but was not. Therefore the health care company was not a "seller" and was not subject to liability on a products liability theory in the patient's action because health care providers render a service to their patients, and the transfer of any type of device to the patient during treatment is merely incidental to that treatment. *Coffman v. Arthrex, Inc.*, — Va. Cir.—, 2005 Va. Cir. LEXIS 143 (Augusta County Mar. 31, 2005).

**VIRGINIA'S MALPRACTICE ACT PERMITTED ANY PARTY TO THE ACTION TO REQUEST A MEDICAL MALPRACTICE REVIEW PANEL;** if a victim of malpractice could obviate such a panel merely by labeling his claim ordinary negligence, the legislative purpose would be thwarted. *In re Mullins*, 56 Va. Cir. 295, 2001 Va. Cir. LEXIS 156 (Spotsylvania County 2001).

**FRAUD CLAIM SUBSUMED.**—Patient's claim for fraud against a podiatrist for altering her medical records to characterize her as argumentative and uncooperative was subsumed into her medical malpractice claim by virtue of this section. Since the fraud alleged was a tort claim against a health care provider, it came under the Medical Malpractice Act and could not be treated as a separate and independent claim. *Langford v. Kelly*, 54 Va. Cir. 310, 2000 Va. Cir. LEXIS 602 (Roanoke 2000).

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**VIDA SAMI v. MILES VARN, M.D. AND JULIAN ORENSTEIN, M.D.****Record No. 992345****SUPREME COURT OF VIRGINIA***260 Va. 280; 535 S.E.2d 172; 2000 Va. LEXIS 125***September 15, 2000, Decided**

**PRIOR HISTORY:** [\*\*\*1] FROM THE CIRCUIT COURT OF FAIRFAX COUNTY. M. Langhorne Keith, Judge.

**DISPOSITION:** Reversed and remanded.

**COUNSEL:** Richard Murray (Raighne Delaney; Pompan, Murray & Werfel, on brief), for appellant.

William J. Carter (Carr Goodson Warner, on brief), for appellees.

**JUDGES:** Present: All the Justices. **OPINION BY JUSTICE ELIZABETH B. LACY**

**OPINIONBY: ELIZABETH B. LACY**

**OPINION:** [\*282] [\*\*173] **OPINION BY JUSTICE ELIZABETH B. LACY**

In this appeal, we consider whether the trial court erred in holding that an obstetrician-gynecologist was not qualified to give expert testimony on the standard of care for a pelvic examination performed by an emergency room physician.

Vida Sami went to the emergency room of Fairfax Hospital on January 26, 1994. She told the hospital personnel she was pregnant and that she was in pain and experiencing vaginal bleeding. Three separate pelvic examinations were performed on Sami: one by a medical resident; another by an emergency room physician, Dr. Miles Varn; and a third by the resident obstetrician-gynecologist on call at the hospital, Dr. Barbara A. Dill. Their conclusions were that Sami had undergone a spontaneous abortion or miscarriage and, according to Dr. Dill, the "miscarriage had completed itself." Sami was discharged from the hospital and given instructions for a follow-up appointment within four weeks.

Sami returned to the Fairfax Hospital emergency

[\*\*\*2] room in April of that year, and again in June, complaining of pain. Dr. Julian Orenstein, an emergency room physician, performed a pelvic examination and discharged Sami, instructing her to take a non-prescription pain medication.

In late June 1994, Sami went to the office of Dr. Herbert Roberts, an obstetrician-gynecologist, complaining of continuing abdominal pain. Dr. Roberts performed an abdominal examination, administered a sonogram, and found a "pelvic mass." When Dr. Roberts operated on Sami to remove the mass, he discovered that the mass was a second uterus containing a twelve to fifteen-week-old dead fetus.

[\*283] Sami filed a motion for judgment against a number of physicians at Fairfax Hospital, including Drs. Varn and Orenstein, alleging negligence and "infliction of emotional distress." n1 Sami filed a second motion for judgment against Fairfax Hospital on the same theories, claiming that the Hospital breached its duty to properly supervise its employees. The motions for judgment were consolidated.

n1 The other defendants in this action were dismissed by the trial court and are not involved in this appeal.

[\*\*\*3]

During a jury trial, Sami sought to qualify Dr. Roberts as an expert witness on the standard of care. Following voir dire of Dr. Roberts, the trial court concluded that Dr. Roberts was qualified as an expert on the standard of care applicable to the actions of Dr. Dill, an obstetrician-gynecologist, but that he was not qualified to testify to the standard of care applicable to Drs. Varn and Orenstein, emergency room physicians. The trial court held that Dr. Roberts did not "demonstrate[] expert knowledge of the standards of defendant[s]' specialty," and that he did not "have an active clinical practice in ER" or a related field. Without Dr. Roberts' testimony, Sami did not have an ex-



pert to establish the standard of care and breach thereof by Drs. Varn and Orenstein, and the trial court sustained a motion by those defendants to dismiss Sami's claims against them.

Following further testimony, the jury returned a verdict in favor of the hospital. Sami filed this appeal asserting that the trial court erred in holding that Dr. Roberts was not qualified to offer expert testimony on the [\*\*174] standard of care applicable to the pelvic examinations performed by Drs. Varn and Orenstein. [\*\*\*4]

The qualification of a witness as an expert is governed by *Code* § 8.01-581.20, which states, in relevant part:

A witness shall be qualified to testify as an expert on the standard of care if he demonstrates expert knowledge of the standards of the defendant's specialty and of what conduct conforms or fails to conform to those standards and if he has had active clinical practice in either the defendant's specialty or a related field of medicine within one year of the date of the alleged act or omission forming the basis of that action.

Drs. Varn and Orenstein argue that the trial court properly declined to qualify Dr. Roberts as an expert on the standard of care applicable to them on two grounds: (1) because Dr. Roberts did not demonstrate expert knowledge of their specialty, emergency room medicine; and [\*\*284] (2) because he had not had a clinical practice in their specialty or a related field within one year preceding the date of the alleged malpractice. We disagree with both of these arguments.

Whether a witness demonstrates expert knowledge of the appropriate standards of the defendant's specialty is a question largely within the sound discretion of the trial court. *Lawson v. Elkins*, 252 Va. 352, 354, 477 S.E.2d 510, 511 (1996) [\*\*\*5] (citing *Grubb v. Hocker*, 229 Va. 172, 176, 326 S.E.2d 698, 700 (1985)). However, we will reverse a holding that a witness is not qualified to testify as an expert when it appears clearly from the record that the witness possesses sufficient knowledge, skill, or experience to make him competent to testify as an expert on the subject matter at issue. *Noll v. Rahal*, 219 Va. 795, 800, 250 S.E.2d 741, 744 (1979).

In this case, Dr. Roberts testified that he was familiar with the standards of care applicable to pelvic examinations and that these standards were the same for an emergency room physician and an obstetrician-gynecologist. Dr. Dill, a defense witness, testified that she knew of no "variation among the medical profession on performance of a pelvic examination."

Nothing in the record in this case contradicts the testimony of Drs. Roberts and Dill, that the standards applicable to the performance of a pelvic examination by an obstetrician-gynecologist and an emergency room physician are the same. Dr. Roberts' lack of knowledge regarding certain procedures of emergency medicine might disqualify him from rendering expert testimony as to those [\*\*\*6] procedures, but that lack of knowledge does not preclude him from giving expert testimony on procedures which are common to both emergency medicine and the field of obstetrics-gynecology and are performed according to the same standard of care. See *Griffett v. Ryan*, 247 Va. 465, 472-73, 443 S.E.2d 149, 153-54 (1994).

In light of the record in this case, the trial court was not entitled to ignore the uncontradicted testimony that the standard of care for the performance of pelvic examinations was common to both specialties. *Cheatham v. Gregory*, 227 Va. 1, 4, 313 S.E.2d 368, 370 (1984). In qualifying Dr. Roberts to testify as an expert regarding Dr. Dill's performance of a pelvic examination, the trial court acknowledged Dr. Roberts' knowledge of the relevant standard of care for that procedure. Therefore, we conclude that the trial court abused its discretion in holding that Dr. Roberts did not demonstrate sufficient knowledge of the standard of care at issue in this case to qualify as an expert witness on that standard.

[\*285] Drs. Varn and Orenstein also argue that the trial court's ruling was correct because Dr. Roberts did not have an active [\*\*\*7] clinical practice in their specialty or a field related to their specialty, as required by § 8.01-581.20. Dr. Roberts does not have an active clinical practice in emergency medicine, but he does have an active clinical practice in obstetrics-gynecology. Sami argues that obstetrics-gynecology and emergency medicine should be considered related fields of medicine for the purposes of § 8.01-581.20 in the instant case because the procedure at issue is performed in both specialties and the standard for performance is identical. We agree with Sami.

We have not previously considered the application of the phrase "related field of medicine" in circumstances similar to those [\*\*175] presented in this case. n2 The phrase contemplates a clinical practice which differs from that of the defendant, but the statute provides no guidance for determining whether a clinical practice is "related." The purpose of the requirement in § 8.01-581.20 that an expert have an active practice in the defendant's specialty or a related field of medicine is to prevent testimony by an individual who has not recently engaged in the actual performance of the procedures at issue in a case. Therefore, we conclude that, [\*\*\*8] in applying the "related field

260 Va. 280, \*285; 535 S.E.2d 172, \*\*175;  
2000 Va. LEXIS 125, \*\*\*8

of medicine" test for the purposes of § 8.01-581.20, it is sufficient if in the expert witness' clinical practice the expert performs the procedure at issue and the standard of care for performing the procedure is the same.

n2 In *Fairfax Hospital System, Inc. v. Curtis*, 249 Va. 531, 537, 457 S.E.2d 66, 70 (1995), the proffered expert had previously practiced as an attending physician in the defendant's specialty, but at the time of the alleged malpractice was the "director of a helicopter transport service," an activity which did not qualify as any type of clinical practice.

In this case, as recited above, the procedure at issue, a pelvic examination, is governed by the same standard of care in both the emergency room and obstetric-

gynecology practice settings. Nothing in this record indicates that the emergency room setting required the procedure to be performed in a manner different than it would be performed under other circumstances. Dr. Roberts had an [\*\*\*9] active clinical practice which included the performance of pelvic examinations within one year of the alleged malpractice. Thus, we conclude that Dr. Roberts had an active clinical practice in a related field of medicine for purposes of § 8.01-581.20.

Because Dr. Roberts satisfied both requirements of § 8.01-581.20, it was an abuse of discretion by the trial court to rule that Dr. Roberts was unqualified to give expert testimony on the standard of [\*286] care for the performance of a pelvic examination by the emergency room physicians in this case. Accordingly, we will reverse the judgment of the trial court and remand the case for further proceedings consistent with this opinion.

Reversed and remanded.

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CODE OF VIRGINIA  
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\*\*\* CURRENT THROUGH THE 2005 REGULAR SESSION, Acts 2005, cc. 1 to 951 \*\*\*  
\*\*\* ANNOTATIONS CURRENT THROUGH JANUARY 1, 2006 \*\*\*

TITLE 8.01. CIVIL REMEDIES AND PROCEDURE  
CHAPTER 21.1. MEDICAL MALPRACTICE  
ARTICLE 1. MEDICAL MALPRACTICE REVIEW PANELS; ARBITRATION OF MALPRACTICE CLAIMS

**GO TO CODE OF VIRGINIA ARCHIVE DIRECTORY**

*Va. Code Ann. § 8.01-581.2 (2006)*

§ 8.01-581.2. Request for review by medical malpractice review panel; rescission of request; determination on request

A. At any time within thirty days from the filing of the responsive pleading in any action brought for malpractice against a health care provider, the plaintiff or defendant may request a review by a medical malpractice review panel established as provided in § 8.01-581.3. The request shall be forwarded by the party making the request to the Clerk of the Supreme Court of Virginia with a copy of the Motion for Judgment and a copy of all responsive pleadings. A copy of the request shall be filed with the clerk of the circuit court, and a copy shall be sent to all counsel of record. The request shall include the name of the judge to whom the case is assigned, if any. Upon receipt of such request, the Supreme Court shall select the panel members as provided in § 8.01-581.3:1 and shall designate a panel within sixty days after receipt of the request. If a panel is requested, proceedings on the action based on the alleged malpractice shall be stayed during the period of review by the medical review panel, except that the judge may rule on any motions, demurrers, or pleas that can be disposed of as a matter of law, set the trial date after the panel has been designated and, prior to the designation of the panel, shall rule on any motions to transfer venue.

B. After the selection of the members of the review panel, the requesting party may rescind a request for review by the panel only with the consent of all parties or with leave of the judge presiding over the panel.

C. Any health care provider named as a defendant shall have the right to request a panel and, in that event, shall give notice of its request to the other health care providers named in the motion for judgment as well as to the plaintiff and his counsel of record. When a request for a medical review panel is made by any party, a single panel shall be designated and all health care providers against whom a claim is asserted shall be subject to the jurisdiction of such panel. The provisions of this subsection shall not prohibit the addition of parties pursuant to § 8.01-581.2:1.

**HISTORY:** Code 1950, § 8-912; 1976, c. 611; 1977, c. 617; 1982, c. 151; 1984, cc. 443, 777; 1986, c. 227; 1989, c. 561; 1993, c. 928; 1994, c. 38; 1995, c. 367; 2000, c. 213; 2001, c. 252.

**NOTES:**

**THE 2000 AMENDMENTS.**—The 2000 amendment by c. 213, in subsection A, substituted "party making the request to" for "clerk of the circuit court" and added "with a copy of the Motion for Judgment and a copy of all responsive pleadings" in the second sentence, added a third and a fourth sentence, and added "and shall designate a panel within sixty days after receipt of the request" at the end of the fifth sentence.

**THE 2001 AMENDMENTS.**—The 2001 amendment by c. 252 inserted "set the trial date after the panel has been designated" near the end of subsection A.

**LAW REVIEW.**—For survey of Virginia tort law for the year 1975-1976, see 62 *Va. L. Rev.* 1489 (1976). For note on constitutional analysis of Virginia's Medical Malpractice Act, see 37 *Wash. & Lee L. Rev.* 1192 (1980). For a re-

examination of sovereign tort immunity in Virginia, see *15 U. Rich. L. Rev. 247 (1981)*. For comment, "A Frivolous Lawsuit May Destroy the Career of a Professional: Is There No Remedy?", see *17 U. Rich. L. Rev. 421 (1983)*. For article, "Medical Malpractice Review Panels in Operation in Virginia," see *19 U. Rich. L. Rev. 273 (1985)*. For comment, "Scope of Permissible Pretrial Discovery of Medical Malpractice Review Panel Deliberations in Virginia: Klarfeld v. Salsbury," see *10 Geo. Mason L. Rev. 577 (1988)*. For survey on medical malpractice in Virginia for 1989, see *23 U. Rich. L. Rev. 731 (1989)*.

MICHIE'S JURISPRUDENCE REFERENCES.—For related discussion, see *12A M.J. Limitation of Actions*, §§ 3, 53; *14B M.J. Physicians and Surgeons*, § 15; *18 M.J. Torts*, § 2.

## I. DECISIONS UNDER CURRENT LAW.

### EDITOR'S NOTE. —

Some of the cases below were decided under this article as it read prior to later amendments.

THE STATUTORY LANGUAGE IS CLEAR AND UNAMBIGUOUS; thus, the court will apply the plain meaning of the act's language to the facts of each case. *Hagan v. Antonio*, 240 Va. 347, 397 S.E.2d 810 (1990).

NON-ADVERSARIAL PROCEDURE FOR DEVELOPING MEDICAL RECORDS.—This unique pre-litigation procedure gives a Virginia health care provider an opportunity to develop the medical record in a non-adversarial fashion. *Gardner v. Aetna Cas. & Sur. Co.*, 841 F.2d 82 (4th Cir. 1988).

VIRGINIA'S PROCEDURAL REQUIREMENTS NOT APPLICABLE TO EMTALA CLAIMS.—The notice of claim provisions of this section conflict with the requirements of the federal Emergency Medical Treatment and Women in Active Labor provisions, 42 U.S.C. § 1395 dd, of the Consolidated Omnibus Budget Reconciliation Act (COBRA), and therefore, are inapplicable to such causes of action. *Smith v. Richmond Mem. Hosp.*, 243 Va. 445, 416 S.E.2d 689, cert. denied, 506 U.S. 967, 113 S. Ct. 442, 121 L. Ed. 2d 361 (1992).

Because Virginia's procedural requirements under this section are potentially in direct conflict with, and therefore inconsistent with the Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd, they are not applicable to an EMTALA claim. *Power v. Arlington Hosp. Ass'n*, 42 F.3d 851 (4th Cir. 1994).

OR TO ACTIONS COMMENCED IN FEDERAL COURT.—Even if federal courts are required to apply the provisions of the Virginia Medical Malpractice Act under the *Erie* doctrine, the malpractice review provisions otherwise available to a defendant in state court litigation are not available when the action is commenced in federal court. *Adkins v. Commonwealth ex rel. UVA Medical Ctr.*, 154 F.R.D. 139 (W.D. Va. 1994); *Swaim v. Fogle*, 68 F. Supp. 2d 703 (E.D. Va. 1999).

TREATMENT OF FILING PROCEDURE IN MEDICAL MALPRACTICE RULES.—The provisions of Rule Two(c) (see now Rule 2(a)) of the Medical Malpractice Rules stating that the request for a panel shall be deemed to be filed when delivered or mailed be registered or certified mail, do not conflict with the provisions of the Medical Malpractice Act, in violation of Va. Const., Art. VII, § 5. The authors of the act expressly empowered the Chief Justice to promulgate rules necessary to carry out its provisions. Rule Two(c)(see now Rule 2(a)) merely particularizes the mechanics of the filing requirements of this section and former § 8.01-581.9. *Horn v. Abernathy*, 231 Va. 228, 343 S.E.2d 318 (1986).

A BATTERY ARISING FROM HEALTH CARE IS MALPRACTICE within the clear meaning of the malpractice statutes and the required notice should have been given. *Glisson v. Loxley*, 235 Va. 62, 366 S.E.2d 68 (1988).

CLINICAL LABORATORY NOT HEALTH CARE PROVIDER.—A clinical laboratory, which provided erroneous test results to a physician, was not a health care provider under the *Virginia Medical Malpractice Act*. *Richman v. National Health Labs., Inc.*, 235 Va. 353, 367 S.E.2d 508 (1988).

Clinical laboratory was not an agent or employee of doctors and thus was not a health care provider. Consequently, this act did not apply to the lab, and filing the notice of claim under the act did not toll the statute of limitations as to the claim of negligence against the lab. *Richman v. National Health Labs., Inc.*, 235 Va. 353, 367 S.E.2d 508 (1988).

THE METHOD OF SERVICE OF A CLAIM specified in this section is a procedural requirement which is deemed waived if an objection is not timely raised. *Hewitt v. Virginia Health Servs. Corp.*, 239 Va. 643, 391 S.E.2d 59 (1990).

THE NOTICE REQUIRED BY THIS SECTION is neither a bill of particulars nor a pleading of any other kind. It is not required to contain a summary of the plaintiff's evidence or an exposition of the plaintiff's theories of the case; rather, its purpose is simply to call the defendant's attention to the identity of the patient, the time of the alleged malpractice, and a description of the alleged acts of malpractice sufficient to enable the defendant to identify the case to which the plaintiff is referring. *Hudson v. Surgical Specialists, Inc.*, 239 Va. 101, 387 S.E.2d 750 (1990).

THIS SECTION CALLS FOR REASONABLE NOTICE. However, a notice of claims by its nature is not meant to be a particularized statement of claims. A notice calls the recipient's attention to the general time, place, and character of the events complained of in the malpractice suit. *Grubbs v. Rawls*, 235 Va. 607, 369 S.E.2d 683 (1988).

NOTICE DOES NOT NEED TO CONTAIN PARTICULARIZED STATEMENT OF CLAIMS.—This section does not intent that the notice contain a particularized statement of claims; trial court erred in restricting plaintiff's evidence in malpractice case to the specific facts alleged in her notice of claim. *Hudson v. Surgical Specialists, Inc.*, 239 Va. 101, 387 S.E.2d 750 (1990).

THE GIVING OF NOTICE TO AN ADVERSE PARTY IS NOT A FILING. *Horn v. Abernathy*, 231 Va. 228, 343 S.E.2d 318 (1986).

NOTICE LETTERS HELD SUFFICIENT to encompass negligent post-operative treatment as well as failure to obtain informed consent and negligent surgery. *Grubbs v. Rawls*, 235 Va. 607, 369 S.E.2d 683 (1988).

APPLICATION OF NOTICE AND PANEL REVIEW PROVISIONS IN FEDERAL COURT.—The notice requirement set forth in this section and the provision for panel review set forth in this section at the instance of either party to a medical malpractice action are so intimately bound up with the rights and obligations being asserted as to require their application in federal courts under the doctrine of *Erie R.R. v. Tompkins*, 304 U.S. 64, 58 S. Ct. 817, 82 L. Ed. 1188 (1938). *DiAntonio v. Northampton-Accomack Mem. Hosp.*, 628 F.2d 287 (4th Cir. 1980).

REASONABLE COMPLIANCE REQUIRED FOR DEFECTIVE NOTICE.—When faced with an allegedly defective notice of claim, as opposed to the failure to file any such notice, reasonable compliance with the notice requirements is all that is mandated. *Dolwick v. Leech*, 800 F. Supp. 321 (E.D. Va. 1992).

SECOND NOTICE AND FAILURE TO SEEK LEAVE TO AMEND FIRST NOTICE.—Despite plaintiff's failure to seek any leave to amend its June 18 notice of claim, the October 25 notice operated independently to reasonably comply with the requirements of the Virginia Medical Malpractice Act and tolled the running of the statute of limitations; further, the procedural requirements of the act were deemed waived since no timely objection was made. *Dolwick v. Leech*, 800 F. Supp. 321 (E.D. Va. 1992).

FORMER § 8.01-581.9 COMPENSATED FOR THIS SECTION'S RESTRICTIONS UPON FREE ACCESS TO COURTS.—As a result of this section as it read prior to amendment in 1993, a medical malpractice claimant was absolutely forbidden from filing an action until 90 days after notification to the health care provider and then, if a review panel was requested, for the entire period the matter was under review by the panel. In an obvious effort to compensate for these restrictions upon a claimant's usual free access to the courts and to provide relief from an otherwise harsh application of the statute of limitations, the General Assembly enacted former § 8.01-581.9, providing for tolling of the statute of limitations upon the giving of notice of a claim, etc. *Baker v. Zirkle*, 226 Va. 7, 307 S.E.2d 234 (1983); *Dye v. Staley*, 226 Va. 15, 307 S.E.2d 237 (1983).

PROHIBITION AGAINST FILING SUIT PRIOR TO 90 DAYS AFTER NOTICE.—The prohibition contained in this section prior to its amendment in 1993 against filing suit prior to 90 days after giving notice of a medical malpractice claim was a mandatory procedural requirement; failure to comply with this provision did not divest the court of subject matter jurisdiction. *Morrison v. Bestler*, 239 Va. 166, 387 S.E.2d 753 (1990).

THE MEDICAL MALPRACTICE ACT ITSELF GAVE PLAINTIFF FAIR NOTICE AFFECTING THE RIGHT TO FILE SUIT, where under this section as it read prior to amendment in 1993 the notice of claim foreclosed that right for 90 days, but the running of the two-year statute of limitations, which otherwise would have expired, was suspended for 120 days with 10 days of the two-year period remaining. Thus, plaintiff was on notice that the act authorized suit to be filed any time after the 90-day period expired and before the running of the limitations period. *Horn v. Abernathy*, 231 Va. 228, 343 S.E.2d 318 (1986).

EFFECT ON SUBSTANTIVE RIGHTS.—Where plaintiff could have filed a motion for judgment instead of a notice of claim in a timely manner, pursuant to the 1993 amendment to this section, her substantive right to seek damages for the alleged medical malpractice was not materially curtailed. *Harris v. DiMattina*, 250 Va. 306, 462 S.E.2d 338 (1995).

Where the tolling provisions of former Code § 8.01-581.9 provided necessary statutory relief from the running of the statute of limitations, since this section as it read prior to 1993 amendment prohibited plaintiffs from filing a motion for judgment until 90 days after they had given notice of claim, and after the review panel process had been completed, delays imposed by the statute when plaintiff filed his notice of claim and refrained from filing suit, would result in a miscarriage of justice if he was denied benefit of the tolling provisions. *Harris v. DiMattina*, 250 Va. 306, 462 S.E.2d 338 (1995).

SANCTION FOR NONCOMPLIANCE WITH PROHIBITION.—The proper sanction for noncompliance with the provision in this section as it read prior to amendment in 1993, prohibiting filing suit prior to 90 days after giving notice, would depend on the circumstances of each case; other courts which have considered the issue have seen fit to dismiss the suit without prejudice, stay the proceedings, or abate the proceedings. *Morrison v. Bestler*, 239 Va. 166, 387 S.E.2d 753 (1990).

SOVEREIGN IMMUNITY NOT EXTENDED TO FACULTY MEMBERS OF MEDICAL SCHOOL.—In an action to recover damages for personal injuries resulting from alleged negligent acts of defendant doctors, the defendants, who were fully licensed to practice medicine, and were full-time members of the faculty of the Medical School of the University of Virginia and attending staff physicians of the University of Virginia Hospital, were not entitled to invoke the doctrine of sovereign immunity. *James v. Jane*, 221 Va. 43, 267 S.E.2d 108 (1980).

*Edwards v. City of Portsmouth*, 237 Va. 167, 375 S.E.2d 747 (1989); *Cowan v. Psychiatric Assoc.*, 239 Va. 59, 387 S.E.2d 747 (1990); *Gonzalez v. Fairfax Hosp. Sys.*, 239 Va. 307, 389 S.E.2d 458 (1990); *Pierce v. Caday*, 244 Va. 285, 422 S.E.2d 371 (1992).

1 of 1 DOCUMENT

**FRED S. BLACK v. MARK R. BLADERGROEN, M.D., ET AL.****Record No. 990065****SUPREME COURT OF VIRGINIA***258 Va. 438; 521 S.E.2d 168; 1999 Va. LEXIS 131***November 5, 1999, Decided**

**PRIOR HISTORY:** [\*\*\*1] FROM THE CIRCUIT COURT OF THE CITY OF RICHMOND. Randall G. Johnson, Judge.

1997, his executrix, Heidi S. Levinson, was substituted as a party defendant in his place.

[\*\*\*2]

**DISPOSITION:** Reversed and remanded.

**COUNSEL:** Robert H. Hovis, III for appellant.

S. Vernon Priddy, III (M. Pierce Rucker; Jack B. Russell; Sands, Anderson, Marks & Miller, on brief), for appellees.

n2 A number of other health care providers were also named as defendants, but they were dismissed from the case on motions for summary judgment or voluntary nonsuit and are not parties to this appeal.

**JUDGES:** OPINION BY CHIEF JUSTICE HARRY L. CARRICO.

A jury trial resulted in a verdict in favor of the defendants, upon which the trial court entered judgment. We awarded the plaintiff this appeal.

**OPINIONBY:** HARRY L. CARRICO

**OPINION:** [\*440] [\*\*169] Present: All the Justices

OPINION BYCHIEF JUSTICE HARRY L. CARRICO

In this medical malpractice case, the sole question for decision is whether the trial court erred in excluding the testimony of a medical expert called by the plaintiff. Finding the trial court's action erroneous, we will reverse.

Prior to the events in question, the plaintiff had suffered from heart disease for some time and had endured two heart attacks. In October 1994, he experienced pain and was admitted to Henrico Doctors Hospital, where he came under the care of the defendant physicians. Following cardiac bypass surgery, he developed complications. His blood pressure dropped to dangerously low levels, and he had problems with circulation in his right leg. When the circulatory problems could not be corrected, the leg was amputated. The plaintiff was diagnosed as having suffered an anaphylactic reaction, which set off a chain of events resulting in the loss of the leg.

In a motion for judgment filed October 17, 1996, the plaintiff, Fred S. Black, sought to recover damages from the defendants, Mark R. Bladergroen, M.D., Harold J. Levinson, M.D., n1 Thomas P. Christopher, M.D., and Cardiac Surgical Associates, Ltd. n2 In the motion for judgment, the plaintiff alleged that the individual defendants, Drs. Bladergroen, Levinson, and Christopher, were duly licensed physicians who carried on a practice of cardiac surgery in the employment [\*441] of the corporate defendant, Cardiac Surgical Associates, Ltd. The plaintiff alleged further that the defendants' negligence resulted in the amputation of his right leg during a period of hospitalization in 1994.

During his case-in-chief, the plaintiff called W. Dudley Johnson, M.D., a board-certified thoracic [\*\*\*3] surgeon from Milwaukee, Wisconsin, to testify as an expert on the standard of care applicable to the defendants' treatment of the plaintiff. On voir dire examination, Dr. Johnson stated that he attended the University of Illinois Medical School, and, after finishing medical school and an internship, entered surgical training, which consisted of four years of general surgery and two years of heart surgery. He was an associate clinical professor of surgery at the medical school in Milwaukee, belonged to numerous medical associations and societies, and had served on the Wisconsin

n1 Upon Dr. Levinson's death on November 3,

State Medical Licensing Board, in which capacity he examined the credentials of "all kinds of physicians . . . from all over the country and around the world" who wanted to come to Wisconsin to practice medicine.

Dr. Johnson testified further that he "initially developed and perfected the modern [coronary] bypass operation [which] is now done throughout the world" and that he was "the first person to put in two, three, four, five, six bypasses" and the first to "describe secondary operations and . . . third and fourth operations for coronary disease." He said that he personally had performed between [\*\*\*4] eight and nine thousand cardiac operations, that he had operated in eight or nine foreign countries, and that patients had come to him for surgery from approximately thirty-five foreign countries and every state in the union. He also said that "around 68" of his patients had come [\*442] from Virginia and that he had operated on "47 or 48" of them. He had reviewed the records of his Virginia patients and had communicated with their Virginia surgeons and cardiologists regarding their care and treatment.

When asked on direct examination whether he was "familiar with the standard of care that would have been adhered to by a reasonably prudent board-certified cardiothoracic surgeon practicing in Virginia in 1994," Dr. Johnson said, "Yes." When asked to tell the jury "how [he had] that familiarity," he stated: [\*\*170] "Because all the surgeons in the country take the same required exams. There is one national board and one national certification for heart surgeons. We don't have a certification for heart surgeons in Wisconsin. I don't know of any state that has separate certifications for any specialty."

On redirect examination, Dr. Johnson testified he knew what the Virginia standard of care [\*\*\*5] is because of his "background and experience and several years on [the Wisconsin] medical board [reviewing credentials of all] kind of physicians . . . from all over the country" and because Virginia cardiothoracic surgeons "have to go through the same training and take the same exams as every other thoracic surgeon . . . in the country." When asked whether "there is any board certification of thoracic surgeons applicable only to Virginia," he answered, "No . . . they took the same ones I took. National exams."

In urging the trial court to exclude the testimony of Dr. Johnson, the defendants offered no evidence of their own. Instead, they relied solely on testimony he gave on cross-examination. In response to defense counsel's questions, Dr. Johnson stated that he had never been licensed to practice in Virginia, that he had never performed surgery in Virginia, and that he had neither demonstrated nor witnessed heart surgery performed in Virginia. He stated that

while he had discussed topics relating to cardiac surgery in general with cardiac surgeons at national or regional meetings, he was "not certain whether any of those cardiac surgeons actually practice in Virginia." He [\*\*\*6] admitted he could not name any patient referred to him from Virginia with a history similar to the plaintiff's. And, finally, in what the defendants term a "concession," he said he thought he was familiar with the Virginia standard of care for cardiac surgeons because he believed "there is a national standard of care applicable."

On appeal, citing *Bly v. Rhoads*, 216 Va. 645, 222 S.E.2d 783 (1976), the defendants say this Court "has firmly rejected the availability in Virginia of a recourse in a medical malpractice action to a [\*443] national standard of care" on the ground it is for the General Assembly to decide whether there should be a national standard. 216 Va. at 652-653, 222 S.E.2d at 789; see also *Poliquin v. Daniels*, 254 Va. 51, 55, 486 S.E.2d 530, 533 (1997); *Henning v. Thomas*, 235 Va. 181, 186, 366 S.E.2d 109, 112 (1988). In *Bly*, we said a community standard of care applied in Virginia. However, following *Bly*, the General Assembly enacted *Code § 8.01-581.20* and established a statewide standard. 1979 Va. Acts ch. 325.

We have no intention of retreating from the position we took in *Bly* that it is [\*\*\*7] for the General Assembly to say whether a national standard of care should apply in Virginia and, hence, we have no inclination to adopt such a standard ourselves. But nothing in *Bly* or any other provision of law prohibits Virginia physicians from practicing according to a national standard if one exists for a particular specialty, even though neither the General Assembly nor this Court has adopted such a standard.

Moreover, the law concerning medical experts has changed since we decided *Bly*. In an amendment to *Code § 8.01-581.20*, the General Assembly created a presumption that favors the admissibility of the testimony of medical experts, including out-of-state experts. 1989 Va. Acts ch. 146. Thus, the question in this case is simply whether Dr. Johnson's statements on cross-examination, including his "concession" in which he related the Virginia standard of care to the standard elsewhere, were sufficient to overcome the presumption provided by *Code § 8.01-581.20*.

The statutory language creating the presumption reads as follows:

Any physician who is licensed to practice in Virginia shall be presumed to know the statewide standard of care in the specialty or [\*\*\*8] field of medicine in which he is qualified and certified.



This presumption shall also apply to any physician who is licensed in some other state of the United States and meets the educational and examination requirements for licensure in Virginia. [Emphasis added.]

The defendants raise a preliminary question. They argue that the plaintiff failed to establish Dr. Johnson's entitlement to the presumption provided by *Code § 8.01-581.20*. [\*\*171] However, Dr. Johnson was asked on his voir dire examination whether he "possessed the qualifications [\*444] to take the Virginia licensing to become licensed in Virginia," and he replied, "I believe I do, yes, sir."

At the conclusion of the voir dire hearing, the trial court refused to allow Dr. Johnson to testify. The refusal, however, was not on the ground the doctor was not entitled to the presumption but because he lacked familiarity with the Virginia standard of care.

The next day, the plaintiff offered into evidence a sworn letter from the Commonwealth's Department of Health Professions, Board of Medicine, stating that Dr. Johnson's credentials "meet the educational and examination requirements for licensure in Virginia." The trial [\*\*\*9] court refused to admit the letter on the ground it came too late, but, when the plaintiff's counsel asked the trial judge whether he "accepted the [previous day's] testimony of Dr. Johnson that he met the educational and examination requirements for licensure," the judge stated: "I accept that testimony."

The defendants failed to make any objection in the trial court to Dr. Johnson's testimony concerning his qualifications for licensure, to the trial judge's acceptance of that testimony, or to the sufficiency of the evidence offered to invoke the presumption provided by *Code § 8.01-581.20*. Because the defendants raise the question whether the plaintiff established Dr. Johnson's entitlement to the presumption for the first time on appeal, we will not consider the question. Rule 5:25.

This brings us to the question whether the defendants rebutted the presumption provided by *Code § 8.01-581.20*. The trial court held that the defendants had overcome the presumption by showing on cross-examination of Dr. Johnson that he "has never talked to anyone in Virginia, he never practiced in Virginia, [and] he has never read about what the standard of care is in Virginia." However, [\*\*\*10] Dr. Johnson stated that he had reviewed the records of his Virginia patients and had communicated with their surgeons and cardiologists about their treatment; the presumption provided by *Code § 8.01-581.20* is not predicated upon previous practice in Virginia; and

the evidence showed that there was no "such thing as a Virginia textbook of cardiothoracic surgery" for Dr. Johnson to read.

Furthermore, "there is no rigid formula to determine the knowledge or familiarity of a proffered expert concerning the Virginia standard of care. Instead, that knowledge may derive from study, experience, or both." *Henning v. Thomas*, 235 Va. at 186, 366 S.E.2d at 112. Dr. Johnson's extensive "background and experience" and his familiarity with the manner of practice of "all kind of physicians . . . from all over the country" offset any effect the shortcomings [\*445] perceived by the trial court may have had upon the presumption. Hence, the matters listed by the trial court were insufficient to overcome the presumption.

Neither do we consider that Dr. Johnson's "concession," in which he related the standard of care in Virginia to the standard elsewhere, had any effect upon the presumption. [\*\*\*11] Once the plaintiff established that Dr. Johnson met the educational and examination requirements for licensure in Virginia and, therefore, was entitled to the statutory presumption that he knew the Virginia standard of care for cardiothoracic surgeons, the burden shifted to the defendants to show Dr. Johnson was wrong in his premise that the Virginia standard and the standard elsewhere are the same. To carry this burden, the defendants were required to show that the Virginia standard differs from the standard elsewhere. See *Griffett v. Ryan*, 247 Va. 465, 473, 443 S.E.2d 149, 154 (1994). Yet, the defendants produced not a scintilla of evidence on the point, and the presumption remained intact.

We do not overlook the rule that "the question whether an expert is qualified rests largely within the sound discretion of the trial court," *Henning v. Thomas*, 235 Va. at 186, 366 S.E.2d at 112, or the maxim that "[a] decision to exclude a proffered expert opinion will be reversed on appeal only when it appears clearly that the witness was qualified." *Noll v. Rahal*, 219 Va. 795, 800, 250 S.E.2d 741, 744 (1979). But, in light of the [\*\*172] defendants' [\*\*\*12] failure to overcome the presumption provided by *Code § 8.01-581.20*, it appears clearly that Dr. Johnson was qualified. Accordingly, it was error for the trial court to exclude his testimony.

The defendants argue, however, that the plaintiff "has utterly failed to demonstrate reversible error." Their argument is two fold. First, they say that the plaintiff "includes in his Brief of Appellant no discussion of the testimony he hoped to elicit from Dr. Johnson" and, thus, has given this Court "no basis to evaluate the prejudice he now . . . avers he suffered when the trial court excluded Dr. Johnson from testifying on the standard of care applicable to the

defendant doctors."

Second, the defendants say that the plaintiff "obtained the standard of care testimony he sought from Dr. Johnson from another expert witness, Dr. [Alfred Joseph] Martin, [Jr.]," and the plaintiff fails to explain "how the exclusion of Dr. Johnson prejudiced him . . . in light of his success in eliciting the same category of evidence sufficient to get his case to the jury."

[\*446] We disagree with the defendants. In the following passage from his Brief of Appellant, the plaintiff refutes the first prong [\*\*\*13] of the defendants' argument by providing this basis to evaluate the prejudice he avers he suffered when the trial court excluded Dr. Johnson's testimony:

The Court's ruling excluding the testimony of Dr. Johnson clearly prejudiced the plaintiff, Fred Black. He made an appropriate proffer setting forth what Dr. Johnson's testimony against each of the defendants would have been had he been permitted to give it. . . . More importantly, Dr. Johnson was not only qualified to testify as to the Virginia standard of care, he is a world authority whose accomplishments have been accorded international recognition and is the father of the operative procedure out of which this suit arose. His testimony would have carried great weight with the jury. Counsel in opening statements informed the jury of who Dr. Johnson was and expressed

great pride in the fact that he was going to testify on the behalf of the plaintiff. When the court refused to let him testify, Fred Black and his counsel . . . lost credibility with the jury.

In the following passage from his reply brief, the plaintiff answers the second prong of the defendants' argument by providing this explanation of how the exclusion [\*\*\*14] of Dr. Johnson's testimony prejudiced him despite his ability to get his case to the jury with Dr. Martin's testimony:

Dr. Johnson is a world authority on cardiovascular surgery, which is the same specialty as the defendants in this case. . . . Dr. Martin . . . is from a different specialty, vascular surgery, and while he was qualified as being from a related field, he could certainly by no stretch of the imagination be claimed to be a world authority. While much of what he testified to was similar to the proffer that was made for Dr. Johnson, no argument can genuinely be made that his testimony carried as much weight as Dr. Johnson's would have.

For the error in excluding Dr. Johnson's testimony, the judgment of the trial court will be reversed and the case remanded for a new trial in which the doctor's testimony shall be allowed.

Reversed and remanded.

2 of 2 DOCUMENTS

**Mack Rhoades, et al., etc. v. John W. Painter****Record No. 840270****Supreme Court of Virginia****234 Va. 20; 360 S.E.2d 174; 1987 Va. LEXIS 242; 4 Va. Law Rep. 418****September 4, 1987****PRIOR HISTORY:** [\*\*\*1]

Appeal from a judgment of the Circuit Court of the City of Fredericksburg. Hon. John A. Jamison, judge presiding.

**DISPOSITION:**

*Reversed and remanded.*

**HEADNOTES: Torts — Negligence — Wrongful Death — Medical Malpractice — Standard of Care — Local — Statewide — Practice and Procedure — Jury Instructions**

Eight hours after a baby was born, a card was affixed to his hospital crib indicating that the nurses had detected a tinge of jaundice. Similar notations were made several times during the first two days of his life, but these notations were not placed in his medical records or seen by the attending physician who examined the baby and discharged him, noting that his condition appeared satisfactory. The child died less than two years later and the autopsy report cited brain damage. Plaintiffs invoked the wrongful-death statute against the attending physician, based on an allegation of medical malpractice, because he had not ordered a test of the baby's bilirubin level before discharging him. The trial court granted an instruction which told the jurors that they could apply a local standard of care if they found that the defendant had proved by the greater weight of evidence [\*\*\*2] that the health care services and customary practices in the locality made a local standard of care more appropriate than a statewide standard. The jury returned a verdict in favor of the physician and the trial court entered judgment on the verdict. The plaintiffs appealed, contending that the trial court erred by permitting the jury to apply a local standard of care.

1. Medical malpractice actions are governed by a statewide statutory standard unless either party proves by a preponderance of the evidence that local services and practices give rise to a standard of care which is more appropriate.

2. Since the defendant invoked the local standard as that

to be applied to his care of the decedent, he incurred the statutory burden of proving it more appropriate as a measure of his duty than the statewide standard.

3. It is insufficient to satisfy *Code* § 8.01-581.20 that the local standard of care may be more appropriate than that practiced by practitioners at the teaching hospitals in Virginia.

4. Absent the proof required by statute, the trial court erred by instructing the jury that it could apply the local standard of care.

5. Under the harmless error doctrine, [\*\*\*3] the judgment of the trial court will be affirmed when the error complained of could not have affected the result.

6. The doctrine of harmless error is never applied when it appears that the jury has been misinstructed and, had it been properly instructed, that it might have returned a different verdict.

7. Since the jury could have been led by the erroneous instruction to conclude that, because his expert witnesses had testified that defendant had complied with the local standard of care, he was not guilty of actionable negligence, it cannot be said that the erroneous instruction did not, as a matter of law, affect the outcome of the case.

**SYLLABUS:**

*Since it was error to permit the jury to apply a local rather than a statewide standard of medical care in a malpractice case, judgment for defendant is reversed and the case is remanded for retrial.*

**COUNSEL:**

*John C. Maginnis, III*, for appellants.

*Jack B. Russell (Michael L. Goodman; Browder, Russell, Morris & Butcher, P.C., on brief)*, for appellee.

**JUDGES:**

Poff, J., delivered the opinion of the Court.

**OPINIONBY:**

POFF

**OPINION:**

[\*21] [\*174] This is an appeal from a judgment confirming a jury verdict for the defendant [\*\*\*4] in a wrongful-death action based upon an allegation of medical malpractice. The dispositive issue is whether the trial court erred by permitting the jury to apply a local rather than a statewide standard of medical care.

The amended motion for judgment, which invoked *Code* § 8.01-50, the wrongful-death statute, was filed by Mack Rhoades and Thomas Harris, administrators of the estate of Matthew Jacob Rhoades, deceased, against Dr. John Painter and others. n1 Matthew was born December 9, 1977 at Mary Washington Hospital in Fredericksburg. A notation on a card affixed to Matthew's hospital crib showed that nurses had detected a "tinge" of jaundice eight hours after birth. Similar notations were recorded at eight-hour intervals [\*175] during the 48-hour period following birth. According to hospital routine, crib cards were not placed in the infant's medical chart (and, hence, were not seen by the attending pediatrician) until the third day after birth.

n1 The plaintiffs nonsuited claims against all the defendants except Dr. Painter.

[\*\*\*5]

[\*22] Dr. Painter, who had designed the crib-side observation card, first examined Matthew on the second day of his life. He testified that he found no evidence of jaundice then or later, and a nurse's notation on the infant's discharge record dated December 12, 1977 stated: "Condition appears satisfactory." Matthew's mother testified that her son was markedly yellow or jaundiced when they left the hospital. Matthew died October 14, 1979. The autopsy report cited brain damage as a cause of death.

Dr. John Kathwinkel, an expert called as a witness by the plaintiffs, testified that "[j]aundice is yellowness of the skin as a result of high bilirubin level"; that "if the bilirubin level is allowed to get too high . . . it can stain brain cells and eventually kill the brain cells"; and that in its most severe state the resulting condition, known as "kernicterus", "is a condition with seizures and death in about half the patients in early infancy." Asked "what a reasonably prudent Virginia pediatrician would have done" under the circumstances reflected on the crib card, Dr. Kathwinkel replied that "it is basic standard of care that the bilirubin level would be drawn, if jaundice [\*\*\*6] appears in the first twenty-four hours of life." Explaining the statewide standard, he said that the blood test was necessary "[s]o that phototherapy or exchange transfu-

sion could be done if the bulk bilirubin got to too high a level." No such test was performed on Matthew.

Dr. Painter called three pediatricians as expert witnesses to prove the standard of medical care in the Fredericksburg area. Although Dr. Joseph Puglisse did not practice at Mary Washington Hospital, a community hospital, he was attached to the staff of another community hospital and that of a "teaching hospital", both located in Virginia. He testified that fewer laboratory tests are conducted at community hospitals than at teaching hospitals because the former do not have resident staffs. Dr. Seth C. Craig, III, and Dr. Raymond Jones, both of whom had practiced pediatrics for many years in Fredericksburg, agreed that a "tinge" of jaundice in a newborn baby is normal and that a bilirubin test is not customary unless subsequent examinations show a progression of the jaundice. All the defendant's expert witnesses were of opinion that Dr. Painter had not violated the local standard of care.

The trial court [\*\*\*7] granted an instruction which told the jurors that they could apply a local standard of care if they found that "the defendant has proved by the greater weight of the evidence that the health care services and customary practices in the locality [\*23] where the treatment took place make a local standard of care more appropriate than a statewide standard". The jury returned a verdict in favor of Dr. Painter, and the trial court entered judgment on the verdict. We granted the plaintiffs an appeal to consider their contention that the trial court erred by permitting the jury to apply the local standard of care.

[1] In Virginia, the standard of care in medical malpractice actions is governed by statute. Under *Code* § 8.01-581.20, the standard is "that degree of skill and diligence practiced by a reasonably prudent practitioner in the field of practice or specialty in this Commonwealth" unless either party proves "by a preponderance of the evidence that the health care services and health care facilities available in the locality and the customary practices in such locality or similar localities give rise to a standard of care which is more appropriate than a statewide standard." [\*\*\*8]

This statute was in effect when Matthew died, and the plaintiffs agree that the instruction in issue fairly paraphrases the statute. n2 The plaintiffs' complaint is that the instruction permitted the jury to apply the local standard of care when, the plaintiffs say, the defendant had introduced no [\*176] evidence to support a finding that the local standard was more appropriate than the statewide standard.

n2 On brief, the defendant argues that former *Code* § 8.01-581.12:1, the statute in effect when the alleged malpractice occurred, was the controlling

statute. This question is not raised by assignment of cross-error, and we will not notice it on appeal. Rule 5:18.

[2] A review of the transcript shows that Dr. Painter confined his examination of Doctors Craig and Jones to questions concerning the standard of care prevailing in Fredericksburg. The witnesses testified that Dr. Painter had complied with the local standard in caring for Matthew. Having invoked the local standard, Dr. Painter incurred [\*\*\*9] the statutory burden of proving that it was more appropriate as a measure of his duty than the statewide standard. No witness testified to such effect, and the defendant produced no evidence tending to show that Fredericksburg community hospitals had inadequate equipment, facilities, or personnel to perform the bilirubin test or that there was anything peculiar to the Fredericksburg area which would justify applying a standard of medical care lower than that applied in the state at large. Indeed, according to the defendant's own witnesses, the bilirubin test was readily available and frequently performed at Mary Washington Hospital at a cost of only \$10.

[\*24] [3] It is true, as the defendant points out, that Dr. Puglisse testified that fewer laboratory tests are conducted at community hospitals, such as Mary Washington Hospital, than at teaching hospitals. But proof of that fact, standing alone, fails to discharge the defendant's burden. The witness's testimony assumes that the standard of care at Mary Washington is the same as that prevailing at all community hospitals in Virginia. This suggests that Mary Washington's standard is more appropriate than that prevailing [\*\*\*10] at the teaching hospitals located in Virginia. However, that does not satisfy the mandate of *Code § 8.01-581.20* that a party who relies upon a local standard of care prove that such a standard is more appropriate than that "practiced by a reasonably prudent practitioner . . . in this Commonwealth". It is insufficient that the local standard may be more appropriate than that practiced by resident practitioners at the teaching hospi-

tals located in this Commonwealth.

[4] Absent the proof required by statute, we hold that the trial court erred by instructing the jury that it could apply the local standard of care.

[5-6] Nevertheless, Dr. Painter argues that any such error was harmless because the jury's verdict could have been grounded upon a finding that "Dr. Painter did not violate even Dr. Kathwinkel's [statewide] standard since there was no jaundice present by Dr. Painter's examinations." Under the harmless error doctrine, the judgment of the court below will be affirmed whenever we can say that the error complained of could not have affected the result. *Lester v. Simpkins*, 117 Va. 55, 69, 83 S.E. 1062, 1067 (1915). The doctrine is never applied, however, when [\*\*\*11] it appears that the jury has been misinstructed and, had it been properly instructed, that it might have returned a different verdict. *Dir'tor Gen'l v. Pence's Adm'x*, 135 Va. 329, 352, 116 S.E. 351, 358-59 (1923).

[7] We cannot say as a matter of law that the erroneous instruction could not have affected the result in this case. The jury could have found that, because attending nurses had detected jaundice eight hours after Matthew's birth and at every eight-hour interval during the first two days of his life, Dr. Painter had observed or should have observed the condition when he first examined his patient on the second day of his life. The jury had heard evidence that, under such circumstances, the statewide standard of care required a bilirubin test while the local standard did [\*25] not. Notwithstanding the absence of evidence that the local standard was the more appropriate measure of the doctor's duty to his patient, the jury could have been led by the erroneous instruction to conclude that, because his expert witnesses had testified that Dr. Painter had complied with the local standard, he was not guilty of actionable negligence.

Consequently, we hold that [\*\*\*12] the error was not harmless, and we will reverse the judgment and remand the case for a new trial.

*Reversed and remanded.*

## LEXSTAT II-35 VIRGINIA MODEL JURY INSTRUCTIONS – CIVIL INST. NO 35.000

## Virginia Model Jury Instructions – Civil

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## Chapter 35 PROFESSIONAL LIABILITY

*II-35 Virginia Model Jury Instructions – Civil Inst. No 35.000***Inst. No 35.000 Statewide Standard of Care for Health Care Providers****Inst. No. 35.000 Statewide Standard of Care for Health Care Providers**

**A doctor has a duty to use the degree of skill and diligence in the care and treatment of his patient that a reasonably prudent doctor in the same field of practice or specialty in this State would have used under the circumstances of this case.**

**If a doctor fails to perform this duty, then he is negligent.**

**MEMORANDUM**

**STATUTE:** *Code § 8.01-581.20.*

**CASES:** *Whitfield v. Whittaker Memorial Hospital*, 210 Va. 176, 169 S.E.2d 563 (1969) ; *Noll v. Rahal*, 219 Va. 795, 250 S.E.2d 741 (1979) ; *Brown v. Koulizakis*, 229 Va. 524, 331 S.E.2d 440 (1985) ; *Raines v. Lutz*, 231 Va. 110, 341 S.E.2d 194 (1986) ; *Beverly Enterprises-Virginia v. Nichols*, 247 Va. 264, 441 S.E.2d 1 (1994) ; *Griffett v. Ryan*, 247 Va. 465, 443 S.E.2d 149 (1994) ; *King v. Sowers*, 252 Va. 71, 471 S.E.2d 481 (1996) ; *Black v. Bladergroen*, 258 Va. 438, 521 S.E.2d 168 (1999) ; *Powell v. Margileth*, 259 Va. 244, 524 S.E.2d 434 (2000) .

**CAVEAT:** If this instruction is given, Instruction No. 35.010 should not be given. This instruction is used where there is no dispute that a statewide standard applies. Any doctor or health care provider with knowledge of the Virginia standards, with subject matter competency, and with an active clinical practice in the particular specialty or field of medicine within one year of the date of the alleged act or omission forming the basis of the action, may testify concerning what a reasonably prudent practitioner of his field should have done under the circumstances. An expert may give expert testimony on a procedure in his clinical practice that is common to another specialty where the standard of care for the procedure is the same. *Sami v. Varn*, 260 Va. 280, 535 S.E.2d 172 (2000). The testimony of a proffered expert who has failed to maintain an active clinical practice in the defendant's specialty or a related field within one year of the alleged medical malpractice under *Code § 8.01-581.20* may be excluded. *Fairfax Hosp. Sys. v. Curtis*, 249 Va. 531, 457 S.E.2d 66 (1995); *Perdieu v. Blackstone Family Practice Ctr., Inc.*, 264 Va. 408, 568 S.E.2d 703 (2002); *Hinkley v. Koehler*, 269 Va. 82, 606 S.E.2d 803 (2005).

If there is evidence that a local standard should be applied, see Instruction No. 35.010.

This instruction says "same field of practice or specialty." Although "same" is not taken from the express language of *Code § 8.01-581.20*, it clearly is implied by the other language of the statute. But see *Ives v. Redford*, 219 Va. 838, 252 S.E.2d 315 (1979); *Maxwell v. McCaffrey*, 219 Va. 909, 252 S.E.2d 342 (1979).

Objection to an improper instruction is waived if not made. *King v. Sowers*, *supra*.

**COMMENT:** *Code § 8.01-581.1* defines the health care providers to whom *Code § 8.01-581.20* applies, including physicians, hospitals, dentists, pharmacists, registered nurses or licensed practical nurses, optometrists, podiatrists, chiropractors, physical therapists, physical therapy assistants, clinical psychologists, clinical social workers, professional counselors, licensed dental hygienists, health maintenance organizations, professional corporations, partnerships, nursing homes, professional limited liability companies, corporations, limited liability companies, and any other entity except a state-operated facility which employs or engages a "licensed health provider and which primarily renders health services."

## II-35 Virginia Model Jury Instructions - Civil Inst. No 35.000

The appropriate term or the name of the applicable medical specialty may be substituted for "doctor" in the instruction. For example an instruction may read, "An orthopedic surgeon has a duty to use the same degree of skill and diligence ... that a reasonably prudent orthopedic surgeon in Virginia would have used ... ." A plaintiff is not required to present expert testimony to establish the applicable standard of care in all cases. *Beverly Enterprises-Virginia, supra*.

In a case involving multiple defendants with different specialties, this instruction may have to be repeated for each specialty or each defendant as clarity demands.

*Code § 8.01-225* exempts doctors and other persons from liability under certain circumstances, including when rendering emergency care or assistance without compensation at the scene of any emergency or en route there from. See Instruction No. 35.120. Also, a school team physician is immune from liability for emergency care when acting without compensation, and in the absence of gross negligence or willful misconduct. *Code § 8.01-225.1*

## LEXSTAT II-35 VIRGINIA MODEL JURY INSTRUCTIONS – CIVIL INST. NO 35.010

## Virginia Model Jury Instructions – Civil

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## Chapter 35 PROFESSIONAL LIABILITY

*II-35 Virginia Model Jury Instructions – Civil Inst. No 35.010***Inst. No 35.010 Statewide or Local Standard of Care for Health Care Provider****Inst. No. 35.010 Statewide or Local Standard of Care for Health Care Provider**

A doctor has a duty to use the degree of skill and diligence in the care and treatment of his patient that a reasonably prudent doctor in the same field of practice or specialty in this State would have used under the circumstances of this case.

However, if you find that the doctor [patient] has proved by the greater weight of the evidence that the health care services, health care facilities, and customary practices in the locality where the treatment took place make a local standard of care more appropriate than a statewide standard, then the local standard applies and a doctor has a duty to use the degree of skill and diligence in the care and treatment of his patient that a reasonably prudent doctor in the same field of practice or specialty in the same [or a similar] locality would have used under the circumstances of this case.

If a doctor fails to perform this duty under the standard of care you find applicable, then he is negligent.

**MEMORANDUM**

**STATUTE:** *Code § 8.01-581.20.*

**CASES:** *Whitfield v. Whittaker Memorial Hospital*, 210 Va. 176, 169 S.E.2d 563 (1969) ; *Noll v. Rahal*, 219 Va. 795, 250 S.E.2d 741 (1979) ; *Brown v. Koulizakis*, 229 Va. 524, 331 S.E.2d 440 (1985) ; *Raines v. Lutz*, 231 Va. 110, 341 S.E.2d 194 (1986) ; *Griffett v. Ryan*, 247 Va. 465, 443 S.E.2d 149 (1994) ; *Black v. Bladergroen*, 258 Va. 438, 521 S.E.2d 168 (1999) ; *Powell v. Margileth*, 259 Va. 244, 524 S.E.2d 434 (2000) .

**CAVEAT:** If this instruction is given, Instruction No. 35.000 should not be given.

The purpose of *Code § 8.01-581.20* is to make certain that a case is not kept from the jury just because the doctor testifying on the standard of care is not from the same or a similar locality as the defendant doctor. A statewide standard of care applies unless there is evidence that a locality standard is more appropriate. *Rhoades v. Painter*, 234 Va. 20, 360 S.E.2d 174 (1987). It is the jury that determines the appropriate standard and decides whether the doctor was negligent. An expert may give expert testimony on a procedure in his clinical practice that is common to another specialty where the standard of care for the procedure is the same. *Sami v. Varn*, 260 Va. 280, 535 S.E.2d 172 (2000). The testimony of a proffered expert who has failed to maintain an active clinical practice in the defendant's specialty or a related field within one year of the alleged medical malpractice under *Code § 8.01-581.20* may be excluded. *Fairfax Hosp. Sys. v. Curtis*, 249 Va. 531, 457 S.E.2d 66 (1995); *Perdieu v. Blackstone Family Practice Ctr., Inc.*, 264 Va. 408, 568 S.E.2d 703 (2002); *Hinkley v. Koehler*, 269 Va. 82, 606 S.E.2d 803 (2005).

This instruction says "same field of practice or specialty." Although "same" is not taken from the express language of *Code § 8.01-581.20*, it clearly is implied by the other language of the statute. But see *Ives v. Redford*, 219 Va. 838, 252 S.E.2d 315 (1979); *Maxwell v. McCaffrey*, 219 Va. 909, 252 S.E.2d 342 (1979).

**COMMENT:** *Code § 8.01-581.1* defines the health care providers to whom *Code § 8.01-581.20* applies, including physicians, hospitals, dentists, pharmacists, registered nurses or licensed practical nurses, optometrists, podiatrists, chiropractors, physical therapists, physical therapy assistants, clinical psychologists, clinical social workers, professional



counselors, licensed dental hygienists, health maintenance organization, professional corporations, partnerships, nursing homes, professional limited liability companies, corporations, limited liability companies, and any other entity (except a state-operated facility) "which employs or manages a licensed health provider and which primarily renders health services." The definition of "health care provider" in *Code § 8.01-581.1* also includes "a professional corporation, all of whose shareholders or members are so licensed" and "a partnership, all of whose partners are so licensed." The appropriate term or the name of the applicable medical specialty may be substituted for "doctor" in the instruction. For example, "An orthopedic surgeon has a duty to use the same degree of skill and diligence ... that a reasonably prudent orthopedic surgeon in Virginia would have used...."

In a case involving multiple defendants with different specialties, this instruction may have to be repeated for each specialty or each defendant as clarity demands.

*Code § 8.01-225* exempts doctors and other persons from liability under certain circumstances, including rendering emergency care or assistance without compensation at the scene of any emergency or en route there from. See Instruction No. 35-120. Also, a school team physician is immune from liability for emergency care when acting without compensation, and in the absence of gross negligence or willful misconduct. *Code § 8.01-225.1*.

1 of 1 DOCUMENT

**BEVERLY ENTERPRISES-VIRGINIA, INC., T/A, ETC. v. STEVEN C. NICHOLS,  
ADMINISTRATOR, ETC.**

**Record No. 930080**

**SUPREME COURT OF VIRGINIA**

*247 Va. 264; 441 S.E.2d 1; 1994 Va. LEXIS 27; 10 Va. Law Rep. 995*

**February 25, 1994, Decided**

**PRIOR HISTORY:** [\*\*\*1] FROM THE CIRCUIT COURT OF THE CITY OF VIRGINIA BEACH. A. Bonwill Shockley, Judge.

**DISPOSITION:** Affirmed.

**HEADNOTES:**

**Wrongful Death — Code § 8.01-581.20 — Standard of Care — Expert Testimony — Torts — Negligence — Proximate Cause — Nursing Homes**

An elderly woman was diagnosed as having Alzheimer's disease and she was unable to eat unassisted. While she was being cared for by her family, she suffered two severe choking incidents in the year before she was admitted to the nursing home. One of her sons told the administrator of admissions that his mother could not eat unassisted and reported the prior incidents when she had choked on her food, and the need for assistance was noted on the nursing home's records. Two days after the admission, an employee brought a dinner tray to the woman and left it with her. Two employees later noticed that she was not well and went for help. A medical examiner testified that the patient died of asphyxia, caused by food being lodged in her windpipe. The administrator of the estate of a deceased nursing home patient filed a wrongful death action against the nursing home, alleging that the patient had choked and died because employees failed to assist the patient with eating a meal. The plaintiff did not put on an expert witness and properly qualify that witness as an expert on nursing home intake assessments or as an expert witness on how a patient is to be fed. The jury returned a verdict in favor of the administrator and fixed damages at \$100,000. The nursing home appeals.

1. Issues involving medical malpractice often fall beyond the realm of common knowledge and experience of a lay jury and expert testimony is ordinarily necessary to establish the appropriate standard of care, a deviation from that standard, and that such deviation was the proximate

cause of damages.

2. There are certain rare instances where expert testimony is unnecessary because the alleged act of negligence clearly lies within the range of the jury's common knowledge and experience.

3. Here the evidence was sufficient to support the jury's finding of negligence without the necessity of expert testimony on the appropriate standard of care.

4. While *Code § 8.01-581.20* establishes the standard of care imposed upon a health care provider and gives a litigant the right to use qualified expert witnesses to provide testimony regarding that standard, it does not require the plaintiff to present expert testimony to establish the degree of skill and diligence practiced by a reasonably prudent practitioner in all medical malpractice actions.

5. The question whether a reasonably prudent nursing home would permit its employees to leave a tray of food with an unattended patient who had a history of choking and who was unable to eat without assistance is certainly within the common knowledge and experience of a jury.

6. The evidence of record is sufficient to establish proximate causation between the defendant's negligent acts and the patient's death.

**COUNSEL:** Joseph T. McFadden, Jr. (John A. Heilig; Heilig, McKenry, Fraim & Lollar, on brief), for appellant.

Moody E. Stallings, Jr. (Gregory Kim Pugh; Stallings & Richardson, on brief), for appellee.

**JUDGES:** Present: All the Justices.

**OPINIONBY:** LEROY R. HASSELL

**OPINION:** [\*\*\*1] OPINION BY JUSTICE LEROY R. HASSELL

[\*265]

The primary issue we consider in this medical malpractice action is whether the plaintiff is required to present expert testimony to prove the defendant's negligence.

Steven C. Nichols, administrator of the estate of Blanche Allene Nichols, filed this wrongful death action against Beverly Enterprises-Virginia, Inc., t/a Lynn Shores Manor. Beverly Enterprises-Virginia operates a [\*2] nursing home under the trade name Lynn Shores Manor in Virginia Beach. Blanche Nichols was a patient there until her death. Steven Nichols alleged in his amended motion for judgment that Blanche Nichols choked and died because Beverly Enterprises' employees failed to assist her with eating. The jury returned a verdict in favor of the administrator [\*\*\*2] and fixed damages at \$100,000. We awarded the defendant an appeal.

In accordance with well-settled principles, we will review the facts and all reasonable inferences therefrom in favor of the plaintiff, who comes to this Court with a favorable jury verdict, confirmed by the trial judge.

Blanche Nichols was diagnosed as having Alzheimer's disease. When she was no longer able to care for herself, her two sons, Steven [\*266] Nichols and Gary R. Nichols, and their respective wives, provided primary care to her for approximately three years.

Blanche Nichols' mental capacity was impaired, and eventually she had to be restrained. She was unable to eat unassisted. In December 1988, Blanche Nichols choked while eating a pancake. Her daughter-in-law performed a "Heimlich maneuver," which forced the material from Blanche Nichols' throat. In January 1989, Blanche Nichols choked while eating. As a result of this incident, she was admitted to a hospital for approximately a week.

In December 1989, Gary and Steven Nichols concluded that they were unable to provide the care that their mother needed. Subsequently, she was admitted to Lynn Shores Manor on December 15, 1989.

Around the time of admission, [\*\*\*3] Steven Nichols had a lengthy conversation with Jan Aubrey Marion, Jr., administrator of admissions at Lynn Shores Manor. Steven Nichols informed Marion that Mrs. Nichols could not eat unassisted. Steven Nichols also informed Marion of Mrs. Nichols' prior choking incidents. The nursing home's records that Marion completed, dated December 15, 1989, reveal that Mrs. Nichols required assistance when eating.

Kathy Nichols, Steven Nichols' wife, met with Marion around the time of admission and informed him that Blanche Nichols had choked twice previously. Marion informed Kathy Nichols that he would convey this information to the nursing home employees who would be

working with Blanche Nichols.

On December 16, 1989, Kathy Nichols visited with Blanche Nichols "around lunchtime." While Kathy Nichols was visiting her mother-in-law in her room, an employee of Lynn Shores Manor entered the room with a tray of food and placed the tray on a "little roller table." No one from the nursing home, however, returned to assist Blanche Nichols with eating. Therefore, Kathy Nichols assisted her mother-in-law with her food.

Bonita Johnson, an employee at Lynn Shores, delivered a dinner tray to Mrs. Nichols [\*\*\*4] on the evening of December 17, 1989. No one assisted Mrs. Nichols with her food. Phyllis L. Jones, a nurse's assistant helper, delivered a dinner tray to a woman who shared a room with Mrs. Nichols. No one had instructed Jones to assist Mrs. Nichols with her food. As Jones was helping Mrs. Nichols' roommate with her food, Jones noticed that "Mrs. Nichols didn't seem quite right." When Jones observed that Mrs. Nichols was sitting in her chair with her head turned sideways, she "ran immediately to get help."

Rebecca Taylor, a licensed nursing assistant, and Viola Fletcher, a licensed practical nurse, removed Mrs. Nichols from the chair and [\*267] placed her on the bed. According to Taylor, Mrs. Nichols was dead when Taylor and Fletcher placed Nichols' body on the bed. n1

n1 Fletcher, however, testified that during this time, Mrs. Nichols was still alive and talking.

Fletcher knew that Mrs. Nichols "needed to be spoon-fed" and that someone "had to keep an eye" on her. Additionally, Fletcher testified that if Bonita Johnson [\*\*\*5] left a tray of food in Mrs. Nichols' room, then that "would have been a mistake."

Dr. Faruk Presswalla, the deputy chief medical examiner for Tidewater, performed an autopsy on Blanche Nichols' body. He testified that the cause of Mrs. Nichols' death was asphyxia, commonly referred to as choking. Food had obstructed a portion of Mrs. [\*268] Nichols' air passage, and some of the food was lodged in her windpipe.

The defendant asserts that the plaintiff sought to prove that the defendant was negligent because of its failure to inform its employees that Mrs. Nichols needed assistance when eating. The defendant contends that expert testimony is necessary to establish the appropriate standard of care and any breach thereof. Additionally, the defendant says that the plaintiff failed to "show what the standard of care required Lynn Shores to do with the information the Nichols family claimed they gave about the prior choking incidents, or with the information from the hospital record that said that the patient needed to be fed all of her meals.

The plaintiff did not put on an expert witness and properly qualify that witness as an expert on nursing home intake assessments or as an expert witness [\*\*\*6] on how a patient is to be fed." The plaintiff, however, argues that under the facts and circumstances of this case, expert testimony is not necessary. We agree with the plaintiff.

[1] Issues involving medical malpractice often fall beyond the realm of common knowledge and experience of a lay jury. Therefore, in most instances, expert testimony is required to assist the jury. Expert testimony is ordinarily necessary to establish the appropriate standard of care, a deviation from that standard, and that such deviation was the proximate cause of damages. *Raines v. Lutz*, 231 Va. 110, 113, 341 S.E.2d 194, 196 (1986); *Bly v. Rhoads*, 216 Va. 645, 653, 222 S.E.2d 783, 789 (1976).

[2] In certain rare instances, however, as here, expert testimony is unnecessary because the alleged act of negligence clearly lies within the range of the jury's common knowledge and experience. For example, in *Jefferson Hospital, Inc. v. Van Lear*, 186 Va. 74, 41 S.E.2d 441 (1947), we approved the judgment of a trial court confirming a jury verdict in favor of a plaintiff [\*\*\*7] in a medical malpractice action [\*268] without requiring expert testimony. There, the patient, George A. Van Lear, fell and broke his hip while trying to locate a bathroom. Even though he had utilized a device that activated a signal light plainly visible to the floor nurse, neither the nurse nor any other attendant responded to his call during the 20-or 30-minute period that the signal light was activated. *Id.* at 78-79, 41 S.E.2d at 442-43. We held that the evidence was sufficient to support a finding of negligence because:

The attendants of the hospital were, of course, aware of the physical condition of Mr. Van Lear. They knew the nature of his operation and his disabilities. They had been instructed that he should not be permitted to answer a call of nature without the assistance of an orderly. They knew, or should have known, that a delay in answering his call for a nurse or an orderly for a service of this character might induce him to get out of bed and attempt to wait upon himself. Indeed, they had actual notice of this, because both a nurse and an orderly testified that on previous occasions he had gotten out of bed to attend to [\*\*\*8] some trivial need.

*Id.* at 80, 41 S.E.2d at 443.

[3] Here, as in *Jefferson Hospital*, the evidence is sufficient to support the jury's finding of negligence without

the necessity of expert testimony on the appropriate standard of care. The defendant was aware of Mrs. Nichols' mental and physical condition. The defendant knew that she was unable to feed herself and that she had two prior serious choking incidents. In spite of this knowledge, the defendant's employee left a tray of food with Mrs. Nichols and failed to provide assistance to her. Certainly, a jury does not need expert testimony to ascertain whether the defendant was negligent because its employees failed to assist Mrs. Nichols under these circumstances.

Defendant contends that *Code* § 8.01-581.20 requires that the plaintiff present expert testimony to establish the applicable standard of care for a reasonably prudent nursing home. We disagree.

[4-5] *Code* § 8.01-581.20 states, in relevant part:

A. In any . . . action against a . . . health care provider to recover damages alleged to have been caused by medical malpractice where the acts or omissions so [\*4] complained of are alleged [\*\*\*9] to have occurred in this Commonwealth, the standard of care by which the acts or omissions are to be judged shall be that [\*269] degree of skill and diligence practiced by a reasonably prudent practitioner in the field of practice or specialty in this Commonwealth and the testimony of an expert witness, otherwise qualified, as to such standard of care, shall be admitted.

This statute establishes the standard of care imposed upon a health care provider and gives a litigant the right to use qualified expert witnesses to provide testimony regarding that standard. We find nothing in *Code* § 8.01-581.20, however, that requires a plaintiff to present expert testimony to establish "that degree of skill and diligence practiced by a reasonably prudent practitioner" in all medical malpractice actions. Here, the question whether a reasonably prudent nursing home would permit its employees to leave a tray of food with an unattended patient who had a history of choking and who was unable to eat without assistance is certainly within the common knowledge and experience of a jury.

The defendant contends that the trial court erred by failing to strike the plaintiff's evidence or set aside the jury verdict [\*\*\*10] because the plaintiff failed to present evidence of proximate causation. We disagree.

[6] Dr. Presswalla testified that Mrs. Nichols died as a result of a mechanical asphyxiation from a bolus of food. Evidence at trial, taken in the light most favorable to the plaintiff, reveals that Bonita Johnson gave a tray contain-

247 Va. 264, \*269; 441 S.E.2d 1, \*\*4;  
1994 Va. LEXIS 27, \*\*\*10; 10 Va. Law Rep. 995

ing food to Mrs. Nichols and no one helped Mrs. Nichols with her feeding. Even though Mrs. Nichols was unable to use a fork, she was able to use her hand and place food in her mouth. The jury was entitled to infer that she choked on food taken from this tray. n2

n2 We find no merit in the defendant's assertion that the plaintiff was required to prove that Mrs. Nichols did not choke on food purportedly provided to her by some unknown third person.

As we have stated:

"The proximate cause of an event is that act

or omission which, in natural and continuous sequence, unbroken by an efficient intervening cause, produces the event, and without which that event would not have occurred."

*Coleman v. Blankenship Oil Corp.*, 221 Va. 124, 131, 267 S.E.2d 143, 147 (1980) [\*\*\*11] (quoting *Beale v. Jones*, 210 Va. 519, 522, 171 S.E.2d 851, 853 (1970)). Certainly, the evidence of record is sufficient to establish proximate causation between the defendant's negligent acts and Mrs. Nichols' death.

[\*270] Accordingly, we will affirm the judgment of the trial court.

Affirmed.

1 of 1 DOCUMENT

**SHIRLEY DICKERSON v. NASROLLAH FATEHI, M.D., ET AL.****Record No. 961531****SUPREME COURT OF VIRGINIA***253 Va. 324; 484 S.E.2d 880; 1997 Va. LEXIS 46***April 18, 1997, Decided****SUBSEQUENT HISTORY:**

As Corrected April 25, 1997.

**PRIOR HISTORY:** [\*\*\*1] FROM THE CIRCUIT COURT OF THE CITY OF CHESAPEAKE. V. Thomas Forehand, Jr., Judge.

**DISPOSITION:** Reversed and remanded.

**COUNSEL:** Bernard T. Holmes (Holmes & Edmonds, on briefs), for appellant.

R. Barrow Blackwell; (Ann Mayhew Golski; Kaufman & Canoles, on brief), for appellees Nasrollah Fatehi and Atlantic Neurosurgery, P.C..

A. William Charters (John A. Heilig; Deborah S. Prince; Heilig, McKenry, Fraim & Lollar, on brief), for appellees Rachel Jacobs, R.N., etc. and Millicent P. Spruill, ORT, etc..

**JUDGES:** Present: Carrico, C.J., Compton, Stephenson, Lacy, Hassell, and Koontz, JJ., and Whiting, Senior Justice. **OPINION BY JUSTICE ROSCOE B. STEPHENSON, JR.**

**OPINIONBY:** ROSCOE B. STEPHENSON, JR.

**OPINION:** [\*325] [\*\*880] **OPINION BY JUSTICE ROSCOE B. STEPHENSON, JR.**

In this medical malpractice action, the trial court, relying solely upon the pleadings and certain pretrial discovery material, granted summary judgment in favor of a physician and two nurses. The court ruled, inter alia, that expert testimony was necessary to establish the appropriate standards of care and breaches thereof, and the principal issue in this appeal is whether that ruling was erroneous.

Shirley Dickerson filed this action against Nasrollah

Fatehi, [\*\*\*2] M.D., a neurosurgeon, and his professional entity, Atlantic Neurosurgery, P.C. (collectively, Fatehi), and against Rachel Jacobs, R.N., and Millicent P. Spruill, [\*\*881] ORT. n1 Dickerson alleged that, on February 27, 1989, she was admitted to Chesapeake General Hospital for neck surgery to be performed by Fatehi. The next day, Fatehi, assisted by Jacobs, the circulating nurse, and by Spruill, the surgical technician [\*326] who acted as the scrub nurse, performed an anterior cervical discectomy.

n1 Dickerson also filed this action against Chesapeake General Hospital. In a separate action which was consolidated with this suit, Dickerson sued Edward Habeeb, M.D., and his professional entity, Orthopaedic Surgeons, Ltd. (collectively, Habeeb). On Dickerson's motion, however, Habeeb and the Hospital were nonsuited.

Dickerson further alleged that, during the course of the surgery, Fatehi "used a blunt tip 18 gauge hypodermic needle, including a plastic attachment to the syringe, as a metallic marker [which] . . . was intended [\*\*\*3] to be removed prior to closure of the operative site." Fatehi, however, negligently "failed to remove [the] hypodermic needle" from Dickerson's neck at the close of surgery, and Jacobs and Spruill, in violation of their duty of care, negligently failed "to maintain a proper needle count . . . [to] ensure the removal of the needle" after surgery.

Following the surgery, Dickerson allegedly experienced "severe pain . . . [in] her right arm, hand and neck." Fatehi referred her to Dr. Edward Habeeb, an orthopedic surgeon. Habeeb ordered x-rays of Dickerson's neck and shoulder, but was unable to determine the cause of her pain. He referred her to Fatehi for therapy.

Approximately 20 months after the surgery, Dr. Thomas Queen, a general surgeon, discovered and removed the needle, including the plastic attachment to the syringe, from Dickerson's neck. Dickerson alleged that the negligence of Fatehi, Jacobs, and Spruill (collectively,

the Defendants) was a proximate cause of her injuries.

Responding to the Defendants' pretrial discovery requests that Dickerson identify the expert witnesses she expected to call at trial, Dickerson named only a psychiatrist/neurologist and a radiologist. [\*\*\*4] Dickerson had not named any other expert witnesses when the court-ordered discovery cut-off date arrived.

The Defendants moved for summary judgment on the ground that the two experts named by Dickerson were not qualified to testify on the appropriate standards of care.<sup>n2</sup> The trial court agreed and granted summary judgment in favor of the Defendants. At the same time, the trial court rejected Dickerson's contention that the doctrine of res ipsa loquitur applied. The court reasoned that Dickerson's pleadings and "the undisputed facts" showed that the needle marker "was not in the exclusive control of any one defendant."

<sup>n2</sup> The Defendants relied upon *Code* § 8.01-581.20 regarding the requisite knowledge, skill, and experience that a proffered witness must have in order to qualify as an expert witness on the appropriate standard of care. *Code* § 8.01-581.20, however, does not require a plaintiff to present expert testimony in all medical malpractice actions, *Beverly Enterprises v. Nichols*, 247 Va. 264, 269, 441 S.E.2d 1, 4 (1994), and, given our decision in the present case, we do not reach the question whether the proffered witnesses were qualified to testify as experts on the standard of care.

[\*327] [\*\*\*5]

Dickerson contends, on appeal as she did in the trial court, that, based upon the facts shown by her pleadings and the Defendants' admissions, expert testimony is not necessary to establish the appropriate standards of care and breaches thereof. Dickerson asserts that "whether a reasonably prudent neurosurgeon . . . should account for and remove a hypodermic needle from a patient's body before closing the operative wound is within the range of common experience of a jury." Similarly, Dickerson also asserts that "whether a reasonably prudent circulating nurse and scrub nurse . . . [made] and reported an accurate account of all needles . . . used during the surgical procedure . . . [also is a matter] within the common knowledge and experience of a jury."

In almost all medical malpractice cases, expert testimony is necessary to assist a jury in determining a health care provider's appropriate standard of care and whether there has been a deviation from that standard. *Raines v. Lutz*, 231 Va. 110, 113, 341 S.E.2d 194, 196 (1986); *Bly*

*v. Rhoads*, 216 Va. 645, 653, 222 S.E.2d 783, 789 (1976). In [\*\*882] certain rare cases, however, when the alleged negligent acts or omissions [\*\*\*6] clearly lie within the range of a jury's common knowledge and experience, expert testimony is unnecessary. *Beverly Enterprises v. Nichols*, 247 Va. 264, 267, 441 S.E.2d 1, 3 (1994); accord *Jefferson Hospital, Inc. v. Van Lear*, 186 Va. 74, 41 S.E.2d 441 (1947).

In considering a motion for summary judgment, a court must adopt those inferences from the facts that are most favorable to the nonmoving party, unless the inferences are forced, strained, or contrary to reason. *Carson v. LeBlanc*, 245 Va. 135, 139-40, 427 S.E.2d 189, 192 (1993). "Summary judgment shall not be entered if any material fact is genuinely in dispute." Rule 3:18.

This case did not go to trial; consequently, the record on appeal is quite limited. In addition to Dickerson's pleadings, the record discloses that Fatehi's attorney conceded in argument before the trial court that "anybody . . . without regard to any medical training would be able to say that unless the object left in the patient has some therapeutic value, you don't leave a foreign object in the body."

Furthermore, Dickerson submitted the following request for admission to Fatehi:

15. Admit that it was your responsibility [\*\*\*7] as surgeon to remove after surgery the 18 gauge blunt tip hypodermic needle placed in . . . Dickerson's neck during anterior cervical discectomy surgery . . .

[\*328]

Fatehi responded as follows:

15. Denied. It was the obligation of Dr. Fatehi to remove the needle, as he did, prior to the removal of the disk. The request implies the needle was to be removed only after the surgery was performed. Dr. Fatehi relies on the counts of the hospital's OR Technician and circulating nurse at the end of the operation and prior to closing the wound, which counts indicated all needles were accounted for and none was in the surgical wound site and he believed that the counts necessarily included the needle.

In the present case, based upon the record before us, we are of opinion that, if the facts alleged and admitted by Fatehi were presented to a jury, the jurors, absent expert testimony, reasonably could determine, by calling upon

253 Va. 324, \*328; 484 S.E.2d 880, \*\*882;  
1997 Va. LEXIS 46, \*\*\*7

their common knowledge and experience, whether Fatehi was negligent and whether his negligence was a proximate cause of Dickerson's injuries. Therefore, the trial court erred in ruling that expert testimony was necessary to establish the standard [\*\*\*8] of care.

With respect to Jacobs and Spruill, we conclude that the record has not been developed sufficiently to enable either the trial court or this Court to determine that the alleged negligence does not lie within a jury's common knowledge and experience so that expert testimony is necessary. Therefore, the trial court acted prematurely in entering summary judgment in favor of Jacobs and Spruill. Likewise, the record has not been developed sufficiently to enable either the trial court or this Court to determine whether the doctrine of *res ipsa loquitur* is applicable. See *Easterling v. Walton*, 208 Va. 214, 216-17, 156 S.E.2d 787, 789-90 (1967) (doctrine applies where means or

instrumentality causing injury is in exclusive possession and control of person charged with negligence).

Accordingly, we will reverse the trial court's judgment and remand the case for further proceedings consistent with this opinion. n3

n3 We need not consider whether the trial court abused its discretion in refusing to permit Dickerson to supplement her discovery answers by naming additional expert witnesses because the case will be remanded for further proceedings. Upon remand, the court should establish a new date for the completion of discovery, and, therefore, the issue is moot.

[\*\*\*9]

Reversed and remanded.



9 of 9 DOCUMENTS

**CINDY L. BRYAN, PERSONAL REPRESENTATIVE, ETC. v. STEVEN BURT, D.O., ET AL.****Record No. 961409****SUPREME COURT OF VIRGINIA****254 Va. 28; 486 S.E.2d 536; 1997 Va. LEXIS 58****June 6, 1997, Decided**

**PRIOR HISTORY:** [\*\*\*1] FROM THE CIRCUIT COURT OF FAUQUIER COUNTY. James H. Chamblin, Judge.

**DISPOSITION:** Affirmed.

**JUDGES:** Present: All the Justices. **OPINION BY JUSTICE A. CHRISTIAN COMPTON.**

**OPINIONBY:** A. CHRISTIAN COMPTON

**OPINION:** [\*30] [\*\*537] **OPINION BY JUSTICE A. CHRISTIAN COMPTON**

The main appellate issue in this wrongful death action, alleging medical malpractice against both an emergency room physician and a family practitioner, is whether the trial court erred in striking the plaintiff's evidence at the close of the plaintiff's case-in-chief.

Appellant Cindy L. Bryan, who sues as "Personal Representative and Administratrix of the Estate of Shirley A. Robertson, deceased," filed a motion for judgment against appellees Steven M. Burt, D.O., and Eric J. Maybach, M.D., seeking damages for the alleged wrongful death of the decedent. The plaintiff alleged that the decedent came to a hospital emergency department complaining of severe abdominal pain. She alleged that Burt, the emergency room physician, diagnosed constipation as the cause of the pain when it actually was due to a perforated ulcer. The plaintiff alleged Burt discharged the decedent from the hospital after several hours of examination and treatment.

Subsequently, the plaintiff [\*\*\*2] alleged, when the pain did not subside, the decedent's family contacted the office of Maybach, the decedent's family physician. The plaintiff further alleged that as the result of Burt's misdiagnosis, which Maybach "knew or should have known of," the decedent's condition worsened and she died several months later while a patient in another hospital.

In a grounds of defense, Burt denied the plaintiff's allegations of negligence. Maybach filed a grounds of defense also denying he was negligent because "he was not involved in the care and treatment of" the decedent on the day of the alleged misdiagnosis.

Following presentation of the plaintiff's case-in-chief during a four-day jury trial in March 1996, the trial court sustained the defendants' respective motions to strike the evidence. We awarded the plaintiff an appeal from the trial court's April 1996 order entering summary judgment in favor of the defendants.

According to settled principles of appellate review governing a case in which the plaintiff's evidence has been struck at the close of the plaintiff's case-in-chief, we will recite the essential facts in the [\*31] light most favorable to the plaintiff. *Brown v. Koulizakis*, [\*\*\*3] 229 Va. 524, 526, 331 S.E.2d 440, 442 (1985).

The focus of this lawsuit is upon the events of December 13, 1992. Near 9:00 p.m. of that day, a Sunday, the plaintiff's decedent, age 53, went to the emergency department of the Fauquier Hospital in Warrenton, where she was examined and treated by Burt. She complained of pain "covering the entire abdomen." The patient stated she had experienced "the acute onset of the abdominal pain" about three hours earlier.

Upon examination, the patient's "vital signs" were normal. She gave a history of peptic ulcer disease, hypertension, headaches, "a cholesterol problem," and "problems with constipation." She reported that she recently had been taking a number of different medications.

Burt ordered "lab work" and x-rays that were "of a standard nature" and "normal in this sort of situation." Upon making a diagnosis of constipation, the physician ordered injection of a pain relieving drug, Toradol, and giving of "a high soapsuds enema" about 10:00 p.m. Near 11:30 p.m., the patient began receiving "IV fluids, to run at approximately [\*\*538] 500 cc's an hour." About 35

minutes later, she was given "an oil retention enema."

The patient was discharged [\*\*\*4] near 1:00 a.m. on December 14. Upon discharge, Burt instructed the patient to drink "lots of water," to pursue a "high fiber diet," to take specified doses of mineral oil, and "if no bowel movement" resulted, to take "8 oz. of citrate of Magnesia." She was told to return to the emergency room "if fever or any vomiting" developed and to "follow-up" with her personal physician on December 14 or 15 "for recheck" of her blood pressure.

The patient returned to her home, accompanied by her daughter. The pain continued, preventing the patient from sleeping. Over the course of the next few hours, she took the prescribed doses of mineral oil. The pain did not subside and the medication did not produce a bowel movement.

Before noon on December 14, the daughter called Dr. Maybach's office because the patient "wasn't feeling better." The daughter spoke with the physician's receptionist. The daughter called Maybach's office again near 3:00 p.m. on the 14th, and the receptionist relayed a recommendation from Maybach's nurse suggesting a laxative and an enema. Maybach was not present in his office when [\*32] either call was received, and there was no request during either call for the physician [\*\*\*5] to call the daughter.

Near 4:00 p.m. on December 14, the patient "started getting worse." She "started looking bad" and began "gasping for air." About 8:35 p.m., the daughter took her to the emergency room of the Fauquier Hospital, where the patient went into shock and was seen by Dr. Fortune Odend'hal.

Within hours, Dr. J. Paul Wampler performed exploratory abdominal surgery on the patient. As a result, she was diagnosed as having a perforated pyloric ulcer and acute respiratory distress syndrome (ARDS). A plaintiff's medical expert testified the ulcer perforated about 6:00 p.m. on December 13.

Following surgery, the patient's condition "stabilized" and she was admitted to the hospital. The patient remained there until she was transferred to the University of Virginia Medical Center at Charlottesville on February 5, 1993, where she died 20 days later. According to a plaintiff's medical expert, the cause of death was ARDS and respiratory failure. He testified that the ARDS was caused by the perforated pyloric ulcer.

Three medical experts testified for the plaintiff: Dr. Frederick L. Glauser, who is "Board Certified in internal medicine, pulmonary and critical care medicine"; [\*\*\*6] Dr. Philip G. Leavy, an expert in "emergency medicine";

and Dr. Robert Bowman, a "family practitioner of general medicine" presently employed in a hospital emergency department. The plaintiff proffered Glauser as a so-called "causation witness" and Leavy as a so-called "standard of care" expert in emergency medicine; neither purported to express an opinion on the alleged malpractice of defendant Maybach.

Glauser's testimony can be summarized as follows. From a review of the medical records, he said "the medically initiating cause" of the decedent's death "was a perforated pyloric ulcer." Relying, in part, on his study of the pertinent x-rays, the witness opined that the ARDS began with the perforation of the ulcer at 6:00 p.m. on the 13th. He said there was a progression from the perforated ulcer to the ARDS to the death. Glauser's opinion was that the decedent had a 90 to 95 percent chance of survival at 6:00 p.m. on the 13th, a 75 to 80 percent survival chance on the 14th, and a 40 to 50 percent chance of survival on the 15th.

The trial court restricted Glauser's testimony on the basis that he was attempting to offer opinions as a "standard of care" witness and not as a "causation" [\*\*\*7] witness. That action of the court is the [\*33] subject of an assignment of error. We shall not address the substance of the issue because any error committed by limiting the testimony was harmless; the expert fully expressed his views and the excluded information was supplied by the plaintiff's other experts.

Leavy's "standard of care" testimony can be summarized as follows. He opined that Burt "violated the standard of care in his emergency room examination" of the decedent [\*\*539] "on several occasions in several areas of his care" for her.

Specifically, the witness said, Burt failed "to appreciate the significance of the complaint of the abrupt onset of pain in the abdomen"; he "failed to appreciate the medications she was taking and failed to get a history of . . . how often she had been taking them"; he failed to recognize she was being treated with a combination of medications that had a propensity to worsen ulcers; and Burt "turned away from the chief complaint and focused on the chronic constipation problem that she had."

In addition, the expert opined that Burt should have noticed "free air," an abnormal condition, in the decedent's abdomen that was revealed on the x-rays taken on the [\*\*\*8] 13th. The witness' "impression" was that most patients with "perforated ulcers will, in fact, have free air." Also, the witness said Burt's conduct fell below the standard of care by not monitoring more frequently the patient's vital signs during her four-hour emergency room stay on the 13th.

Bowman, proffered as a witness to testify about "the medical care" provided by both defendants to the decedent, opined that both "acted below the standard of care." Bowman's opinions on Burt's conduct were essentially the same as Leavy's. Focusing on the allegations against Maybach, who had been the decedent's family doctor for 18 years, Bowman criticized Maybach's prescription of certain medications in the past as inconsistent with "good care." He also testified: "In the care of her problem that brought her to the emergency room, I think there was an opportunity to have made the care for her in the emergency room to be more directed toward problems that might have diagnosed her correctly had communication been given." Continuing, he said: "I don't have enough information to be able to know what the communication was."

Additionally, the expert said that, upon the decedent's release from the [\*\*\*9] emergency room following her stay on the 13th, Maybach's "office was contacted on two separate occasions and the information that was given was that she was continuing to have abdominal pain," [\*34] and the suggested treatment was to "relieve what was diagnosed as a constipation problem." The witness said Maybach acted below the standard of care because there was no suggestion during the two calls "that she should be reexamined, either by himself or by going back to the hospital."

Also, the witness opined that the standard of care was violated when, assuming Maybach was not in the office when either telephone call was received, Maybach's receptionist or nurse failed "to obtain medical help" for the decedent when her daughter called. The witness said a prudent physician should establish "guidelines" for the office staff to cover such situations. The expert admitted, however, that if Maybach's staff had urged the decedent to return to Fauquier Hospital's emergency room on the 14th, the standard of care would have been met.

As we have said, the main question on appeal is whether the trial court erred in striking the plaintiff's evidence. The issues to be decided under this broad question [\*\*\*10] are whether there was sufficient evidence of primary negligence, in the case of defendant Maybach, and of proximate cause, in the case of both defendants, to have carried those issues to the jury.

The applicable law is settled. A physician is neither an insurer of diagnosis and treatment nor is the physician held to the highest degree of care known to the profession. The mere fact that the physician has failed to effect a cure or that the diagnosis and treatment have been detrimental to the patient's health does not raise a presumption of negligence. Nevertheless, a physician must demonstrate that degree of skill and diligence in the diagnosis and treat-

ment of the patient which is employed by a reasonably prudent practitioner in the physician's field of practice or specialty. *Brown*, 229 Va. at 532, 331 S.E.2d at 445. See Code § 8.01-581.20.

In medical malpractice cases, a plaintiff must establish not only that a defendant violated the applicable standard of care, and therefore was negligent, the plaintiff must also sustain the burden of showing that the negligent acts constituted a proximate [\*\*540] cause of the injury or death. Thus, in a death case, if a defendant physician, by [\*\*\*11] action or inaction, has destroyed any substantial possibility of the patient's survival, such conduct becomes a proximate cause of the patient's death. *Brown*, 229 Va. at 532, 331 S.E.2d at 446. Accord *Poliquin v. Daniels*, 254 Va. 51, 486 S.E.2d 530 (1997), decided today.

[\*35] First, we shall consider the case against Dr. Burt. He does not dispute that the plaintiff presented expert testimony which showed he breached the standard of care and which showed the cause of the decedent's death. However, he contends the plaintiff failed to "present any expert testimony linking these two events."

The plaintiff argues that "proximate cause was shown by expert testimony of a loss of substantial possibility of Mrs. Robertson's survival." We do not agree.

Certainly, the plaintiff presented evidence that Burt's failure to diagnose the perforated ulcer on December 13 constituted a violation of the standard of care, and that her chances of survival diminished from 90 to 95 percent on the 13th to 40 to 50 percent on the 15th. Nonetheless, the plaintiff failed to present evidence of any course of treatment which should have been pursued on the 13th, given a diagnosis of a perforated [\*\*\*12] ulcer, that would have increased the decedent's chances of survival. Affording the plaintiff benefit of all possible inferences, one could infer from the events of the 14th that, if the condition had been properly diagnosed on the 13th, the decedent would have been referred to a surgeon who would have been responsible for her care. But the record is silent about the details of that care and its possible effect on the patient's health.

This case is unlike *Hadeed v. Medic-24, Ltd.*, 237 Va. 277, 377 S.E.2d 589 (1989); *Brown*, *supra*; and *Whitfield v. Whittaker Mem'l Hosp.*, 210 Va. 176, 169 S.E.2d 563 (1969), relied on by the plaintiff. In each of those cases, holding proximate cause to be a jury issue, the plaintiff presented testimony to establish the nature of the treatment the decedent could have undergone had the diagnosis been correct and the probability that such treatment would have extended the decedent's life.

For example, in *Hadeed*, the defendant physicians were charged with negligently failing to timely diagnose

and treat a decedent's coronary artery disease. According to the evidence, treatment in the form of medication or bypass surgery would [\*\*\*13] have improved the decedent's chance of survival. There, we said: "Likewise, proximate cause was a jury question. [The plaintiff] presented evidence that the doctors' failure to meet the applicable standard of care destroyed any substantial possibility of [the deceased's] survival. A jury reasonably could find that with bypass surgery [the deceased] would have had an 85-90 percent chance of living to age 70. With only medical therapy, he would have had a 50 percent chance of living to age 60." 237 Va. at 286-87, 377 S.E.2d at 594.

[\*36] Likewise, in *Brown* we stated: "Prompt diagnosis of the presence of the clot, which existed at least 48 hours before the death, would have enabled the orthopedist to administer treatment in the form of medication which would have substantially increased the patient's chances of living, according to the testimony. This was evidence of proximate cause." 229 Va. at 533, 331 S.E.2d at 446.

Consequently, we hold that the trial court did not err in granting Dr. Burt's motion to strike the plaintiff's evidence.

Second, we shall address the case against Dr. Maybach. The essence of the plaintiff's criticism of Maybach is that he mismanaged the decedent's [\*\*\*14] care prior to December 13, that he should have communicated more of the patient's history to Burt, and that the handling of the two telephone calls on the 14th by Maybach's office staff was improper.

Even if we assume for purposes of this discussion that one or more of those charges somehow support a finding of negligence, nevertheless Maybach's alleged deviations from the standard of care were too remote as a matter of law to be causally related to the decedent's death. Maybach never was afforded the opportunity to see, diagnose, or treat the decedent on the 13th. He was never asked to evaluate her complaints of pain on that day. Actually, the evidence showed he was working at a Front Royal hospital at the time. He was never [\*\*541] asked to read

the x-rays which the plaintiff now argues showed free air in the abdomen indicating a perforated ulcer.

The evidence shows that Maybach's only involvement with the decedent on the 13th consisted of two telephone calls. In the first call, he directed the patient to seek treatment at the Fauquier Hospital because he was on duty in the Front Royal hospital at the time. In the second call, Burt merely advised Maybach that the patient had been seen, [\*\*\*15] evaluated, and discharged with a diagnosis of constipation.

When the telephone calls of the 14th were received, Maybach was not in his office. The decedent's daughter was told, according to the evidence, that if the patient's pain was severe she should be brought to Maybach's office or returned to the hospital. The daughter responded the family did not want to take the patient back to the hospital. The daughter was asked if she wished to leave a message for Maybach, and she declined to do so. The patient never came to Maybach's office for treatment on the 14th.

In sum, as Maybach argues, his involvement with the decedent at the pertinent times "was simply too limited, too remote and [\*37] too indirect" to be causally connected to her death. Thus, we hold the trial court did not err in granting Dr. Maybach's motion to strike.

Finally, we reject the plaintiff's other assignments of error. The trial court did not abuse its discretion in refusing to allow the deposition testimony of a radiologist as part of the plaintiff's case-in-chief. The focus of that area of inquiry was upon what an emergency room physician should have seen and evaluated on x-rays, not what an expert radiologist should [\*\*\*16] have seen and evaluated. And, the trial court properly excluded proof of medical expenses that had not been linked causally to any alleged malpractice of the defendants.

For these reasons, the judgment below in favor of the defendants will be

Affirmed.

1 of 2 DOCUMENTS

**HICKS, Appellant v. UNITED STATES, Appellee****No. 10,432****UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT**

*368 F.2d 626; 1966 U.S. App. LEXIS 4562; 10 Fed. R. Serv. 2d (Callaghan) 1248; 1966 Neg. Cas. (CCH) P434*

**May 31, 1966, Argued  
October 27, 1966, Decided**

**DISPOSITION:** [\*\*1]

Reversed and remanded for determination of damages.

**JUDGES:**

Sobeloff and Bryan, Circuit Judges, and Hemphill, District Judge.

**OPINIONBY:**

SOBELOFF

**OPINION:**

[\*628] SOBELOFF, Circuit Judge:

This action was brought under the Federal Tort Claims Act, 28 U.S.C. § 1346, to recover damages for the death of Carol Greitens. The plaintiff, administrator of her estate, alleges that death was due to the negligence of the doctor on duty at the dispensary of the United States Naval Amphibious Base, Little Creek, Virginia, in diagnosing and treating her illness. The District Court, concluding that the evidence was insufficient to establish that the doctor was negligent, or that his concededly erroneous diagnosis and treatment was the proximate cause of her death, dismissed the complaint. From this action, the administrator appeals.

The decedent, 25 years of age, had been a diabetic since the age of 13, although the condition was under control. As the wife of a Navy enlisted man, she was entitled to medical care at the dispensary. Mrs. Greitens' husband brought her to the dispensary at about 4 a.m. on August 25, 1963, suffering from intense abdominal pain and continual [\*\*2] vomiting which had begun suddenly an hour before. The corpsman on duty in the examining room procured her medical records, obtained a brief history, took her blood pressure, pulse, temperature, and

respiration and summoned the doctor on duty, then asleep in his room at the dispensary. The doctor arrived 15 or 20 minutes later and after questioning the patient concerning her symptoms, felt her abdomen and listened to her bowel sounds with the aid of a stethoscope. Recording his diagnosis on the chart as gastroenteritis, he told Mrs. Greitens that she had a "bug" in her stomach, prescribed some drugs for the relief of pain, and released her with instructions to return in eight hours. The examination took approximately ten minutes.

[\*629] The patient returned to her home, and after another episode of vomiting, took the prescribed medicine and lay down. At about noon, she arose and drank a glass of water, vomited immediately thereafter and fell to the floor unconscious. She was rushed to the dispensary, but efforts to revive her were unsuccessful. She was pronounced dead at 12:48 p.m. and an autopsy revealed that she had a high obstruction, diagnosed formally as an abnormal [\*\*3] congenital peritoneal hiatus with internal herniation into this malformation of some of the loops of the small intestine. Death was due to a massive hemorrhagic infarction of the intestine resulting from its strangulation.

**I**

The plaintiff contends that the doctor at the dispensary did not meet the requisite standard of care and skill demanded of him by the law of Virginia. Compliance with this standard, the plaintiff maintains, would have required a more extended examination and immediate hospitalization. More specifically, plaintiff's expert witnesses, two general practitioners in the Norfolk-Virginia Beach area, testified that, according to prevailing practice in the community, the doctor should have inquired whether the patient had had diarrhea and should have made a rectal examination to determine whether the patient was suffering from an obstruction rather than from gastroenteritis. While the latter condition does not ordinarily require immediate radical treatment, a high obstruction is almost in-

variably lethal unless promptly operated upon. Plaintiff's experts further testified that on observing the symptoms manifested by Mrs. Greitens, the procedure of general practitioners [\*\*4] in the community would have been to order immediate hospitalization. This the dispensary physician failed to do, although the Naval Hospital in Portsmouth was available to him.

The standard of care which Virginia law exacts from a physician, in this case a general practitioner, is stated in *Reed v. Church*, 175 Va. 284, 8 S.E. 2d 285, 288 (1940), as follows:

A physician holds himself out as possessing the knowledge and ability necessary to the effective practice of medicine \* \* \*. However, he is not an insurer, nor is he held to the highest degree of care known to his profession \* \* \*. He must exhibit only that degree of skill and diligence employed by the ordinary, prudent practitioner in his field and community, or in similar communities, at the time.

Accord, *Alexander v. Hill*, 174 Va. 248, 6 S.E. 2d 661 (1940); *Fox v. Mason*, 139 Va. 667, 124 S.E. 405 (1924). See Shepherd, *The Law of Medical Malpractice in Virginia*, 21 Wash. & Lee L. Rev. 212 (1964). Thus, if he uses ordinary care in reaching his diagnosis, and thereafter acts upon it, he incurs no liability, even if the diagnosis proves to be a mistake [\*\*5] in judgment.

It is undisputed that the symptoms of high obstruction and of gastroenteritis are quite similar. The District Court placed great emphasis on this fact as an indication that the doctor's erroneous diagnosis was not negligent, but was merely an error of judgment. It would seem, however, that where the symptoms are consistent with either of two possible conditions, one lethal if not attended to promptly, due care demands that a doctor do more than make a cursory examination and then release the patient. See *Jenkins v. Charleston Gen. Hospital & Training School*, 90 W. Va. 230, 110 S.E. 560, 22 A.L.R. 323 (1922), holding that where a "partial and very hurried investigation" was made, the physician was liable for failure of his diagnosis to disclose an injury which caused detriment to the patient. The fact that an intestinal obstruction is a rare occurrence, and that some form of gastroenteritis is the more likely of the two conditions, [\*630] does not excuse the failure to make inquiries and perform recognized additional tests that might have served to distinguish the one condition from the other. The dispensary doctor himself, as well as the experts [\*\*6] for both sides, agreed that an inquiry as to diarrhea and a rectal examination were the

"proper procedure" and "the accepted standard" in order to be able to rule out gastroenteritis and to make a definite diagnosis of high intestinal obstruction. If he had made the inquiry which he admits was the accepted standard, he would at least have been alerted to the fact that the case was one calling for close observation with a view to immediate surgical intervention if the graver diagnosis were confirmed. In these circumstances, failure to make this investigation constitutes a lack of due care on the part of the physician. It was stated in *Kelly v. Carroll*, 36 Wash. 2d 482, 494, 219 P.2d 79, 86, 19 A.L.R.2d 1174 (1950), cert. denied, 340 U.S. 892, 95 L. Ed. 646, 71 S. Ct. 208 (1950), a case in which an erroneous diagnosis had led to improper treatment, that "if there was a possibility that it was appendicitis, he had no right to gamble with [decedent's] life, on the theory that it might be something else." Only if a patient is adequately examined, is there no liability for an erroneous diagnosis. n1

n1 Numerous cases have held that a physician has a duty to make proper use of all available diagnostic aids to establish a firm basis for the diagnosis and choice of treatment. See, e.g., *Price v. Neyland*, 115 U.S. App. D.C. 355, 320 F.2d 674, 99 A.L.R.2d 1391 (1963) (pediatrician negligent in stopping short of making all possible diagnostic tests which might have enabled him to distinguish physiologic from pathologic jaundice); *Kingston v. McGrath*, 232 F.2d 495, 54 A.L.R.2d 267 (9th Cir. 1956) (ordinary skill and care required further examination of patient and taking of additional X-ray pictures even though first X-rays did not disclose fracture); *Dowell v. Mossberg*, 226 Or. 173, 355 P.2d 624 (1960), rev'd on other grounds on rehearing, 226 Ore. 187, 359 P.2d 541 (1961) (failure to diagnose disease as diabetes negligent because blood sugar test not performed); *Harvey v. Silber*, 300 Mich. 510, 2 N.W. 2d 483 (1942) (doctor's erroneous diagnosis of position of bullet in decedent's body negligent because of reliance on manual examination rather than X-rays); *Peterson v. Hunt*, 197 Wash. 255, 84 P.2d 999 (1938) (diagnosis of ovarian cyst as pregnancy negligent because of failure to employ standard "rabbit test"); *Ramberg v. Morgan*, 209 Iowa 474, 218 N.W. 492 (1929) (erroneous diagnosis of auto accident victim's condition as intoxication, rather than skull fracture, negligent because of failure to give more thorough examination, including X-rays); *Coleman v. Wilson*, 85 N.J.L. 203, 88 A. 1059 (1913) (negligent failure to analyze tissue of growth in decedent's nostril, leading to improper operation, when analysis would have revealed non-malignant character of growth); Note, *Problems of Negligent Malpractice*, 26 Va. L.

*Rev. 919, 922 (1940).*

[\*\*7]

Our conclusion that the physician was negligent in his diagnosis and treatment of the patient is not inconsistent with *Fed. R. Civ. P. 52(a)*, which declares that the trial judge's findings of fact are not to be disturbed unless clearly erroneous. This Rule comes into play primarily where the trial judge as fact finder has had to reconcile conflicting testimony. Where the veracity of witnesses is in issue, the decision is for the judge who has had the opportunity to see and evaluate the witnesses' demeanor. The trial court's findings of fact on conflicting evidence will not be disturbed by the appellate court unless clearly erroneous. *United States v. General Motors Corp.*, 384 U.S. 127, 141 n. 16, 16 L. Ed. 2d 415, 86 S. Ct. 1321 (1966); *Walling v. Gen. Industries Co.*, 330 U.S. 545, 550, 91 L. Ed. 1088, 67 S. Ct. 883 (1947); *Nationwide Mutual Ins. Co. v. DeLoach*, 262 F.2d 775, 778 (4th Cir. 1959). But we are dealing here with the testimony of expert witnesses who are not in controversy as to the basic facts; thus, the opportunity of the trial court to observe the witnesses is of limited significance. It has often been held that where the [\*\*8] trial court's conclusions are [\*631] based on undisputed facts, they are not entitled to the finality customarily accorded basic factual findings under Rule 52(a). *United States v. General Motors Corp.*, *supra*; *United States v. Parke, Davis & Co.*, 362 U.S. 29, 44, 4 L. Ed. 2d 505, 80 S. Ct. 503 (1960); *Shapiro, Bernstein & Co. v. H.L. Green Co.*, 316 F.2d 304, 306-307 (2d Cir. 1963); *St. Louis Union Trust Co. v. Finnegan*, 197 F.2d 565, 568 (8th Cir. 1952).

The question before us is not one of fact in the usual sense, but rather whether the undisputed facts manifest negligence. Although the absence of a factual dispute does not ALWAYS mean that the conclusion is a question of law, it becomes so HERE since the ultimate conclusion to be drawn from the basic facts, i.e., the existence or absence of negligence, is actually a question of law. For this reason, the general rule has been that when a judge sitting without a jury makes a determination of negligence, his conclusion, as distinguished from the evidentiary findings leading to it, is freely reviewable on appeal. *Mamiye Bros. v. Barber Steamship Lines, Inc.*, 360 F.2d 774, 776 (2d Cir. 1966). [\*\*9] The determination of negligence involves not only the formulation of the legal standard, but more particularly in this case, its application to the evidentiary facts as established; and since these are uncontested, there is no basis for applying the "clearly erroneous" rule. *United States v. Parke, Davis & Co.*, *supra*; *Kippen v. American Automatic Typewriter Co.*, 324 F.2d 742, 745 (9th Cir. 1963); *Romero v. Garcia & Diaz, Inc.*, 286 F.2d 347, 355 (2d Cir. 1960), cert. denied, 365 U.S. 869, 5 L.

*Ed. 2d 860, 81 S. Ct. 905 (1961); Galena Oaks Corp. v. Scofield*, 218 F.2d 217, 219 (5th Cir. 1954).

The government's expert opined that the dispensary physician exercised "average judgment," but analysis of his entire testimony points unavoidably to the opposite conclusion. Revealing are his statements that it was wrong not to inquire about diarrhea, conceding that "that is one question that one usually asks," and that given a patient with abdominal pain of one hour's duration, it is too soon "to expect anybody to come up with a proper diagnosis." Furthermore, his opinion was predicated upon a factual assumption not permissible [\*\*10] in this case. His assumption was that the dispensary physician had made only a "working" or "tentative" diagnosis, which the expert felt to be appropriate in view of the fact that the symptoms had their onset such a short time before. However, the uncontradicted evidence indicates that this was not a "tentative" diagnosis.

The examining doctor himself testified that he had already considered and ruled out at the beginning of his examination the possibility of an obstruction, without making the additional differentiating diagnostic tests. He said that his only reason for asking the patient to return eight hours later was because her diabetic condition could become complicated by a case of gastroenteritis. A further indication of the final nature of the diagnosis is his notation of gastroenteritis on the chart, made without further qualification. He also testified that he told the woman not to return for eight hours, regardless of the persistence of pain; yet even the government's expert testified that if abdominal pain were present for "THREE OR FOUR hours and wouldn't go away, you would probably have to operate." By releasing the patient, the dispensary physician made his [\*\*11] diagnosis final, allowing no further opportunity for revision, and this prematurely determined final diagnosis was based on an investigation not even minimally adequate.

On careful scrutiny, therefore, the government's expert is seen to have demonstrated that the examiner did NOT conform to the required standard of care. Coupled with the explicit testimony of the plaintiff's experts, the government's testimony leads us inevitably to the conclusion that the doctor was negligent [\*632] as a matter of law. We think that the District Court gave undue weight to the purely conclusory opinion of the government witness. The District Court is not bound by his statement that "average judgment" had been exercised, nor are we bound by it. Only the standard of care is to be established by the testimony of experts. If under the undisputed facts the defendant failed to meet that standard, it is not for the expert but for the court to decide whether there was negligence.

## II

The government further contends that even if negligence is established, there was no proof that the erroneous diagnosis and treatment was the proximate cause of the death, asserting that even if surgery had been [\*12] performed immediately, it is mere speculation to say that it would have been successful. The government's contention, however, is unsupported by the record. Both of plaintiff's experts testified categorically that if operated on promptly, Mrs. Greitens would have survived, and this is nowhere contradicted by the government expert. *Price v. Neyland*, 115 U.S. App. D.C. 355, 320 F.2d 674, 99 A.L.R.2d 1391 (1963), decided under Virginia law, held that a doctor was liable for negligent diagnosis, although even when correctly diagnosed, the disease requires IMMEDIATE treatment for success.

When a defendant's negligent action or inaction has effectively terminated a person's chance of survival, it does not lie in the defendant's mouth to raise conjectures as to the measure of the chances that he has put beyond the possibility of realization. If there was any substantial possibility of survival and the defendant has destroyed it, he is answerable. Rarely is it possible to demonstrate to an absolute certainty what would have happened in circumstances that the wrongdoer did not allow to come to pass. The law does not in the existing circumstances require the plaintiff [\*13] to show to a CERTAINTY that the patient would have lived had she been hospitalized and operated on promptly. *Harvey v. Silber*, 300 Mich. 510, 2 N.W. 2d 483 (1942). n2

n2 In *Harvey*, the defendant negligently diagnosed the decedent's wound as merely superficial, whereas a correct diagnosis would have indicated that the intestine had been pierced, and that an operation would be necessary to stop the hemorrhaging. As here, the expert witnesses in that case agreed that the decedent could not have survived without an operation. Since the negligent diagnosis was the proximate cause of the failure to operate, and there was testimony to the effect that there was a probability that an operation would have saved decedent's life, it was held that the negligent diagnosis was the proximate cause of death. The appellate court found that the jury had been properly charged when told that it was "not incumbent on the plaintiff to show that to a certainty surgical intervention would have saved his life." *Id.* 300 Mich. at 521, 2 N.W. 2d at 488.

[\*\*14]

An apt analogy is found in a case which arose in this

circuit. n3 In *Gardner v. National Bulk Carriers, Inc.*, 310 F.2d 284, 91 A.L.R.2d 1023 (4th Cir. 1962), cert. denied, 372 U.S. 913, 9 L. Ed. 2d 721, 83 S. Ct. 728 (1963), a seaman, last [\*633] seen on board at 6 p.m., was not discovered to be missing until 11:30 p.m. A search was then made of the ship, but the master did not alter the speed or course of the vessel or take other steps to find the missing seaman. It was contended that there was no causal connection between the failure to reverse the course of the ship to conduct a search and the seaman's death, since there was no definite showing that when it was discovered that he was missing, he was still alive and could have been saved. This court held, however, that the master's duty to attempt a rescue

is of such a nature that its omission will contribute to cause the seaman's death. The duty arises when there is a reasonable possibility of rescue. Proximate cause is tested by the same standard, i.e., CAUSATION IS PROVED IF THE MASTER'S OMISSION DESTROYS THE REASONABLE POSSIBILITY OF RESCUE. Therefore, proximate cause here is implicit [\*15] in the breach of duty. Indeed, the duty would be empty if it did not itself embrace the loss as a consequence of its breach. ONCE THE EVIDENCE SUSTAINS THE REASONABLE POSSIBILITY OF RESCUE, AMPLE OR NARROW, ACCORDING TO THE CIRCUMSTANCES, total disregard of the duty, refusal to make even a try, as was the case here, imposes liability. *Id.* at 287.

n3 Other circuits have similarly held that if the victim might have been saved by a precaution which the defendant negligently omitted, the omission is deemed to have caused the harm, even though it is not possible to demonstrate conclusively that the precaution would in fact have saved the victim. See, e.g., *Kirincich v. Standard Dredging Co.*, 112 F.2d 163 (3d Cir. 1940) (seaman who could not swim was thrown inch heaving line rather than larger and more buoyant object); *Zinnel v. United States Shipping Board*, 10 F.2d 47 (2d Cir. 1925) (whether guard rope, absence of which constituted negligence of defendant, would have prevented plaintiff's intestate from being washed overboard). In the latter case, it was stated that although nobody could be sure intestate would have seized rope or that it would have stopped his body, the court was



not "justified, where certainty is impossible, in insisting upon it."

[\*\*16]

In sum, the dispensary physician's negligence in failing to make a thorough examination and in omitting standard diagnostic tests, led to an erroneous diagnosis. Because of this, he sent the patient home with instructions

not to return for eight hours, rather than immediately admitting her to a hospital. Since the uncontradicted testimony was that with prompt surgery she would have survived, the conclusion follows that the dispensary doctor's negligence nullified whatever chance of recovery she might have had and was the proximate cause of the death.

Judgment reversed and cause remanded for the determination of damages.

2 of 3 DOCUMENTS

**Lucy E. SAWYER, Administratrix of the Estate of William O. Sawyer, Deceased, Plaintiff,  
v. UNITED STATES of America, Defendant**

Civ. A. No. 77-718-N

**UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF VIRGINIA,  
NORFOLK DIVISION**

*465 F. Supp. 282; 1978 U.S. Dist. LEXIS 14289*

November 20, 1978

**COUNSEL:** [\*\*1]

Leonard D. Levine, Virginia Beach, Va., for plaintiff.

John F. Kane, Asst. U. S. Atty., Alexandria, Va.,  
Laurence A. Froehlich, Business and Administrative Law  
Division, Dept. of HEW, Washington, D. C., for defend-  
ant.

**OPINIONBY:**

KELLAM

**OPINION:**

[\*284]

## MEMORANDUM OPINION

Plaintiff seeks to recover damages from the United States under the provisions of the Federal Tort Claims Act, 28 U.S.C. § 2672 and other provisions of Chapter 171 of that Title, the procedure for which is prescribed by 28 U.S.C. § 2401, jurisdiction for which is found in 28 U.S.C. § 1346, based on the alleged negligence of the United States in the care and attention of plaintiff's decedent, who was a patient of the United States at the United States Public Health Service Hospital in Norfolk.

## I.

Plaintiff's decedent was injured in an automobile accident in Virginia Beach, Virginia on November 6, 1976. He was transported to Bayside Hospital in Virginia Beach, where he remained as an inpatient (part of the time in intensive care) until November 18, 1976, when, at decedent's request, he was transferred by ambulance to the United States Public Health Service Hospital at Norfolk, Virginia. He remained there [\*\*2] until November 28, 1976, when he died.

Plaintiff's decedent had suffered severe injuries in his accident, including the fracture of more than one vertebrae of his back, resulting in injury to his spinal cord.

Following two major surgical procedures, the fractured vertebrae were fused and portions of the bone pressing on the spinal cord and nerves were removed. Even so, he was almost totally paralyzed in his lower extremities. At the time of his request to be transferred to the Public Health Service Hospital, he was placed in a plaster of paris cast extending from his neck and shoulders down to his middle or lower abdomen at his hips. The principal purpose of placing him in the cast was to stabilize his back position (vertebrae which had been fused) so that he could be transferred to the Public Health Hospital. At that time his condition was stable and he was regaining his functions. His condition required intensive nursing care and special medical attention.

Soon after he was received at the Public Health Service Hospital the physician who was in charge of the decedent's care and attention sought to have him transferred to a Spinal Cord Injury Center. He asserted such a facility [\*\*3] existed at Staten Island. The mother of the decedent opposed such a transfer and the physician then sought to have him transferred to the Veterans Administration Hospital at Kecoughtan. He pursued such endeavor and a day or two before the decedent died, he had arranged for such transfer to take place on November 28th or 29th.

At the time the decedent entered the Public Health Service Hospital he was on numerous types of medication, some of which were continued, in larger or smaller dosages, and in addition, other types of medication were prescribed.

[\*285] Not unexpectedly, the decedent resisted the cast. He complained numerous times. The physician under whose care he came said that he had mental problems, thought someone was trying to kill him, and asserted people were putting knives under his cast. That physician related he saw him only a few times when the patient was normal and able to carry on a conversation, although the record shows that numerous others carried on normal

conversations with him and were able to understand his complaints.

Plaintiff asserts that the cause of death of her decedent was negligence on the part of employees of defendant, resulting in a [\*\*4] lack of proper care and attention, and particularly by the physician who was in charge of his care. She asserts the care and attention did not meet the standards required of such institutions in the community or of physicians in the community.

The records from the Bayside Hospital, where plaintiff's decedent was first confined, and from the Public Health Service Hospital, have been introduced in evidence in this case, along with other exhibits. Testimony of the attending physicians at the Bayside Hospital and physicians at the Public Health Service Hospital were presented, either in person or by depositions. The relevant evidence will hereafter be set out. First, we look at the law which will govern the determination of the issue of liability.

## II.

To recover in this action under the Federal Tort Claims Act, the plaintiff must establish negligence or a wrongful act or omission of an employee of the United States, without which showing of negligence the alleged conduct is not actionable under the Act. *Laird v. Nelms*, 406 U.S. 797, 92 S. Ct. 1899, 32 L. Ed. 2d 499 (1972); *Dalehite v. United States*, 346 U.S. 15, 45, 73 S. Ct. 956, 97 L. Ed. 1427 (1953). The liability of the United [\*\*5] States under the Act is "in the same manner and to the same extent as a private individual under like circumstances," 28 U.S.C. § 2674, and is to be determined by the standard of whether "a private person would be liable to the claimant in accordance with the law of the place where the act or omission occurred." 28 U.S.C. § 1346(b). The alleged negligence and malpractice which are the bases of this suit and the resulting injury, occurred in Virginia; hence, the law of Virginia is to be applied. *United States v. Muniz*, 374 U.S. 150, 83 S. Ct. 1850, 10 L. Ed. 2d 805 (1963); *Richards v. United States*, 369 U.S. 1, 82 S. Ct. 585, 7 L. Ed. 2d 492 (1962); *Massachusetts Bonding & Insurance Co. v. United States*, 352 U.S. 128, 77 S. Ct. 186, 1 L. Ed. 2d 189 (1956); *Jennings v. United States*, 374 F.2d 983 (4 Cir. 1967); *Murray v. United States*, 329 F.2d 270 (4 Cir. 1964).

When an agency of the United States undertakes a task, it must perform the task with due care. *Rogers v. United States*, 397 F.2d 12 (4 Cir. 1968). The law of Virginia accords with this principle. *City of Richmond v. Virginia Bonded Warehouse Corp.*, 148 Va. 60, 138 S.E. 503, 507. A party is entitled to assume another party [\*\*6] will perform his duty, and may act upon such until

the contrary appears, or reasonably should appear. *Harris Motor Lines v. Green*, 184 Va. 984, 37 S.E.2d 4 (1946). The issues of negligence and proximate cause in actions like this are to be determined from the evidence by the trier of the facts. *Biggs v. Martin*, 210 Va. 630, 172 S.E.2d 767 (1970); *Talley v. Draper Construction Co.*, 210 Va. 618, 172 S.E.2d 763 (1970); *Iatomasi v. Rhodes*, 407 F.2d 498 (4 Cir. 1969); *Nuckoles v. F. W. Woolworth Co.*, 372 F.2d 286 (4 Cir. 1967). In *Clark v. United States*, 402 F.2d 950 (4 Cir. 1968), the court said that it "appears to be settled in Virginia that the question of causation is for the trier (jury) -- --

In order for defendant's negligence to be a proximate cause of the injury, it is not necessary that defendant "shall have foreseen the precise injury that occurred," but, it "is sufficient if an ordinary, careful and prudent person ought, under the circumstances, to have foreseen that an injury might probably result from the negligence act." *Cox v. Mabe*, 214 Va. 705, 204 S.E.2d 253 (1974).

[\*286] To determine whether the actions or omissions of defendant establish negligence on the [\*\*7] part of the defendant in the care, attention and treatment given plaintiff's decedent, and whether there is liability under the Federal Tort Claims Act, we turn to the law of Virginia.

The standard of care prescribed for physicians in Virginia is "that degree of skill and diligence employed by the ordinary, prudent practitioner in his field and community, or in similar communities at the time." *Reed v. Church*, 175 Va. 284, 8 S.E.2d 285, 288 (1940); *Clark v. United States*, *supra*, *Morgan v. Schlanger*, 374 F.2d 235, 241 (4 Cir. 1967), and "the standard of care required of specialists in Virginia is that of other like specialists in good standing in the same or similar localities." *Little v. Cross*, 217 Va. 71, 225 S.E.2d 387, 390 (1976). In *Bly v. Rhoads*, 216 Va. 645, 222 S.E.2d 783, 788 (1976), Reaffirmed in *Little v. Cross*, *supra*, the court stated it this way:

In Virginia, at least since 1918, when we decided *Hunter v. Burroughs*, *supra*, 123 Va. at 131, 96 S.E. at 366, the standard of due medical care applicable to specialists has been that of "other like specialists in good standing, in the same or similar localities as defendant." We reiterated this rule in *Fox v. Mason*, 139 Va. [\*\*8] 667, 671, 124 S.E. 405, 406 (1924), where we set out the "same or similar community" standard applicable to physicians and surgeons and then said, "(t)he rule is the same as to specialists."

*Clark v. United States*, *supra*, sets forth that the court in *Reed v. Church*, *supra*, sustained an instruction to the jury

applying the above set out standard to diagnosis, as well as treatment, saying that under certain circumstances, "failure to make (this) investigation constitutes a lack of due care on the part of the physician." *Hicks v. United States*, 368 F.2d 626, 630 (4 Cir. 1966).

A physician holds himself out as possessing knowledge and ability necessary to the effective practice of medicine and impliedly represents that he possesses, and the law places upon him the duty of possessing, that reasonable degree of learning and skill which is ordinarily possessed by physicians in the locality in which he practices and which is ordinarily regarded by those conversant with the employment as necessary to qualify him to engage in the business of the practice of medicine. *Varga v. United States*, 314 F. Supp. 671 (D.C.Va.1969), *Aff'd*, 422 F.2d 1333; *White v. United States*, 244 F. Supp. 127 [\*9] (D.C.Va.1965), *Aff'd*, 359 F.2d 989; *Hicks v. United States*, *supra*.

The mere fact a diagnosis was erroneous does not furnish a basis for liability. Bad results, standing alone, are not sufficient to raise an inference of negligence on the part of a physician or surgeon. A physician is not an insurer of the patient's cure, and a failure to effect cure does not raise a presumption of negligence. *Vann v. Harden*, 187 Va. 555, 47 S.E.2d 314; *Hicks v. United States*, *supra*; *Varga v. United States*, *supra*. But there is a distinct difference in an error of judgment in diagnosis and treatment, as opposed to a failure to properly examine, treat and make use of aids to diagnosis. The Fourth Circuit put it this way in *Clark v. United States*, *supra*, at p. 953:

That the diagnosis was erroneous does not, of course, furnish a basis for liability, but "there is a vast difference between an error of judgment and negligence in the collection and securing of factual data essential to arriving at a proper conclusion or judgment. If a physician, as an aid to diagnosis, i. e., his judgment, does not avail himself of the scientific means and facilities open to him for the collection of the best factual [\*10] date upon which to arrive at his diagnosis, the result is not an error of judgment but negligence in failing to secure an adequate factual basis upon which to support his diagnosis or judgment." *Smith v. Yohe*, 412 Pa. 94, 194 A.2d 167, 173 (1963). See also, *Hicks v. United States*, 368 F.2d 626, 630 n. 1 (4 Cir. 1966).

In *Hicks v. United States*, *supra*, the court, after holding a failure to make an investigation constituted a lack of due care on the part of the physician, continued at p. 630:

[\*287] It was stated in *Kelly v. Carroll*, 36 Wash.2d 482, 494, 219 P.2d 79, 86, 19 A.L.R.2d 1174 (1950), Cert. denied, 340 U.S. 892, 71 S. Ct. 208, 95 L. Ed. 646 (1950), a case in which an erroneous diagnosis had led to improper treatment, that "if there was a possibility that it was appendicitis, he (defendant) had no right to gamble with (decedent's) life, on the theory that it might be something else."

In *Hicks*, the court further said that "only if a patient is adequately examined, is there no liability for an erroneous diagnosis." 368 F.2d 630. Footnote 1 of that decision recites numerous cases in support of the fact "that a physician has a duty to make proper use of [\*11] all available diagnostic aids to establish a firm basis for the diagnosis and choice of treatment." Here, the principal complaint is not an error of judgment, but a failure to act.

### III.

Plaintiff asserts the record clearly establishes that the defendant was negligent by acts of omission and commission. She asserts the evidence abundantly establishes

- (a) a failure to make proper and timely physical examination of the patient
- (b) a failure to make adequate and proper laboratory tests of the patient
- (c) a complete failure to make any type of examination of the patient within the last 24 to 48 hours before his death
- (d) improperly prescribing medication, prescribing and changing medication and dosages without any physical or visual examination of the patient or a proper review of his chart.

Plaintiff's decedent had sustained severe injuries and was clearly not out of danger when he was transferred to the Public Health Service Hospital. But his condition was stable, the back had started to fuse, he was regaining his functions, his vital signs were stable and satisfactory, he showed improvement in his lower extremities, he was free from infection, and [\*12] his prognosis was good.

But, he was not out of danger. His condition required intensive care by doctors and nurses. He was a potential candidate for infections and complications of the lungs was a possibility. He had multiple problems and complications which had to be followed. His injuries and condition required that doctors physically examine him daily, and have proper laboratory tests run and make regular evaluations of his condition. They should be on

guard for lack of gastro-motility, necessitating, among other things, palpation of the stomach. He was described as difficult to treat, but not difficult to handle.

A.

As a result of the loss of the use of his lower extremities decedent required substantial medication and the intake of a great quantity of liquid. Much of this was necessary to keep his bladder and bowels functioning. A catheter remained in him during his stay at Public Health Service Hospital to drain his bladder. He was given quantities of medication and numerous enemas to keep his bowels functioning. The catheter presented a real danger of infection.

Strong medications were prescribed for him, some to assist him with bowel movements, to quiet his nerves, [\*\*13] for pain, for infection, and for other reasons. It was increased and changed several times. Some of the medication was prescribed and dosages reduced or increased by the physician without an examination or even viewing the patient; that is, by answer to a telephone call from one of the nurses.

It would serve no good purpose to attempt to set forth each day's record of the patient's treatment and the little attention given by the physician. With the cast covering the upper portion of the patient's body, the doctors seemed to agree it was difficult, if not next to impossible, to listen to the patient's heartbeat or sounding of his lungs, or to examine other portions of the upper body. Even with the cast on, they could make examinations and palpation of the lower abdomen by inserting the hand under the cast. But this was not done.

[\*288] B.

More important and necessary in order to meet the standard of care due such a patient, suffering as he was, was a requirement that holes should have been cut in the cast over the heart and lungs and portions of the stomach, in order to permit a complete and full examination. The evidence seems to clearly establish that the standard of [\*\*14] care in the community required this and if there was any difficulty in making the examinations in that manner, then the standard of care in the community required that the cast be removed completely so that the examinations could be made. The removal could be done by cutting the cast along each side, lifting off the top and removing the bottom half, and after the examination had been completed by replacing it and taping it together. It should be noted that this was done by the Public Health Service Hospital physicians about an hour before the patient expired and at a time when he was in extremis. It was just too little too late.

The credible evidence established that the standard of care of physicians in the community required at least daily physical examination of the patient, listening to the heart and lungs, and palpation of the stomach. Palpation of the stomach in cases like this was very important to determine whether the stomach and gastric system was properly functioning, and if not, to take immediate measures to correct it. There was real danger if this was not done.

From the day following the patient's admission to the Public Health Service Hospital, until his death, [\*\*15] he was not given an examination by any physician either to test the condition of his heart, lungs or stomach, nor were there adequate and proper laboratory tests run or other examinations made for his care and attention. It seems the only tests ordered were those ordered in the absence of the patient's attending physician by another doctor who went in to examine or discuss with the patient his mental condition. This was on the day before the patient died, and such tests were not even scheduled to be made until Monday, November 28th. The patient died on the 27th.

C.

Dr. Loxley, an orthopedic surgeon, reviewed all of the records from each of the hospitals, the autopsy report and other data available. He testified the evidence clearly showed the decedent was regaining functions at the time he was removed from the Bayside Hospital; that the condition of the patient required that a physician must be on guard to determine if there was any loss of gastro-motility; that numerous means were available for making such determination and particularly one of feeling the stomach and abdomen by inserting the hand under the cast and if there was any difficulty or restriction, by cutting off part [\*\*16] of the cast, or removing the cast entirely; that the record established there was no proper examination to determine the gastro-motility of the stomach and abdomen on the day before the patient died, or for several days before that; that such an examination was necessary; that no proper evaluation was made of the patient; that it was clear his stomach was not working and was filled up and distended, and his bowels were swollen. Dr. Loxley further testified that the records clearly demanded the cast should have been removed on the day before the patient expired, and that if an examination had been made, in his opinion the patient could have been saved. He said mere filling and distension of the stomach would have alerted a physician exercising due care to the condition which brought about his death; namely, the fact that the stomach was filled and distended, leading to vomiting. Death was caused, in his opinion, by aspiration of the vomit into the lungs, causing pneumonia and causing them to swell and cut off the intake of air. Most of the doctors who testified

said that this was the normal result in cases similar to this and that a physician should be on guard to avoid this. He [\*\*17] further said that vomiting was a signal to the physician to make an examination of the stomach. The patient had had spells of vomiting on Saturday before he died on Sunday, and even prior to Saturday. Yet, there was no palpation of the stomach on [\*\*289] Saturday. Dr. Butts said the patient required intensive care by doctors, and nurse Stainback said the patient, on numerous occasions, complained of stomach cramps and stomach pains. This should have alerted the physician to examine the stomach.

The evidence established it was common knowledge in the medical community that a full and distended stomach was likely to lead to vomiting and often to aspiration. Added to this danger was a patient who had little or no use of his lower extremities, and enclosed in a cast from neck to the lower part of his abdomen. Dr. Loxley described the treatment and care as deplorable. In his opinion, the patient would have recovered and been able to resume a normal life, limited, in all probability, by only not being able to climb, but otherwise perform the normal duties he had been previously performing. Dr. Butts, the neurosurgeon who did the surgery at Bayside Hospital, said the patient [\*\*18] was in good condition when transferred to the Public Health Service Hospital, free from infection and his prognosis was good; that since there was only partial injury to the spinal cord, he looked at the prognosis favorably. He pointed out that while at Bayside Hospital, X-rays were taken daily. Yet, none were taken at the Public Health Service Hospital.

Dr. Butts said that before and at the time of the transfer there were no symptoms of pneumonia, and that there was improvement in his chest and lungs. He said that at Bayside X-rays were taken daily because of the potential of complications; and that his condition was closely followed. He was corroborated by his associate, Dr. Reina. Dr. Fekete, an internist, was of the same opinion, asserting that his potential for recovery was good; that at time of transfer the patient's condition was stable, he was improving and the potential was good; that the treatment which the patient received at the Public Health Service Hospital was a departure from the normal procedures; that while he was treated with appropriate medication, there was too much medication; that X-rays should have been taken; that on admission he was treated for inhalation, [\*\*19] but this was stopped three days before he expired. He too agreed that with the cast on they could not take X-rays or properly assess the condition and that it required an opening of the cast, or its removal and reinstallation. He said the patient died from acute gastric dilatation.

There was credible testimony accepted by the court

that the prescribing of drugs by telephone for such a patient was not proper and in accord with the standard of care employed by the ordinary and prudent practitioner in his field in the community.

D.

The physician who had the responsibility for the care and attention of the decedent had not seen the patient for considerably more than 48 hours. Nor had he arranged for any other physician to see the patient. Even the Chief of Professional Services at the Public Health Service Hospital said that it was not the practice for patients to go for 24 hours without being seen by a physician. It is true that Dr. Vanderdecker saw the patient about 10:30 or 11:00 o'clock in the morning of November 27, and had seen him the day before, but it is equally clear he made no physical examination of the patient, and his visit was solely to observe his mental condition. [\*\*20]

On November 26, the nurse advised Dr. Dannis that the patient had one complaint after another, including super anxiety, stomach cramps, stomach pains, and that his stomach was distended. The nurse feared a drug buildup and intoxication all at once and advised Dr. Dannis of this. Dr. Dannis merely prescribed some medication by telephone. The patient at that time had an impaction of the bowel. The condition was such that the nurse manually removed the impaction. Dr. Dannis prescribed a laxative combination of milk of magnesia and cascara, but still no examination of the stomach was made.

The evidence establishes that with such lack of care, the dangers were foreseeable and the cause of the patient's death was predictable by one exercising proper care. The patient had vomited previously. Dr. [\*\*290] Hyatt, the Chief of Professional Services at the Public Health Service Hospital, said he vomited because he was ill; that he was getting medications which were capable of making him vomit; he had problems with a fecal impaction and patients whose colons are disturbed, do secondarily vomit; that he was on a lot of other medications, all of which could make him vomit; and that he [\*\*21] was an agitated patient and that could make him vomit. Dr. Dannis said that one thing that could have caused the patient to vomit was screaming. Although fully alerted that the patient had been vomiting and that he might again vomit, they should have anticipated that one in such condition, confined as he was, could and probably would aspirate. Surely, they knew what would likely result from aspiration of the vomit, which should have alerted him to an existing danger.

The patient's mother visited him on November 26th, the day before he died. She was much disturbed about his condition and made numerous efforts that day and into

the night to contact the attending doctor. On that day the patient complained his stomach felt like it was swelling. She noticed his arms were cold and clammy and his face was wet. When she was unable to contact the doctor, she insisted the nurse do so. The nurse reported to her that he could not reach Dr. Dannis. She wanted to remain with him, but was compelled by the security guard to leave. She then insisted that they get some doctor. When she returned to her home she called back to the nurses station to again try to locate the doctor or to have [\*\*22] the nurse do so, but was advised the doctor was out of town.

E.

Dr. Dannis complained that the patient was not able to carry on a normal conversation after the first day. Yet, the nurses seemed to have carried on normal conversations and recorded the events throughout the patient's stay at the Public Health Service Hospital. The mother, who visited him numerous times, testified that she saw no evidence of any mental condition and that her son carried on a normal conversation with her.

There is evidence that the plaintiff's decedent had made some previous use of drugs and that on an occasion some short while before the accident, he exhibited unusual behavior. There is also evidence that his conduct while at the Public Health Service Hospital was disruptive of other patients and that he was difficult to treat, and at times he may have been difficult to manage. Nurse Stainback described him as difficult to take care of, but not to control. Whether this situation was the result of a mental condition or from his lack of ability to tolerate the cast, his discomfort, or lack of attention is not clear, but this is of no real consequence on the issue of liability in this case.

F. [\*\*23]

Plaintiff says that the defendant failed to meet the standard of care in the community for similar patients; that no physical examinations were made of the patient by a physician after the first day of his admission; that no laboratory tests were run or other tests performed; that no proper review was made of the hospital chart; that no examination of any kind was made of the patient within 24 hours of his death and little or no examination for the last several days prior to his death; and that medication was prescribed without the making of examinations or even viewing the patient.

The record shows that Dr. Dannis prescribed medication to continue for a period of three months, six months or a year, all of which was contrary to the standard procedures of the Public Health Service Hospital. Dr. Hyatt said such prescriptions were contrary to their procedures and the only reason he could give for Dr. Dannis doing

this way, was the doctor's wish to avoid having to write a prescription again at the end of each week. He said Dr. Dannis objected to the standard procedures of the hospital and this was one of his personal traits of voicing his objection to the standing policies by writing [\*\*24] such prescriptions; and that he had [\*\*291] previously discussed the matter with Dr. Dannis. Dr. Hyatt said that their orders require that certain medicines would continue for only some few days and that when that time expired the nurses would not administer the medicine without a new prescription or new order. Where medication required the order of a doctor was to be given for a period longer than seven days, it would clearly appear writing a prescription for three months or more would be negligence, for he knew the nurse would cease giving the medicine at the end of the seven day period, and unless he issued a new order, the medication would not be administered.

G.

From the moment plaintiff's decedent was admitted to the Public Health Service Hospital, Dr. Dannis sought to have him removed to some other facility, first Staten Island and then Kecoughtan. He explained the delay in the transfer to Kecoughtan by saying someone was making an investigation to determine the patient's eligibility for that facility. There would seem to be two answers to this question. First, if he was not eligible for Kecoughtan, how could he have been eligible for Staten Island? Secondly, and [\*\*25] more important, delay in determining eligibility was pure negligence. All that was necessary to be done was to call the patient's mother, who had his certificate of eligibility and would have made it available. It appears Dr. Dannis' only concern was to transfer the patient to another facility, and thereby be relieved of the necessity of treating or caring for him.

H.

Defendant seeks to excuse its failure to cut holes in the cast so as to be able to examine the heart, lungs and portions of the stomach by suggesting that with the agitated condition of the patient, he might insert his hands in the holes and tear the cast off. The fallacy of such suggestion lies in the fact that a chest tube was in the patient's chest to permit drainage and a catheter was inserted in the patient to relieve his bladder. Surely, if cutting a hole in the cast posed a danger of his tearing the cast off, what prevented him from pulling out the drainage tube and the catheter? But even if this danger existed, there were ways to deal with it. The holes could have been closed after examination. It was much more important to keep the patient alive than to maintain the cast.

While defendant asserts much [\*\*26] time was required in treatment to keep the patient's bowels function-

ing, Dr. Loxley explained that it was much more important to devote time to the care of stomach; that keeping the bowels functioning was a matter of comfort, while care of the stomach was a matter of life or death.

The court finds there was negligence on the part of the defendant in the care and treatment, or rather there was gross lack of treatment and care of the patient, and that the degree of care, skill and diligence employed by defendant did not meet the standard required and that it was not the degree of care, skill and treatment employed by the ordinary and prudent practitioner in his field and community or in similar communities at the time, nor did it meet the standard of care required of specialists, here, orthopedic surgeons, in Virginia and the community or similar communities or of like specialists, orthopedic surgeons in the community or in similar communities. Liability is established against the defendant.

#### IV.

In fixing damages in a death action under the Act in Virginia, the trier of the facts is to fix such an award as "may seem fair and just," *Virginia Code 8.01-52*, taking into consideration [\*\*27] (a) sorrow, mental anguish and solace which may include society, companionship, comfort, guidance, kindly offices and advice of the decedent, (b) compensation for reasonably expected loss of income of the decedent, and services, protection, care and assistance provided by the decedent, (c) expenses for the care, treatment and hospitalization of the decedent incident to the injury resulting in death, and (d) reasonable funeral expenses. [\*\*292] As used in the statute, the terms "fair" and "just" are to be given broad and liberal construction. *Pugh v. Yearout*, 212 Va. 591, 186 S.E.2d 58, 61 (1972); *Eisenhower v. Jeter*, 205 Va. 159, 164, 135 S.E.2d 786, 789 (1964).

The monetary damages incurred in the hospitalization of Sawyer between the period of the accident and the time of his transfer to the Public Service Hospital are not shown. The funeral expenses amounted to \$2,044.96. The determination of the other items and elements of damages are more difficult.

Sawyer was 34 years old at the time of his death. He had an average life expectancy of 37.2 years. He had for some number of years been in the Merchant Marine. While his earnings were not shown by the evidence, the evidence [\*\*28] does show that from his earnings he made a monthly allotment to his mother for \$500.00 for her support. Shortly before his death, he became employed by Norfolk Shipbuilding, from which employment he was earning a basic rate of some \$4.73 per hour. For a 40 hour week he would earn \$189.20, or \$9,838.40 per annum. He was survived by his father, mother, two

brothers and two sisters. The family ties were described as close.

Under the broad language of the statute, "any 'pecuniary loss' suffered by the statutory beneficiaries is clearly a proper element of damage," *Gough v. Shaner, Admr.*, 197 Va. 572, 90 S.E.2d 171, 176, but in the later cases of *Pugh v. Yearout*, *supra*; *Denby v. Davis*, 212 Va. 836, 188 S.E.2d 226; and *Claar v. Culpepper*, 212 Va. 771, 188 S.E.2d 86, in dealing with the question of financial or pecuniary loss sustained by the defendants under the former statute, Virginia Code 8-636, the Court held that absent evidence of contribution or the monetary value of services rendered a dependent, there could be no award for loss of services.

Sawyer had been in his new employment for only a short period. Shortly before his accident, he moved from the home of his parents [\*\*29] to an apartment. There was some evidence he contemplated marriage. It would hardly be expected that he would have continued to contribute any substantial sum for the support of his father and mother. Actually, his earnings were not great, and after paying his living expenses, he would not have been able to give them much assistance. However, among other things to be considered are the loss of services, nurture and care, and other advantages and benefits of a pecuniary nature which will be lost in the future. *Gough, supra*; *Wilson v. Whittaker*, 207 Va. 1032, 154 S.E.2d 124; *Matthews v. Hicks*, 197 Va. 112, 87 S.E.2d 629; *Pugh v. Yearout, supra*.

Needless to say, loss of comfort, guidance and society, like sorrow, mental anguish and solace, are virtually incalculable except in a rough and gross manner. There is no measure of the love of or for a dear one. The only real comfort from sorrow and mental anguish is faith in God. Money is no substitute, and under our statute the amount which may be awarded is what "may seem fair and just." Such an award is not suggested or intended to be replacement of the loss sustained. It is the means provided by which the damaging party may make [\*\*30] some amends for the wrong done.

Damages in a death case where the measure is what is fair and just, like in personal injury actions, is to be determined from all of the facts and circumstances. As pointed out in *Sea-Land Services, Inc. v. Gaudet*, 414 U.S. 573, 590, 94 S. Ct. 806, 817, 39 L. Ed. 2d 9 (1974), damages for loss of society can be left to turn mainly upon the good sense and deliberate judgment of the trier, as "insistence on mathematical precision would be illusory," and the judge or jury must be allowed to make a reasonable approximation, guided by judgment and practical experience. It is enough if the evidence shows the extent of damages as a matter of a just and reasonable inference, although the result be only an approximation.



*Story Parchment Co. v. Paterson*, 282 U.S. 555, 563, 51 S. Ct. 248, 75 L. Ed. 544 (1931); *Great Coastal Express v. Int. Brotherhood of Teamsters, etc.*, 511 F.2d 839, 845 (4 Cir. 1975). The language in *Story*, *supra*, has been cited and adopted by the Fourth Circuit in *Kinty v. United Mine Workers of America*, 544 F.2d 706, 725 (4 Cir. 1976), *Great Coastal Express, Inc. v. International Brotherhood of Teamsters, etc.*, *supra*, and earlier [\*\*31] in *United Mine Workers v. Patton*, 211 F.2d 742 (4 Cir. 1954). In *Kinty*, *supra*, the court said, "The Court . . . must do the best it can in fixing fairly the damages due (the) plaintiff(s)." 544 F.2d 725. Likewise, the Supreme Court of Virginia in *United Bank of Fairfax v. Dick Herriman Ford, Inc.*, 215 Va. 373, 210 S.E.2d 158, 161 (1974), pointed out that a litigant is not required to prove his damages with precision.

Guided by the facts and circumstances of the case and the evidence presented, damages are awarded as follows:

(a) To the father and mother the sum of \$2,044.96 to cover the funeral expenses

(b) To David W. Sawyer and Lucy E. Sawyer, father and mother, jointly \$100,000.00.

Under the provisions of the Federal Tort Claims Act, the court must fix the fee to be allowed counsel out of said recovery. The court will reserve this issue until counsel and the court can confer. Counsel are requested to contact the court within ten days so that a proper judgment may be entered in this case.

LEXSTAT II-35 VIRGINIA MODEL JURY INSTRUCTIONS – CIVIL INST. NO 35.040

Virginia Model Jury Instructions – Civil

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Chapter 35 PROFESSIONAL LIABILITY

*II-35 Virginia Model Jury Instructions – Civil Inst. No 35.040*

**Inst. No 35.040 Medical Perfection Not Required**

**Inst. No. 35.040 Medical Perfection Not Required**

**The fact that a doctor's efforts on behalf of his patient were unsuccessful does not, by itself, establish negligence.**

**MEMORANDUM**

**STATUTE:** None.

**CASES:** *Hunter v. Burroughs*, 123 Va. 113, 96 S.E. 360 (1918) ; *Ropp v. Stevens*, 155 Va. 304, 154 S.E. 553 (1930) ; *Reed v. Church*, 175 Va. 284, 8 S.E.2d 285 (1940) ; *Vann v. Harden*, 187 Va. 555, 47 S.E.2d 314 (1948) .

**CAVEAT:** This instruction is not appropriate in those relatively rare cases where the plaintiff sues the doctor in contract.

**COMMENT:** This instruction is a specific variation for a malpractice case of the mere-happening-of-an-accident-is-not-negligence instruction or the defendant-is-not-an-insurer instruction. See Instruction Nos. 4.015, Fact of Accident is not Proof of Negligence, and 22.000, Duty of Care Owed to Passengers Generally. Both suffer from the same flaw: they repeat in somewhat more argumentative terms the fact that negligence is something that the plaintiff must prove. Nevertheless, both have a long history of acceptance.

28 of 29 DOCUMENTS

**LORETTA JONES MURRAY, EXECUTRIX and PERSONAL REPRESENTATIVE of  
the ESTATE OF WESTON MURRAY, Plaintiff, v. UNITED STATES OF AMERICA,  
Defendant.**

Civil Action No. 4:98CV41

**UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF VIRGINIA,  
NEWPORT NEWS DIVISION**

*36 F. Supp. 2d 713; 1999 U.S. Dist. LEXIS 2549*

**February 25, 1999, Decided  
February 25, 1999, Opinion Filed**

**DISPOSITION:** [\*\*1] Judgment in favor of Plaintiff in amount of \$267,282.23 including taxable Court costs on January 8, 1999 GRANTED.

**COUNSEL:** For Plaintiff: Larry W. Shelton, Esq., Shelton & Malone, P.C., Norfolk, VA.

For Defendant: Anita K. Henry, AUSA, U. S. Attorney's Office, Norfolk, VA.

**JUDGES:** HENRY COKE MORGAN, JR., UNITED STATES DISTRICT JUDGE.

**OPINIONBY:** HENRY COKE MORGAN, JR.

**OPINION:**

[\*714] **ORDER and OPINION**

This matter came before the Court on the Complaint ("Plaintiff's Complaint") filed by the Plaintiff, Loretta Jones Murray, Executrix and Personal Representative of the Estate of Weston Murray ("Mrs. Murray" or "Plaintiff"). The Plaintiff's Complaint alleged that the Defendant, the United States of America, through its agents, provided negligent medical care to the Plaintiff's husband, Weston Murray ("Mr. Murray"), and that such negligent medical care was the sole proximate cause of his death. After a bench trial, the Court **FOUND** the Defendant's negligent and **GRANTED** judgment in favor of the Plaintiff in the amount of \$267,282.23 including taxable Court costs, on January 8, 1999. This Opinion further explains the Court's reasoning.

**I. Procedural History**

Mrs. Murray filed [\*\*2] her Complaint on March 19, 1998, alleging that her cause of action arose under the

Federal Tort Claims Act, 28 U.S.C., § 2671, et seq., and that jurisdiction arose under 28 U.S.C., § 1346(b)(1). The Defendant filed its Answer on May 28, 1998, denying that its agents acted negligently and denying all liability. The Defendant's Answer did not contest the statutory basis for the claim or for this Court's jurisdiction. The Plaintiff filed a Motion to File an Amended Complaint on December 7, 1998, and this Court granted that Motion by Order entered December 18, 1998.

The Plaintiff's Amended Complaint ("Plaintiff's Complaint") alleged that McDonald Army Community Hospital ("McDonald") admitted Mr. Murray at approximately 1:03 a.m. on November 26, 1996, with complaints of vomiting and severe abdominal pain. After an examination and several diagnostic tests, Mr. Murray was released at approximately 2:45 a.m. with a diagnosis of a urinary tract infection. Mr. Murray collapsed while waiting for his wife to bring their car to the entrance of McDonald, and was subsequently readmitted. The Complaint alleges that at approximately 3:40 a.m. Mr. Murray collapsed a second time in the examining room. [\*\*3] At 3:55 a.m. Mr. Murray lost his pulse, and at 4:33 a.m. he was pronounced dead. The cause of death was later determined to be a ruptured right common iliac artery aneurysm ("ruptured iliac aneurysm").

The Plaintiff's Complaint alleges that Mr. Murray was critically ill when he entered McDonald and required immediate diagnosis and lifesaving surgery. The Complaint alleges that the Defendant's failure to correctly diagnose and surgically repair Mr. Murray's ruptured iliac aneurysm was the sole proximate cause of his death. The Plaintiff seeks funeral expenses, lost income, damages for sorrow and solace, and other damages provided by the Virginia Wrongful Death statute. On September 17, 1998, the Plaintiff filed an administrative claim for \$1,000,000 with the Department of the Army through the office of

the Staff Advocate, at Fort Eustis, Virginia, pursuant to 28 U.S.C., § 2675. The Defendant has not disputed that the Plaintiff filed the statutorily required administrative claim. The matter was set for bench trial before this Court to commence on January 6, 1992.

## [\*715] II. Pertinent Facts

### A. The Plaintiff's Evidence

Mrs. Murray married Mr. Murray in 1986. He had four [\*4] children from a previous marriage who were 23, 31, 36 and 39 years old, respectively. Mr. Murray was retired from the military in 1996 and received a monthly pension check for \$1262.00. He also worked as a waiter at the George Washington Inn in Colonial Williamsburg for thirty hours a week and was paid roughly \$625.00 per month for that work. She testified that on several occasions he had discussed with her his plan to work as a waiter for another ten years, until he was seventy years old. Mrs. Murray further testified that she and her husband had opened a thrift store named "The Matchbox" in September of 1996.

On November 25, 1996, Mrs. Murray stated that Mr. Murray closed the Matchbox and arrived at their home around 8 p.m. He told her that he was suffering from a great deal of abdominal pain, and informed her of his intention to lay down. Around midnight, Mr. Murray told his wife that his pain had not subsided, he had been vomiting, and that he needed to go to the hospital. They arrived at McDonald some time around 1:00 a.m. and entered its Urgent Care Center. At McDonald, Mrs. Murray stated that Dr. James Hendricks ("Dr. Hendricks"), who was on duty that night in the Urgent [\*5] Care Center, examined her husband. According to Mrs. Murray, Mr. Murray told Dr. Hendricks that "it feels like a hernia, like something is popping in my stomach." Her husband made this same complaint in her presence at least three times to various members of the McDonald staff. She was not present the entire time her husband was being examined. Dr. Hendricks ordered several diagnostic tests and subsequently informed Mr. Murray, in her presence, that he had a urinary tract infection. Mr. Murray questioned Dr. Hendricks about that diagnosis, stating that he had never heard of a man having a urinary tract infection. Dr. Hendricks responded by saying that men could suffer from urinary tract infections. Before his release, Mr. Murray also asked Dr. Hendricks for some medication to relieve his pain.

The Urgent Care Center released Mr. Murray at approximately 2:45 a.m., and Mrs. Murray and her husband walked to the door where he asked her to bring the car around while he waited. However, before Mr. Murray could enter the car, he collapsed and Mrs. Murray rushed

into McDonald to find assistance. Mr. Murray was then readmitted, and then collapsed a second time in the examining room at 3:40 [\*6] a.m. After attempts to resuscitate Mr. Murray were unsuccessful, he was pronounced dead at 4:33 a.m. Mrs. Murray was then told by the McDonald staff that her husband had died of a heart irregularity.

In December of 1997, Mrs. Murray qualified as executrix of Weston Murray's estate. She testified that she incurred funeral expenses totaling \$8,397.43. She also stated that Mr. Murray's youngest daughter, Martina, was still in college when he died. In addition to providing financial support for her, Mr. Murray also provided financial support for all of his older children when they needed it. Mrs. Murray described her husband as a kind, loving man, with whom she had a very close and interdependent relationship.

Two of Mr. Murray's children testified, Michelle Parry ("Michelle"), 39, and Monica Spry ("Monica"), 32. Michelle stated that she lives in Newport News, Virginia, near her father. Michelle stated that she was divorced and that her father's assistance with her children had been very important. According to Michelle, Mr. Murray's sudden death had a significant impact on all of his children and grandchildren. Monica testified that she also lives in Newport News and has two children [\*7] with whom Mr. Murray was very close and saw on regular basis. Monica further stated that her father had financially supported Martina, his youngest daughter, and had a close relationship with all of his children. She concluded by describing the significant impact Mr. Murray's death had had on all of his children, especially his son.

The Plaintiff's other witnesses included Dr. Phillip Leavy, an emergency room physician and expert witness ("Dr. Leavy"), Captain Jimmy Green, M.D., staff pathologist at the Portsmouth Naval Medical Center [\*716] ("Capt. Green"), and Dr. Earl Strahorn ("Dr. Strahorn"), a vascular surgeon and expert witness.

The Court **FINDS** that a CT-Scan is the generally accepted tool through which isolated common iliac aneurysms are diagnosed. It is undisputed that Mr. Murray's cause of death was this form of aneurysm. While the defendant did not formally admit negligence, it directed its efforts primarily toward the proximate cause issue, contending that by the time of his presentment to the clinic, allowing a reasonable time for attempted diagnosis, it was already too late to save his life.

The Court **FINDS** that the diagnosis of urinary tract infection was unsupported [\*8] by the medical evidence, and the lack of an accurate diagnosis compelled the clinic physician to arrange an emergency CT-Scan. The Court **FINDS** that the CT-Scan should have revealed the

aneurysm and established the need for immediate surgery to save Mr. Murray's life.

Dr. Leavy testified that he was board certified as an emergency room physician in 1980, that he practiced with the Emergency Room Physicians of Tidewater, and that he had been chairman of a peer review committee. That committee reviewed and counseled emergency rooms and their physicians at over twenty hospitals throughout the Commonwealth of Virginia. Furthermore, the committee had set the standards for the different levels of emergency room care. Dr. Leavy described Riverside Regional Medical Center in Newport News as a level two trauma center. According to Dr. Leavy, level two trauma centers are required to have doctors on-call who can arrive within fifteen to twenty minutes and have CT-Scan technicians in-house twenty-four hours a day. Dr. Leavy stated that he was very familiar with the standard of care required of emergency room physicians and this standard applied to physicians serving urgent care centers. [\*\*9]

Dr. Leavy testified that he had reviewed the medical records of Mr. Murray's visits to McDonald on November 26, 1996. Based on those records and his own expertise, Dr. Leavy stated that it was his opinion that Dr. Hendricks' diagnosis and treatment of Mr. Murray fell well below the standard of care applicable to emergency room physicians. He further stated that in his expert opinion, Dr. Hendricks made the following mistakes in diagnosing and treating Mr. Murray: (1) he failed to do a complete physical exam, (2) he failed to properly evaluate the lab results, which clearly did not indicate a diagnosis of urinary tract infection, (3) he improperly evaluated the X-rays failing to notice the obscuring of the psoas muscle, (4) he failed to test for blood in the stool, (5) he failed to palpate the femoral artery which could have discovered the ruptured iliac aneurysm, (6) he failed to consider that vomiting is not a symptom of a urinary tract infection, and (7) he failed to refer Mr. Murray to another hospital for further diagnostic tests, specifically a CT-Scan, which would have indicated the ruptured iliac aneurysm.

Dr. Leavy stated that a proper reading of the lab results accompanied [\*\*10] by a more complete physical exam would have led to the conclusion that the cause of the pain was unknown and that further diagnostic tests were necessary. Furthermore, those diagnostic tests would necessarily have included a CT-Scan, and possibly an ultrasound, both of which would have required transferring Mr. Murray to another hospital. That second hospital also could have performed the surgery necessary to save Mr. Murray's life. Dr. Leavy concluded his evaluation of the record by opining that Mr. Murray would have survived if he had received the necessary emergency surgery before the aneurysm ruptured causing the loss of pulse, and that

in his experience under these circumstances Mr. Murray had an 80 percent survival rate. Dr. Leavy conceded that abdominal pain is very common in emergency rooms. He stated that the iliac aneurysm is the second most common type of aneurysm, but that most iliac aneurysms are accompanied by an aortic aneurysm. Thus, isolated iliac aneurysms are not common.

Captain Jimmy Green ("Capt. Green"), M.D., has been the staff pathologist at the Portsmouth Naval Medical Center since 1992, and performed Mr. Murray's autopsy on November 29, 1996, at 0900 hours. [\*\*11] Capt. Green determined that the cause of death was a ruptured common iliac aneurysm. He [\*\*17] further testified that Mr. Murray's aneurysm was relatively large and measured 5.5 centimeters by 4.0 centimeters by 3.5 centimeters, or roughly 77 cubic centimeters. He explained that arteriosclerosis, or fatty deposits in the artery, cause aneurysms. Capt. Green also testified that during the autopsy that he could not palpate the aneurysm, and noted that Mr. Murray was 5' 6" tall and weighed about 240 lbs. Capt. Green testified that the Portsmouth Naval Medical Center normally does two autopsy reports: an initial report after two to three days and a final report after the toxicology test results are received. In Mr. Murray's case three autopsy reports were completed, including one done by outside consultants. All three reports revealed the same cause of death. Finally, Capt. Green testified that he could not opine whether Mr. Murray's aneurysm could have been palpated while he was alive.

Dr. Strahorn, a vascular surgeon who practices in Norfolk, Virginia, testified that he had reviewed both Mr. Murray's medical records and his X-rays. Dr. Strahorn stated that in his expert opinion Mr. Murray [\*\*12] was a good candidate for lifesaving surgery up until approximately 3:45 a.m. He explained that a preliminary reading from a CT-Scan would have indicated the common iliac aneurysm, and that in his opinion, a surgical resident could have clamped the artery in the event of a rupture immediately proceeding surgery. He stated that Mr. Murray had a seventy percent chance of survival if the surgery began while his artery was merely leaking, before it had fully ruptured. Finally, Dr. Strahorn suggested reasonable times for the various steps involved in a diagnosis and surgical repair of Mr. Murray's iliac aneurysm. First, the CT-Scan would require no more than ten to 15 minutes, because he believes the technician should zoom in on the abdomen once the large abnormality was noticed. Second, surgery preparation requires five to ten minutes, and third, Dr. Strahorn could have clamped the artery in six minutes. After the artery is clamped, a vascular surgeon has one hour within which to repair the artery.

## **B. The Defendant's Evidence**

The Defendant's witnesses included Dr. James Hendricks, Mr. Murray's treating physician, Dr. William Horstman, a radiologist who works at Leigh Memorial Hospital, [\*\*13] Ronald K. Battle, a CT Technician at Mary Immaculate Hospital ("Mary Immaculate"), Paula Burcher, the director of radiological services at Riverside Regional Medical Center ("Riverside"), Dr. Michael Bono an Emergency Room Physician, Dr. Fernd Parent, a vascular surgeon, Dr. Kendall Mann, who was working in McDonald on November 26, 1996, Carol Van, a Registered Nurse at McDonald, Joyce Raynor, who was working at McDonald on November 26, 1996, and Lewis Valcott an EMT at the Urgent Care Center at McDonald. The first witness was Dr. James Hendricks, Mr. Murray's treating physician at McDonald on November 26, 1999. Dr. Hendricks is currently stationed at Fort Bragg in North Carolina and obtained his degree from the Philadelphia College of Osteopathy. In November 1996, Dr. Hendricks was stationed at Fort Eustis and was in his second year of residency.

Dr. Hendricks was the only physician on duty in the Urgent Care Center at McDonald in the early hours of the morning on November 26, 1996. He stated that he had ordered CT-Scans before and had experience performing abdominal exams. After examining Mr. Murray's medical records from that evening, portions of which he had prepared, Dr. Hendricks [\*\*14] stated that a triage nurse first examined Mr. Murray at 1:05 a.m. on November 26, 1996. Dr. Hendricks first saw Mr. Murray at 1:15 a.m., and at 1:50 a.m., he ordered several diagnostic tests, including a blood work-up, urinalysis, and X-rays. Sometime after 2:10 a.m. he saw Mr. Murray a second time, and around 2:35 a.m. he diagnosed Mr. Murray's condition as a urinary tract infection. Dr. Hendricks prescribed an antibiotic and pain medication, and discharged Mr. Murray at 2:45 a.m.

Dr. Hendricks, using Mr. Murray's medical report as a reference, described Mr. Murray's pain as a "dull ache which flared up every so often," but stated that there was no acute distress. The medical report did not list Mr. Murray's height and weight. Dr. [\*\*718] Hendricks explained that his urinary tract infection diagnosis was based on the location and quality of Mr. Murray's pain, his elevated white blood cell count, and his slightly elevated blood sugar count. He stated that he saw no reason to suspect a vascular problem during Mr. Murray's first presentation. After the second presentation, Mr. Murray was put on a heart monitor at 3:05 a.m. and lost his pulse at 3:55 a.m. After attempting to revive Mr. Murray [\*\*15] for thirty-eight minutes, he was pronounced dead at 4:33 a.m., on November 26, 1996.

Dr. Hendricks could not recall whether Mr. Murray

described his pain as "feeling like a hernia," or whether Mr. Murray described his pain as severe. He did state that the Mr. Murray's pain appeared to be fluctuating. Furthermore, Dr. Hendricks indicated that he had done a lower extremity exam but could not remember whether he palpated the femoral artery. However, he did not do a peripheral exam in the arteries in the feet. Dr. Hendricks stated that he had no suspicion of an iliac aneurysm and admitted that he was unsure at that time what was wrong with Mr. Murray. Dr. Hendricks had referred patients for a CT-Scans at Langley Hospital, and was aware of McDonald's protocol for the transfer of a patient to a facility with a higher level of care. He does recall Mr. Murray asking for pain medication before his discharge at 2:45 a.m. and recalls that Mr. Murray's pain was worse during the second presentation. Dr. Hendricks persisted in his urinary tract infection diagnosis until Mr. Murray's collapse at 3:40 a.m..

The Defendant's next witness was Dr. William Horstman, a radiologist who is the Chairman [\*\*16] of Radiology at Eastern Virginia Medical School. Dr. Horstman spends almost 50 percent of his work day reviewing CT-Scans and 30 to 40 percent of his day reviewing X-rays. He testified that the psoas muscle is obscured to some degree in 45 percent of patients. Furthermore, Dr. Horstman stated that the obscuring of the psoas may be caused by pathological reasons or it may not, and thus, he disagreed with Dr. Leavy's statement that the obscuring of Mr. Murray's psoas muscle was diagnostically significant. In his opinion, Mr. Murray's X-ray appears normal, despite the obscuring of the psoas muscle. A CT Technician can complete a CT-Scan by himself in ten to 15 minutes, and when a radiologist is on staff, the CT-Scan can be completed and interpreted in 15 to 20 minutes. However, if the CT-Scan were concentrated on the abdominal area it would take only five to ten minutes. When a radiologist is merely on call, the results of the CT-Scan can be transmitted to his or her home in several minutes. Dr. Horstman described the CT-Scan as an excellent tool for diagnosing large abdominal aneurysms and added that Mr. Murray's common iliac aneurysm would have been immediately apparent to either a [\*\*17] CT technician or a radiologist viewing the CT-Scan image.

Ronald K. Battle ("Battle") has been a CT Technician at Mary Immaculate for ten years. He testified that a non-emergency abdominal CT-Scan takes twenty minutes, and that the on-call radiologists are available twenty-four hours a day to receive CT-Scan images over the phone lines. Mary Immaculate can convey those images in thirty seconds to a radiologist, and such a radiologist would be the first person that Battle would contact. Battle also stated no CT Technician was on duty in Mary Immaculate Hospital on November 26, 1996, between

the hours of one and four in the morning. However, a CT Technician was on call and had thirty minutes to arrive at Mar Immaculate once contacted. Battle testified that he usually arrived at Mary Immaculate Hospital in fifteen to twenty minutes, and that he could diagnose an aneurysm.

Paula Burcher ("Burcher") is the Director of Radiological Services at Riverside and has managed the CT-Scan department there for twenty years. She stated that in her experience a CT-Scan took thirty minutes to complete, and seven minutes to transmit in 1996. Burcher further testified that at Riverside and all level [\*\*18] 2 trauma centers CT Technicians and physicians had twenty minutes to respond to acute traumas when they are on-call. On November 26, 1996, Dr. John Wirth was the general surgeon on-call, and Dr. Hop Graham was the vascular surgeon on-call. Burcher was not sure if the general surgeon, the vascular surgeon or the radiologist were [\*\*19] on the premises in the early hours of the morning on November 26, 1996. Furthermore, she stated that the CT Technician on-call on November 26, 1996 lived seven miles away, and that a CT Technician could arrive at Riverside at the same time as an emergency patient referral from another hospital.

Dr. Michael Bono ("Dr. Bono") testified as the Defendant's expert emergency room physician and practices at the Emergency Physicians of Tidewater with Plaintiff's expert, Dr. Leavy. Dr. Bono practices emergency medicine at six hospitals in the Tidewater, Virginia area and lectures at the Eastern Virginia Medical School in Norfolk, Virginia. He stated that it is generally difficult to diagnose aneurysms, and that it is exceptionally difficult to diagnose isolated iliac aneurysms. Dr. Bono stated that he had only seen one isolated iliac aneurysm in fourteen years, but [\*\*19] added that CT-Scans are 95% accurate in diagnosing such aneurysms. He further testified that he had never heard of a diagnosis based upon palpating an iliac aneurysm. Dr. Bono stated that he had reviewed Mr. Murray's medical records, including his X-rays, and that he believed it very unlikely that he could have diagnosed Mr. Murray's aneurysm during the initial presentation. He also stated that Mr. Murray lacked the classic symptoms of an aneurysm, such as abdominal pain, low blood pressure, and a pulsatile abdominal mass.

Dr. Bono further testified that Dr. Hendricks' physical exam was insufficiently documented, and that Dr. Hendricks should have done more thorough abdominal, extremity and genital exams. He also stated that he did not believe that Dr. Hendricks' incomplete physical exam impacted his ability to diagnose Mr. Murray's iliac aneurysm. Dr. Bono further concluded that there was no negligent delay in the treatment and diagnosis of Mr. Murray during his first presentation. Regarding the sec-

ond presentation, Dr. Bono testified that Dr. Hendricks did violate the applicable standard of care during his treatment and diagnosis of Mr. Murray. That conclusion was based on the following [\*\*20] facts: (1) Mr. Murray's pain was continuing and had intensified, (2) the urinary tract diagnosis was unsupported by the urinalysis and other lab results, and (3) therefore, Mr. Murray required further diagnostic tests, specifically a CT-Scan.

Dr. Fernd Parent ("Dr. Parent"), the Defendant's vascular surgeon, stated that he became board certified in general surgery in 1989 and in vascular surgery in 1991, and lectures four to six times a year at Eastern Virginia Medical School in Norfolk. Dr. Parent stated that he had published an article in the medical journal, *Vascular Surgery*, entitled "Aortic and Iliac Aneurysms." Dr. Parent described an aneurysm as the unusual enlargement of a blood vessel such that the affected vessel becomes at least twice its normal size. He described the location of the two iliac arteries, stating that they begin at the base of the aorta and proceed into the pelvis, each one moving towards a different leg. The iliac arteries end where the femoral arteries begin. Dr. Parent testified based on his experience and his review of the literature on iliac aneurysms, that they occur 90 percent of the time in conjunction with aortic aneurysms, and thus, an isolated [\*\*21] iliac aneurysm, such as Mr. Murray's, occurs only ten percent of the time.

The only treatment for a bleeding aneurysm, defined as one that has ruptured and has begun leaking blood into the tissue surrounding the vessel, is emergency surgery to repair the vessel. Dr. Parent stated that when an individual begins to feel pain associated with an aneurysm, that the pain indicates two things. First, that the aneurysm is enlarging, and second, that the aneurysm has begun leaking and distending adjacent tissue. Most iliac aneurysms are discovered during a CT-Scan directed to undiagnosed pain or discomfort. The most common symptoms of an iliac aneurysm are pain and, after enough blood has been lost, low blood pressure. In Dr. Parent's opinion an isolated iliac aneurysm cannot be diagnosed by palpations because the iliac arteries are located deep within the pelvis. Furthermore, he does not see how Dr. Hendricks could have diagnosed Mr. Murray's iliac aneurysm because his symptoms were nausea, vomiting, pain, and blood pressure within the normal range. Dr. Parent also testified that he did not believe palpating the femoral and foot pulses would [\*\*22] have aided the diagnosis of Mr. Murray's iliac [\*\*22] aneurysm. However, he admitted that a preliminary diagnosis of a potential abdominal or pelvic hemorrhagic catastrophe could have been made during Mr. Murray's first presentation.

However, Dr. Parent admitted that it is quite possible

that Mr. Murray's femoral pulse could have been weakened by the iliac aneurysm. He also testified that Dr. Hendricks incorrectly diagnosed a urinary tract infection when the lab results did not support it, that such a misdiagnosis was "indefensible," and that because the lab results did not support any diagnosis, more diagnostic tests were necessary, specifically a CT-Scan. Therefore, Dr. Parent concluded that Dr. Hendricks should have recommended a transfer for a CT-Scan at 2:00 a.m., when the lab results returned and indicated no specific cause for Mr. Murray's pain. According to Dr. Parents, Mr. Murray's life could have been saved by surgery and a clamping of the artery up until the time he collapsed in the examining room at 3:40 a.m. Dr. Parent testified that it took him five minutes to prep for surgery, and six minutes to clamp Mr. Murray's iliac aneurysm. He also stated that the iliac aneurysm would have been readily apparent to either a radiologist [\*\*23] or a CT Technician on a CT-Scan image because of its size.

Dr. Kendall Mann ("Dr. Mann") was working as the staff intern at McDonald on November 26, 1996, and participated in the attempt to resuscitate Mr. Murray. He testified that he received a page and reported to the Urgent Care Center in McDonald about 4:25 a.m. Dr. Mann then assumed responsibility for the attempt to resuscitate Mr. Murray, which had been ongoing for thirty minutes. At 4:33 a.m., Dr. Mann stopped life support and declared the time of death. Dr. Mann stated that there were no surgeons assigned to McDonald on November 26, 1996, and that he had referred and transferred patients to both Mary Immaculate and Riverside for CT-Scans in both emergency and routine situations. In an emergency situation, Dr. Mann stated that the treating physician would call one of those two hospitals and speak with an emergency room physician. Once the transfer was arranged and the necessary paperwork completed, the patient would be transferred by ambulance to the receiving hospital. The whole process took thirty minutes to sixty minutes.

Carol Van, a registered nurse, testified that she has been the head nurse at the McDonald Urgent Care [\*\*24] Center for two years, and that she had worked at the Center for four years. She stated that she had participated in the transfer of patients from McDonald to other facilities for CT-Scans between 60 and 80 times in her four years there. She admitted, however, that only one of those was an early morning transfer, such as Mr. Murray required. Van also stated that once the physician from McDonald has spoken to the physician from the receiving hospital that the transfer takes between 30 and 60 minutes. In her opinion and experience, the most important factor in a transfer is to stabilize the patient. Mr. Murray was stable until his collapse at 3:40 a.m.

Joyce Raynor testified that she works in MacDonald's Prime 1, but that she never examined or treated Mr. Murray. Lewis Valcort ("Vaclort") stated that he is employed at the McDonald Urgent Care Center as an Emergency Medical Technician and was so employed on the night of November 26, 1996. His job includes transferring patients by ambulance to other facilities. Valcort remembered meeting Mr. Murray, and took his vital signs after his collapse in the examining room at 3:40 a.m. After the collapse Valcort believes it would have required [\*\*25] ten minutes to move Mr. Murray to the ambulance for transfer because he was thrashing about. However, while Mr. Murray was stable, placing him in the ambulance would have taken less than five minutes. Valcort also provided testimony on the travel time from McDonald to Riverside, stating that it took ten to fifteen minutes with flashing lights and twenty minutes without lights; and that it took five to ten minutes with lights and ten to fifteen minutes without lights to drive to Mary Immaculate.

### III. The Applicable Standard of Medical Care

The applicable standard of care for an emergency room physician in the treatment [\*\*721] and diagnosis of a presenting patient is the same as that for an urgent care center in Virginia. The Defendant does not dispute that standard of care, and both the Plaintiff's and Defendant's expert witnesses agreed with this standard of care.

#### Analysis

The applicable standard of medical care, as set forth by the Virginia Supreme Court, is that:

[a] physician holds himself out as possessing the knowledge and ability necessary to the effective practice of medicine.\* \* \* However, he is not an insurer, nor is he held to the highest degree [\*\*26] of care known to his profession. \* \* \* He must exhibit only that degree of skill and diligence employed by the ordinary, prudent practitioner in his field and community, or in similar communities, at the time.

*Reed v. Church*, 175 Va. 284, 292, 293, 8 S.E.2d 285, 288 (1940). Accord *Easterling v. Walton*, 208 Va. 214, 218, 156 S.E.2d 787, 790 (1967). Therefore, the Court **FINDS** that the standard it must employ in determining whether or not the Defendant was negligent is did the Urgent Care Center physician exhibit the degree of skill and diligence employed by the ordinary, prudent emergency room practitioner in his community.



#### IV. The Test for Proximate Cause under Virginia Law

Once a party establishes the physician's negligence in diagnosis or treatment, the applicable test for proximate cause is whether that negligence destroyed a substantial possibility of the decedent's survival from the condition misdiagnosed or mistreated. *Whitfield v. Whittaker*, 210 Va. 176, 184, 169 S.E.2d 563, 568 (1969). *Bryan v. Burt*, 254 Va. 28, 486 S.E.2d 536 (1997), and *Poliquin v. Daniels*, 254 Va. 51, 486 S.E.2d 530 (1997), reaffirm the Virginia Supreme Court's decision [\*\*27] in *Whitfield*. *Blondel v. Hays*, 241 Va. 467, 403 S.E.2d 340 (1991), which held that the substantial possibility of survival standard is the proper one for a motion to strike, but that it is not a proper instruction for the jury, may be distinguished. The Virginia Supreme Court did not cite *Blondel* in its more recent opinions of *Bryan* or *Poliquin*, and this supports a finding that *Blondel* does not set forth the standard to be applied by the finder of fact.

#### Analysis

The Virginia Supreme Court stated in *Whitfield* that:

when a physician's or surgeon's negligent action or inaction has effectively terminated a person's chance of survival, he will not be permitted to raise conjectures as to possible chances for survival that he has put beyond realization. If there was any substantial possibility of survival and the defendant has destroyed it, he is answerable. Rarely is it possible to demonstrate to an absolute certainty what would have happened if certain actions had been taken. The law does not in all circumstances require a plaintiff to show to a certainty that a patient would have lived had he been operated on promptly.

210 Va. at [\*\*28] 184, 169 S.E.2d at 568-69 (citing *Hicks v. United States*, 368 F.2d 626, 632 (1966) (citations omitted)). In *Brown v. Koulizakis*, the Virginia Supreme Court reaffirmed *Whitfield*, relying upon that case for the proposition that in a medical malpractice case involving wrongful death, proof that the defendant physician has destroyed a substantial possibility of the patient's survival becomes the proximate cause of the patient's death. 229 Va. 524, 532, 331 S.E.2d 440, 446 (1985) (citing *Whitfield*, 210 Va. at 184, 169 S.E.2d at 568-69). The *Brown* Court went on to hold that the plaintiff had presented sufficient evidence of negligence and proximate cause to carry both issues to the jury, and that the jury could have found that the inaction of the defendant doctor had deprived the plaintiff of a substantial possibility of survival. *Id.* In *Hadeed v. Medic-24, Ltd.*, the Virginia Supreme Court held that the

defendant doctors failure to correctly diagnose the plaintiff decedent's severe coronary artery disease destroyed any substantial possibility that the plaintiff would survive. 237 Va. 277, 286-87, 377 S.E.2d 589, 594 (1989). The Hadeed Court stated that the [\*\*29] jury could have found that the plaintiff had a eighty-five to ninety percent chance to live to age seventy [\*\*722] if he had undergone bypass surgery and that with only medical therapy he had a fifty percent chance of living to age sixty. *Id.* at 287, 377 S.E.2d at 594.

In *Blondel v. Hays*, the Virginia Supreme Court held that it was proper for a trial judge to decline to instruct the jury that if they believe the defendant destroyed a substantial possibility of survival that they should find the defendant liable. 241 Va. at 473-74, 403 S.E.2d at 344. The Court further stated that the Court should employ the substantial possibility of survival test to determine whether or not there exists sufficient evidence to submit the case to the jury, but that the jury's function is the same in a medical malpractice case as in any other tort action: to decide the issues of negligence, proximate cause and damages. *Id.* at 474, 403 S.E.2d at 344. A United States District Court in 1992 stated that the substantial possibility of survival theory did not provide a separate cause of action in a wrongful death action with diverse parties. *Dolwick v. Leech*, 800 F. Supp. 321, 327 (1992).

Less than [\*\*30] two years ago the Supreme Court of Virginia held in *Poliquin v. Daniels* that where the Plaintiff's experts testified that if the defendants had known what they should have known about the plaintiff decedent's condition prior to surgery, and employed the appropriate procedures during surgery, that the decedent would have survived the surgery, the issue of proximate cause was properly submitted to the jury. 486 S.E.2d at 534. The Court cited *Whitfield* for the proposition that a defendant's action or inaction which has destroyed any substantial possibility of survival is a proximate cause of the patient's death. *Id.* The *Poliquin* Court also cited *Bryan*, which was decided the same day and also relied upon the standard set forth in *Whitfield* that evidence of the destruction of a substantial possibility of survival is proof of proximate cause. 486 S.E.2d at 534. In *Bryan* the Court upheld the trial court's decision to strike the plaintiff's evidence because she had failed to present any evidence of a course of treatment that could have increased her chance of survival from the date of the defendant's negligence. *Id.* 486 S.E.2d at 540. Neither *Poliquin* nor *Bryan* [\*\*31] cited *Blondel*.

The Court does not accept the proposition that under Virginia Law there are two tests which it must apply, one upon a motion for judgment as a matter of law in federal court, and another in its capacity as a finder of fact.

The cases relied upon hold that if the plaintiff meets the substantial possibility of survival test, than the plaintiff has also met the general proximate cause test. Therefore, the Court **FINDS** that the proximate cause test which it must apply to the facts in this case is did the negligence of the Urgent Care Center physician deprive the Plaintiff of a substantial possibility of surviving the aneurysm. The Virginia Supreme Court has not defined substantial in this context, and therefore, the Court looks to the plain meaning of the word. Webster's Third New International Dictionary defines substantial as "not seeming or imaginary, not illusive, real or true."

#### V. The Application of the Law to the Facts

The Court **FINDS** that the Defendant's negligence, through its agent Dr. Hendricks, destroyed a substantial possibility of Mr. Murray's survival of the aneurysm on November 26, 1996. Dr. Hendricks examination of Mr. Murray [\*\*32] was incomplete, and further, his diagnosis of a urinary tract infection was unsupported by any of Mr. Murray's test results. Dr. Hendricks misdiagnosis and failure to order further diagnostic tests, specifically a CT-Scan, destroyed a substantial possibility of Mr. Murray receiving the lifesaving surgery he required.

The Defendant tacitly, if not directly, conceded that Dr. Hendricks was negligent, but argued that even if Dr. Hendricks had not been negligent that there was not sufficient time available to save Mr. Murray by transferring him to either Mary Immaculate or Riverside, performing a CT-Scan, reading the results, preparing him for surgery, and performing that surgery. Therefore, the Defendant contends that Dr. Hendricks' negligence did not destroy a substantial possibility of Mr. Murray's survival because he did not have a substantial possibility of survival when he presented at McDonald.

[\*723] Both Dr. Leavy and Dr. Bono testified (1) that Dr. Hendricks medical record of Mr. Murray from November 26, 1996 was incomplete, (2) that Dr. Hendricks physical exam was incomplete and inadequate, and (3) that the laboratory results did not support Dr. Hendricks diagnosis that Mr. Murray [\*\*33] had a urinary tract infection. Furthermore, both Dr. Leavy and Dr. Bono stated that a CT-Scan was necessary because Dr. Hendricks should have recognized that he did not have a diagnosis for Mr. Murray's complaints. Dr. Bono, the Defendant's emergency room physician, testified that he probably would have ordered a CT-Scan for Mr. Murray within thirty minutes of having first seen him. Dr. Parent, the Defendant's vascular surgeon, described the error of a misdiagnosis in this case by Dr. Hendricks as "indefensible." Therefore, the Court **FINDS** that the Defendant, through its agent, Dr., Hendricks, was negligent in its di-

agnosis and treatment of Mr. Murray on November 26, 1996.

To establish liability, however, the Plaintiff must also establish that the Defendant's negligence destroyed a substantial possibility that Mr. Murray would have survived his iliac aneurysm, and thus, that Dr. Hendricks' negligence proximately caused Mr. Murray's death. The Court **FINDS** that the preponderance of the evidence establishes that Mr. Murray would have survived if he had arrived in an operating room ready for surgery prior to 3:55 a.m., when he lost his pulse.

Therefore, the issue that remains [\*\*34] is whether Mr. Murray reasonably could have arrived in an operating room prior to 3:55 a.m., absent the Defendant's negligence. The Court **FINDS** that the time estimates for the various procedures necessary to transfer, diagnose, and perform a CT-Scan and surgery upon Mr. Murray were inconclusive. The evidence is also not clear regarding the specific time when Dr. Hendricks should have ordered a CT-Scan, and part of the reason for this lack of clarity is the insufficient medical record prepared by Dr. Hendricks on November 26, 1996. The Court **FINDS** that Dr. Hendricks should have ordered a CT-Scan no later than 2:00 a.m. Based on all of the evidence before the Court, the Court **FINDS** that neither side has proven by a preponderance of the evidence whether or not the decedent could have secured life saving surgery by 3:55 a.m. Accordingly, the Court **FINDS** that the Plaintiff has not proven by a preponderance of the evidence that it is more probable than not that Mr. Murray would have survived. However, the Virginia law does not require that the Plaintiff prove it is more probable than not that he would have survived the aneurysm. The Court **FINDS** that Mr. Murray [\*\*35] possibly could have obtained life saving surgery, and his possibility of survival in these circumstances was between thirty and sixty percent. The Court arrives at these percentages by combining the percentage survival rate with the possibility of obtaining surgery in the available time frame. The Court **FINDS** that thirty to sixty percent constitutes a substantial possibility that Mr. Murray could have obtained life saving surgery. Accordingly, the Court **FINDS** that the Plaintiff has proven that the Defendant's negligence was a proximate cause of the decedent's death. The final issue before the Court is the determination of the Plaintiff's damages.

#### V. Damages

The evidence regarding Mr. Murray's monthly earnings and his funeral expenses was undisputed. The life expectancy tables set forth in the Virginia Code establish that the decedent would have lived until age 78. Based upon that life expectancy the Court requested that

the parties seek an agreement as to the pecuniary loss. The parties calculations agree that the pecuniary loss is \$83,444.30, which represents the decedent's pension and projected earnings to age seventy discounted by two (2) percent value and [\*\*36] divided by one-half (1/2). n1 The evidence also established that Mr. Murray and Mrs. Murray had a happy marriage, and that Mr. Murray played an integral and vital role in the lives of his children. The Defendant did not present any expert evidence from which [\*\*724] the Court could find that the decedent had a diminished life expectancy, and therefore, the Court **FINDS** that the Virginia life expectancy tables are applicable. The Court further **FINDS** that the Mr. Murray's life expectancy was 78 years at the time of his death.

n1 The parties agreement to these computations is without prejudice to their positions regarding other damages and without prejudice to the Government's position regarding its liability.

Next, the Court must determine the amount of the three types of recoverable damages in a wrongful death suit: (1) funeral and burial expenses, (2) pecuniary damages, including lost income to beneficiaries, and (3) non-pecuniary damages, including damages for loss of services, solace, and comfort. The Court [\*\*37] **FINDS** that the Plaintiff incurred \$8,397.43 in funeral expenses. Second, the Court **FINDS** that Loretta Jones Murray is entitled to recover \$83,444.30 in pecuniary losses from the Defendant. n2 Third, the Court **AWARDS** the Plaintiff Court costs of \$440.50.

n2 First, although the Plaintiff presented some evidence that Mr. Murray had provided irregular financial support for his adult children, insufficient evidence of any quantifiable amount of support was presented. Therefore, the Court has not awarded any pecuniary losses to the Plaintiff's children.

Second, the Plaintiff presented insufficient evidence regarding the viability or potential profitability of Mr. and Mrs. Murray's thrift store, "The Matchbox," and did not argue for damages related to the fact that Mrs. Murray had to close the business after her husband's death. Therefore, the Court

has not awarded any pecuniary losses from the closing of "The Matchbox."

Fourth, the Court must decide the amount of non-pecuniary loss incurred by [\*\*38] the decedent's wife and children. First, as a 60 year old man, Mr. Murray had lived most of his life before his premature death on November 26, 1996. Second, Mr. Murray and Mrs. Murray had a successful second marriage and had been married for ten years at the time of his death. The Court **FINDS** that Mrs. Murray is entitled to recover \$75,000 in non-pecuniary losses from the Defendant. Based upon the evidence of Mr. Murray's care and concern for his children, the Court **FINDS** that each of Mr. Murray's four children are entitled to recover \$25,000 in non-pecuniary losses from the Defendant, for a total of \$100,000. Accordingly, the Court **FINDS** that the Plaintiff is entitled to recover \$267,282.23 in total damages from the Defendant including taxable Court costs.

## VI. Conclusion

The Court **FINDS** that the Defendant, through its agent Dr. Hendricks, was negligent in the diagnosis and treatment of Mr. Murray on November 26, 1996. The Court **FINDS** that under Virginia law proof by a preponderance of the evidence that the defendant's negligence destroyed a substantial possibility of the decedent's survival of the iliac aneurysm establishes such negligence [\*\*39] as a proximate cause of the decedent's death. Accordingly, the Court **AWARDS** the Plaintiff \$267,282.23 including taxable Court costs. The Court shall issue a supplementary order specifying the distribution of the judgment and costs among the beneficiaries and counsel.

The Clerk is **REQUESTED** to send a copy of this Opinion and Order to counsel for both parties.

It is so **ORDERED**.

HENRY COKE MORGAN, JR.

UNITED STATES DISTRICT JUDGE

Norfolk, Virginia  
February 25, 1999

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**Karen Guess Raines, et al. v. Wallace B. Lutz****Record No. 821730****Supreme Court of Virginia****231 Va. 110; 341 S.E.2d 194; 1986 Va. LEXIS 171****March 7, 1986****PRIOR HISTORY:** [\*\*\*1]

Appeal from a judgment of the Circuit Court of Shenandoah County. Hon. Arthur W. Sinclair, judge designate presiding.

**DISPOSITION:**

*Affirmed.*

**HEADNOTES: Pleading and Practice — Torts — medical malpractice — Review Panel — Expert Testimony — Written Opinion — Evidence**

Plaintiffs filed a claim against defendant under the medical malpractice statutes alleging dental malpractice. Defendant requested a review and hearing by a panel. At the conclusion of the hearing, a majority of the panel subscribed to an opinion that defendant failed to comply with the appropriate standard of care and that such failure was the proximate cause of the alleged damages. A minority report concluded that the defendant had failed to comply with the appropriate standard of care, but that such failure was not the proximate cause of the alleged injuries.

At trial, plaintiffs presented the testimony of the dentist who treated them after they had left the care of the defendant. He described the conditions he observed and the treatment he provided, but did not give an opinion as to the appropriate standard of care governing defendant's treatment or whether defendant departed from such a standard. [\*\*\*2] Plaintiffs then offered in evidence the opinion of the review panel, and the judge read to the jury both the majority and minority reports. The plaintiffs did not call any panel members as witnesses, but rested their cases, taking the position that the panel report supplied the required expert testimony.

Defendant moved to strike the evidence, but was overruled, and the case was sent to the jury with an instruction that the opinion of the review panel was not binding upon the jury, but was to be considered along with the other evidence. The jury returned two separate verdicts in favor of the plaintiffs. Defendant filed a motion to set aside the

verdicts, and the court, in a letter opinion, sustained the motion. The court entered judgment for the defendant and the plaintiffs appeal.

1. Health care providers are required to exercise that degree of skill practiced by a reasonably prudent practitioner in the same field of practice in Virginia. Expert testimony is ordinarily necessary to establish the appropriate standard of care, a deviation from that standard, and proximate causation.

2. The medical malpractice review panel, although it states opinions concerning deviation [\*\*\*3] from the appropriate standard of care and proximate causation, does not inform the jury what the standard of care is.

3. The medical malpractice statutes did not supersede the jury system. The jury must objectively determine whether the appropriate standard of care has been followed, which it cannot do without evidence of what the standard was.

4. If the jury is given no evidence of the nature of the standard of care, it must base its verdict entirely on expert opinion that some unspecified standard was violated, and will have lost to a panel of experts its prerogative to determine whether the standard of care was violated.

5. In enacting the medical malpractice statutes, the legislature chose not to make the review panel's opinion a sufficient substitute for expert testimony.

6. The written opinion of the medical malpractice review panel was not in itself sufficient in medical malpractice cases to fulfill the requirements of expert testimony on the appropriate standard of care, a deviation from the standard, and causation.

**SYLLABUS:**

*Judgment is affirmed in a dental malpractice action where the trial court correctly set aside plaintiffs' verdicts because a written [\*\*\*4] opinion of a medical malpractice review panel expressing only the conclusions prescribed in the statute is not sufficient to fulfill the requirement of expert testimony on the standard of care, deviation from the standard, and causation.*

**COUNSEL:**

*William B. Allen, III* (*Allen & Allen*, on brief), for appellants.

*Ronald D. Hodges* (*Wharton, Aldhizer & Weaver*, on brief), for appellee.

**JUDGES:**

Russell, J., delivered the opinion of the Court.

**OPINIONBY:**

RUSSELL

**OPINION:**

[\*111] [\*195] This case presents the question whether the written opinion of a medical malpractice review panel, when admitted into evidence at trial pursuant to *Code* § 8.01-581.8, is in itself sufficient to establish a prima facie case of negligence and proximate cause for the plaintiff. The question, more specifically, is whether such a written opinion satisfies the requirements, governing professional malpractice cases generally, that the appropriate standard of care, as well as any departure from that standard, must be proved by expert testimony.

The plaintiffs, Karen Guess Raines and her sister, Kristine Guess, filed a notice of claim against Wallace B. Lutz, a dentist [\*112] practicing in Edinburg, [\*\*\*5] Shenandoah County, pursuant to the medical malpractice statutes (*Code* § 8.01-581.1, et seq.) alleging dental malpractice. Dr. Lutz requested review and hearing by a panel. At the conclusion of the hearing, a majority of the panel, consisting of one dentist and three attorneys, subscribed an opinion that Dr. Lutz had failed to comply with the appropriate standard of care and that such failure was the proximate cause of the alleged damages. A minority report was signed by the remaining two dentists on the panel, who concluded that Dr. Lutz had failed to comply with the appropriate standard of care, but that such failure was *not* a proximate cause of the alleged damages.

The plaintiff sisters filed separate suits against Dr. Lutz which were consolidated for a jury trial. At trial, the plaintiffs and their mother testified to the course of their treatment by Dr. Lutz over a ten-year period. The plaintiffs also presented the testimony of Dr. Douglas S. Bruce, a dentist practicing in New Market, who treated them after they had left the care of Dr. Lutz. Dr. Bruce testified that both plaintiffs suffered from conditions of poor oral hygiene and required extensive restorative work. [\*\*\*6] He described the conditions he observed and the treatment he provided, but he was not asked to express, and did not express, any opinion as to the appropriate standard

of care governing Dr. Lutz' treatment or whether Dr. Lutz had departed from such a standard.

At the conclusion of Dr. Bruce's testimony, the plaintiffs offered in evidence the opinion of the review panel. The trial judge read to the jury both the majority [\*196] and minority reports of the panel, identifying the names and professions of the panel members who had subscribed each opinion. The plaintiffs did not call any panel members as witnesses, but rested their cases, taking the position that the panel report supplied the requirement of expert testimony.

Dr. Lutz moved to strike, but the court denied the motion and the jury heard evidence for the defense. The defense renewed its motion to strike at the close of all the evidence, but the court again overruled it, sending the case to the jury with an instruction that the opinion of the review panel was not binding upon the jury, but was to be considered along with the other evidence. The jury returned separate verdicts for the two plaintiffs, each in the [\*\*\*7] amount of \$10,000. The defendant filed a motion to set aside the verdicts. After taking the matter under consideration, the court [\*113] sustained the motion and set aside the verdicts. The court's letter opinion stated:

I certainly assume that the primary purposes [of the medical malpractice statutes] were to protect health care providers from frivolous claims and to encourage settlement of meritorious claims. . . . I do not believe that one of the purposes was to relieve a party plaintiff of the necessity of producing expert testimony on the subjects of negligence and proximate cause, and the fact that the opinion of the Malpractice Review Panel is made admissible by statute in no way relieves a plaintiff of the burden of making out a *prima facie* case exclusive of the panel's opinion.

The court entered judgment for the defendant and we awarded the plaintiffs a consolidated appeal.

[1] Health care providers are required by law to possess and exercise only that degree of skill and diligence practiced by a reasonably prudent practitioner in the same field of practice or speciality in Virginia. n1 We have held that expert testimony is ordinarily [\*\*\*8] necessary to establish the appropriate standard of care, to establish a deviation from the standard, and to establish that such a deviation was the proximate cause of the claimed damages. n2 *Bly v. Rhoads*, 216 Va. 645, 653, 222 S.E.2d 783, 789 (1976); see also *Little v. Cross*, 217 Va. 71, 75, 225 S.E.2d 387, 390 (1976).

231 Va. 110, \*113; 341 S.E.2d 194, \*\*196;  
1986 Va. LEXIS 171, \*\*\*8

n1 This statewide standard has applied since the effective date of *Code § 8.01-581.20* in 1979. The older "same or similar community" standard applied to this case because Dr. Lutz' course of treatment was alleged to have ended in 1976 with respect to each plaintiff.

n2 Exceptions exist in those rare cases in which a health care provider's act or omission is clearly negligent within the common knowledge of laymen. *Easterling v. Walton*, 208 Va. 214, 218, 156 S.E.2d 787, 790-91 (1967) (foreign object left by surgeon in patient's body). *Id.* at 218.

Plaintiffs concede that the law was in the posture outlined above before 1976, but argue that the enactment of the [\*\*\*9] medical malpractice statutes, *Code §§ 8.01-581.1, et seq.*, effected a procedural change whereby the written opinion of a medical malpractice review panel, when admitted into evidence at trial pursuant to *Code § 8.01-581.8*, n3 "satisfies the requirements for expert testimony [\*114] to establish the standard of care and the instances of negligence." This is so, say the plaintiffs, because the panel's report is itself an expert opinion. n4

n3 § 8.01-581.8: **Admissibility of opinion as evidence; appearance of panel members as witnesses; immunity from civil liability.** — An opinion of the medical review panel shall be admissible as evidence in any action subsequently brought by the claimant in a court of law, but such opinion shall not be conclusive and either party shall have the right to call, at his cost, any member of the panel, except the chairman, as a witness. If called, each witness shall be required to appear and testify. The panelist shall have absolute immunity from civil liability for all communications, findings, opinions and conclusions made in the course and scope of duties prescribed by this chapter.

[\*\*\*10]

n4 Plaintiffs here rely on *Hines v. Elkhart General Hospital*, 465 F. Supp. 421 (N.D. Ind.), *aff'd*, 603 F.2d 646 (7th Cir. 1979); *Eastin v. Broomfield*, 116 Ariz. 576, 570 P.2d 744 (1977); *Butler v. Flint-Goodridge Hospital of Dillard*, 354 So. 2d 1070 (La. Ct. App. 1978); *Prendergast v. Nelson*, 199 Neb. 97, 256 N.W.2d 657 (1977); *Suchit v. Baxt*, 176 N.J. Super. 407, 423 A.2d 670 (1980); *Comiskey v. Arlen*, 55 A.D.2d 304, 390 N.Y.S.2d 122 (1976). In these cases the several courts upheld the constitutionality of medical

malpractice statutes and held that the reports of the statutory panels were admissible in evidence. None, however, decided the question involved here: whether such a report would be sufficient to make out a prima facie case if it were the *sole* evidence. The only authority cited by plaintiffs for that proposition is *Robinson v. Mroz*, 433 A.2d 1051 (Del. Super. Ct. 1981), which plaintiffs concede was based upon a statute expressly providing that the panel's opinion would be a sufficient substitute for expert testimony.

[\*\*\*11]

[2] [\*\*197] The flaw in plaintiffs' argument is that the panel's opinion, although it may state opinions concerning deviation from the appropriate standard of care as well as proximate causation, does nothing to educate the jury with respect to the standard of care itself. If the opinion of the panel were the sole expert evidence in the case, the jury would be left to speculation concerning a vital element of the alleged wrong. The General Assembly made no provision for an expression of opinion by the panel with regard to the nature of the appropriate standard. The panel's report follows a format prescribed by statute:

Opinion of panel. – A. Within thirty days, after receiving all the evidence, the panel shall have the duty, after joint deliberation, to render one or more of the following opinions:

1. The evidence does not support a conclusion that the health care provider failed to comply with the appropriate standard of care;
2. The evidence supports a conclusion that the health care provider failed to comply with the appropriate standard of care and that such a failure is a proximate cause of the alleged damages;
3. The evidence supports a conclusion [\*\*\*12] that the health care provider failed to comply with the appropriate standard of [\*115] care and that such failure is not a proximate cause in the alleged damages; or
4. The evidence indicates that there is a material issue of fact, not requiring an expert opinion, bearing on liability for consideration by a court or jury.

*Code § 8.01-581.7(A).*

[3] The medical malpractice statutes did not supersede the jury system. The determination of negligence, proximate cause, and damages remains within the jury's

province. In cases of this kind, the jury must make an objective determination, based upon evidence and not upon speculation, whether the appropriate standard of care has been followed. The jury cannot make such a determination without evidence of what the standard was.

[4] Moreover, the jury has not lost to a panel of experts its prerogative to determine whether the standard was violated. The statute specifies that the panel's opinion is not conclusive upon the jury. If the jury, however, is given no evidence of the nature of the standard, but must base its verdict entirely on an expert opinion that some unspecified standard was or was not violated, just [\*\*\*13] such a loss will have occurred.

[5] The General Assembly, in enacting the medical malpractice laws, did not decide to make the review panel's opinion a sufficient substitute for expert testimony, or indeed, conclusive upon the jury. By providing that the panel members might be called as witnesses, the General Assembly not only met the beneficent legislative purposes

mentioned in the trial court's opinion, but also provided meritorious plaintiffs with ready (although not necessarily inexpensive) access to an expert witness. By striking that balance, the legislature preserved the defendant's right to cross-examine the plaintiff's expert witness in the jury's presence. That valuable right would be lost if we were to take the view urged by the plaintiffs.

[6] We adhere to the rule of *Bly v. Rhoads*, that expert testimony is ordinarily required in malpractice cases "on [1] the standard of care, [2] a deviation from the standard, and [3] causation," 216 Va. at 653, 222 S.E.2d at 789, and we hold that the written opinion of the medical malpractice review panel was not in itself sufficient to fulfill those requirements. It follows that the [\*116] trial court correctly [\*\*\*14] set aside the verdicts and entered final judgments for the defendant.

[\*\*198] The judgments will be

*Affirmed.*

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TITLE 44. MILITARY AND EMERGENCY LAWS  
CHAPTER 3.2. EMERGENCY SERVICES AND DISASTER LAW

**GO TO CODE OF VIRGINIA ARCHIVE DIRECTORY**

*Va. Code Ann. § 44-146.16 (2006)*

§ 44-146.16. Definitions

As used in this chapter unless the context requires a different meaning:

*"Communicable disease of public health threat"* means an illness of public health significance, as determined by the State Health Commissioner in accordance with regulations of the Board of Health, caused by a specific or suspected infectious agent that may be reasonably expected or is known to be readily transmitted directly or indirectly from one individual to another and has been found to create a risk of death or significant injury or impairment; this definition shall not, however, be construed to include human immunodeficiency viruses or tuberculosis, unless used as a bioterrorism weapon. *"Individual"* shall include any companion animal. Further, whenever *"person or persons"* is used in Article 3.02 (§ 32.1-48.05 et seq.) of Chapter 2 of Title 32.1, it shall be deemed, when the context requires it, to include any individual;

*"Discharge"* means spillage, leakage, pumping, pouring, seepage, emitting, dumping, emptying, injecting, escaping, leaching, fire, explosion, or other releases;

*"Emergency"* means any occurrence, or threat thereof, whether natural or man-made, which results or may result in substantial injury or harm to the population or substantial damage to or loss of property or natural resources and may involve governmental action beyond that authorized or contemplated by existing law because governmental inaction for the period required to amend the law to meet the exigency would work immediate and irrevocable harm upon the citizens or the environment of the Commonwealth or some clearly defined portion or portions thereof;

*"Emergency services"* means the preparation for and the carrying out of functions, other than functions for which military forces are primarily responsible, to prevent, minimize and repair injury and damage resulting from natural or man-made disasters, together with all other activities necessary or incidental to the preparation for and carrying out of the foregoing functions. These functions include, without limitation, fire-fighting services, police services, medical and health services, rescue, engineering, warning services, communications, radiological, chemical and other special weapons defense, evacuation of persons from stricken areas, emergency welfare services, emergency transportation, emergency resource management, existing or properly assigned functions of plant protection, temporary restoration of public utility services, and other functions related to civilian protection. These functions also include the administration of approved state and federal disaster recovery and assistance programs;

*"Hazard mitigation"* means any action taken to reduce or eliminate the long-term risk to human life and property from natural hazards;

*"Hazardous substances"* means all materials or substances which now or hereafter are designated, defined, or characterized as hazardous by law or regulation of the Commonwealth or regulation of the United States government;

*"Interjurisdictional agency for emergency management"* is any organization established between contiguous political subdivisions to facilitate the cooperation and protection of the subdivisions in the work of disaster prevention, preparedness, response, and recovery;



*"Local emergency"* means the condition declared by the local governing body when in its judgment the threat or actual occurrence of an emergency or disaster is or threatens to be of sufficient severity and magnitude to warrant coordinated local government action to prevent or alleviate the damage, loss, hardship or suffering threatened or caused thereby; provided, however, that a local emergency arising wholly or substantially out of a resource shortage may be declared only by the Governor, upon petition of the local governing body, when he deems the threat or actual occurrence of such an emergency or disaster to be of sufficient severity and magnitude to warrant coordinated local government action to prevent or alleviate the damage, loss, hardship or suffering threatened or caused thereby; provided, however, nothing in this chapter shall be construed as prohibiting a local governing body from the prudent management of its water supply to prevent or manage a water shortage;

*"Local emergency management organization"* means an organization created in accordance with the provisions of this chapter by local authority to perform local emergency service functions;

*"Major disaster"* means any natural catastrophe, including any: hurricane, tornado, storm, high water, wind-driven water, tidal wave, tsunami, earthquake, volcanic eruption, landslide, mudslide, snowstorm or drought, or regardless of cause, any fire, flood, or explosion, in any part of the United States, which, in the determination of the President of the United States is, or thereafter determined to be, of sufficient severity and magnitude to warrant major disaster assistance under the Stafford Act (P.L. 43-288 as amended) to supplement the efforts and available resources of states, local governments, and disaster relief organizations in alleviating the damage, loss, hardship, or suffering caused thereby and is so declared by him;

*"Man-made disaster"* means any condition following an attack by any enemy or foreign nation upon the United States resulting in substantial damage of property or injury to persons in the United States and may be by use of bombs, missiles, shell fire, nuclear, radiological, chemical or biological means or other weapons or by overt paramilitary actions; terrorism, foreign and domestic; also any industrial, nuclear or transportation accident, explosion, conflagration, power failure, resources shortage or other condition such as sabotage, oil spills and other injurious environmental contaminations that threaten or cause damage to property, human suffering, hardship or loss of life;

*"Natural disaster"* means any hurricane, tornado, storm, flood, high water, wind-driven water, tidal wave, earthquake, drought, fire or other natural catastrophe resulting in damage, hardship, suffering or possible loss of life;

*"Political subdivision"* means any city or county in the Commonwealth and for the purposes of this chapter, the Town of Chincoteague and any town of more than 5,000 population that chooses to have an emergency management program separate from that of the county in which such town is located;

*"Resource shortage"* means the absence, unavailability or reduced supply of any raw or processed natural resource, or any commodities, goods or services of any kind that bear a substantial relationship to the health, safety, welfare and economic well-being of the citizens of the Commonwealth;

*"State of emergency"* means the condition declared by the Governor when in his judgment, the threat or actual occurrence of an emergency or a disaster in any part of the Commonwealth is of sufficient severity and magnitude to warrant disaster assistance by the Commonwealth to supplement the efforts and available resources of the several localities, and relief organizations in preventing or alleviating the damage, loss, hardship, or suffering threatened or caused thereby and is so declared by him.

**HISTORY:** 1973, c. 260; 1974, c. 4; 1975, c. 11; 1978, c. 60; 1979, c. 193; 1981, c. 116; 1984, c. 743; 1993, c. 671; 2000, c. 309; 2004, cc. 773, 1021.

**NOTES:**

**CROSS REFERENCES.**—For provision authorizing the Governor to waive certain statutory mandates and regulations to expedite certain highway construction projects in order to meet certain emergencies, see § 33.1-223.2:5. For the Line of Duty Act, see §§ 9.1-400 et seq. As to workers' compensation coverage for first responders in off-duty capacity during state of emergency, see § 65.2-104.

**EDITOR'S NOTE.**—Acts 2004, cc. 973 and 1021, cl. 2, provides: "That the Board of Health shall promulgate regulations to implement the provisions of this act to be effective within 280 days of its enactment."

THE 2000 AMENDMENTS.—The 2000 amendment by c. 309 inserted "terrorism, foreign and domestic" near the middle of subdivision (2); in subdivision (2a), substituted "any occurrence, or threat thereof, whether natural or man-made, which results or may result in substantial injury or harm to the population or substantial damage to or loss of property or natural resources and may involve" for "a sudden and unforeseeable occurrence or condition, either as to its onset or as to its extent, of such disastrous severity or magnitude that," deleted "is required" following "existing law," and inserted "or the environment"; in subdivision (4), substituted "catastrophe, including any: hurricane, tornado, storm, high water, wind-driven water, tidal wave, tsunami, earthquake, volcanic eruption, landslide, mudslide, snowstorm or drought, or regardless of cause, any fire, flood, or explosion" for "or man-made disaster," substituted "warrant major disaster assistance under the Stafford Act (P.L. 43-288 as amended) to supplement the efforts and available resources of the several states, local governments, and disaster relief" for "warrant disaster assistance above and beyond emergency services by the federal government to supplement the efforts and available resources of the several states, local governments, and relief"; in subdivision (5), inserted "an emergency or" near the middle, and deleted "when it is evident that the resources of the Commonwealth are adequate to cope with such disasters" at the end; in subdivision (6), substituted "of an, emergency or disaster" for "of a disaster" near the beginning, substituted "of such an emergency or disaster" for "of a disaster" near the middle, and substituted "supply to prevent or manage a water shortage" for "supply, in the absence of a declared state of emergency, to prevent a water shortage" at the end; in subdivision (7), inserted "management"; in subdivisions (8) and (9), substituted "emergency management" for "emergency services"; and added subdivision (13).

THE 2004 AMENDMENTS.—The 2004 amendments by cc. 773, effective April 12, 2004, and 1021, effective April 21, 2004, are nearly identical, and rewrote the section. The definition of "Communicable disease of public health threat" is set out above as directed by the Virginia Code Commission.

LAW REVIEW.—For note, "Federal and State Remedies to Clean Up Hazardous Waste Sites," see *20 U. Rich. L. Rev.* 379 (1986).

ACUTE MOTOR VEHICLE FUEL SHORTAGE OF 1973 WAS A "DISASTER" within the meaning of this chapter. *Boyd v. Commonwealth*, 216 Va. 16, 215 S.E.2d 915 (1975).

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TITLE 44. MILITARY AND EMERGENCY LAWS  
CHAPTER 3.2. EMERGENCY SERVICES AND DISASTER LAW

**GO TO CODE OF VIRGINIA ARCHIVE DIRECTORY**

*Va. Code Ann. § 44-146.14 (2006)*

§ 44-146.14. Findings of General Assembly

(a) Because of the ever present possibility of the occurrence of disasters of unprecedented size and destructiveness resulting from enemy attack, sabotage or other hostile action, resource shortage, or from fire, flood, earthquake, or other natural causes, and in order to insure that preparations of the Commonwealth and its political subdivisions will be adequate to deal with such emergencies, and generally to provide for the common defense and to protect the public peace, health, and safety, and to preserve the lives and property and economic well-being of the people of the Commonwealth, it is hereby found and declared to be necessary and to be the purpose of this chapter:

(1) To create a State Department of Emergency Management, and to authorize the creation of local organizations for emergency management in the political subdivisions of the Commonwealth;

(2) To confer upon the Governor and upon the executive heads or governing bodies of the political subdivisions of the Commonwealth emergency powers provided herein; and

(3) To provide for rendering of mutual aid among the political subdivisions of the Commonwealth and with other states and to cooperate with the federal government with respect to the carrying out of emergency service functions.

(b) It is further declared to be the purpose of this chapter and the policy of the Commonwealth that all emergency service functions of the Commonwealth be coordinated to the maximum extent possible with the comparable functions of the federal government, other states, and private agencies of every type, and that the Governor shall be empowered to provide for enforcement by the Commonwealth of national emergency services programs, to the end that the most effective preparation and use may be made of the nation's resources and facilities for dealing with any disaster that may occur.

**HISTORY:** 1973, c. 260; 1974, c. 4; 1975, c. 11; 2000, c. 309.

**NOTES:**

THE 2000 AMENDMENTS.—The 2000 amendment by c. 309, in subdivision (a)(1), substituted "Emergency Management" for "Emergency Services" twice; and added "and" at the end of subdivision (a)(2).

IMPORTANCE OF ADEQUATE SUPPLY OF MOTOR VEHICLE FUEL.—The health, safety and welfare of the people of Virginia depend upon an adequate supply of motor vehicle fuel. *Boyd v. Commonwealth*, 216 Va. 16, 215 S.E.2d 915 (1975).

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TITLE 44. MILITARY AND EMERGENCY LAWS  
CHAPTER 3.2. EMERGENCY SERVICES AND DISASTER LAW

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*Va. Code Ann. § 44-146.17 (2006)*

**STATUS: CONSULT SLIP LAWS CITED BELOW FOR RECENT CHANGES TO THIS DOCUMENT LEXSEE**  
2006 Va. ALS 140 — See section 1.

§ 44-146.17. Powers and duties of Governor

The Governor shall be Director of Emergency Management. He shall take such action from time to time as is necessary for the adequate promotion and coordination of state and local emergency services activities relating to the safety and welfare of the Commonwealth in time of natural or man-made disasters.

The Governor shall have, in addition to his powers hereinafter or elsewhere prescribed by law, the following powers and duties:

(1) To proclaim and publish such rules and regulations and to issue such orders as may, in his judgment, be necessary to accomplish the purposes of this chapter including, but not limited to such measures as are in his judgment required to control, restrict, allocate or regulate the use, sale, production and distribution of food, fuel, clothing and other commodities, materials, goods, services and resources under any state or federal emergency services programs.

He may adopt and implement the Commonwealth of Virginia Emergency Operations Plan, which provides for state-level emergency operations in response to any type of disaster or large-scale emergency affecting Virginia and that provides the needed framework within which more detailed emergency plans and procedures can be developed and maintained by state agencies, local governments and other organizations.

He may direct and compel evacuation of all or part of the populace from any stricken or threatened area if this action is deemed necessary for the preservation of life, implement emergency mitigation, preparedness, response or recovery actions; prescribe routes, modes of transportation and destination in connection with evacuation; and control ingress and egress at an emergency area, including the movement of persons within the area and the occupancy of premises therein.

Executive orders, to include those declaring a state of emergency and directing evacuation, shall have the force and effect of law and the violation thereof shall be punishable as a Class 1 misdemeanor in every case where the executive order declares that its violation shall have such force and effect.

Such executive orders declaring a state of emergency may address exceptional circumstances that exist relating to an order of quarantine or an order of isolation concerning a communicable disease of public health threat that is issued by the State Health Commissioner for an affected area of the Commonwealth pursuant to Article 3.02 (§ 32.1-48.05 et seq.) of Chapter 2 of Title 32.1.

Except as to emergency plans issued to prescribe actions to be taken in the event of disasters and emergencies, no rule, regulation, or order issued under this section shall have any effect beyond June 30 next following the next adjournment of the regular session of the General Assembly but the same or a similar rule, regulation, or order may thereafter be issued again if not contrary to law;

(2) To appoint a State Coordinator of Emergency Management and authorize the appointment or employment of other personnel as is necessary to carry out the provisions of this chapter, and to remove, in his discretion, any and all persons serving hereunder;

(3) To procure supplies and equipment, to institute training and public information programs relative to emergency management and to take other preparatory steps including the partial or full mobilization of emergency management organizations in advance of actual disaster, to insure the furnishing of adequately trained and equipped forces in time of need;

(4) To make such studies and surveys of industries, resources, and facilities in the Commonwealth as may be necessary to ascertain the capabilities of the Commonwealth and to plan for the most efficient emergency use thereof;

(5) On behalf of the Commonwealth enter into mutual aid arrangements with other states and to coordinate mutual aid plans between political subdivisions of the Commonwealth;

(6) To delegate any administrative authority vested in him under this chapter, and to provide for the further delegation of any such authority, as needed;

(7) Whenever, in the opinion of the Governor, the safety and welfare of the people of the Commonwealth require the exercise of emergency measures due to a threatened or actual disaster, he may declare a state of emergency to exist;

(8) To request a major disaster declaration from the President, thereby certifying the need for federal disaster assistance and ensuring the expenditure of a reasonable amount of funds of the Commonwealth, its local governments, or other agencies for alleviating the damage, loss, hardship, or suffering resulting from the disaster; and

(9) To provide incident command system guidelines for state agencies and local emergency response organizations.

**HISTORY:** 1973, c. 260; 1974, c. 4; 1975, c. 11; 1981, c. 116; 1990, c. 95; 1997, c. 893; 2000, c. 309; 2004, cc. 773, 1021.

**NOTES:**

**CROSS REFERENCES.**—For local authority to supply emergency financial assistance to farmers during declared major disasters, see § 3.1-22.19. As to punishment for Class 1 misdemeanors, see § 18.2-11.

**EDITOR'S NOTE.**—Acts 2004, cc. 773 and 1021, cl. 2, provides: "That the Board of Health shall promulgate regulations to implement the provisions of this act to be effective within 280 days of its enactment."

**THE 2000 AMENDMENTS.**—The 2000 amendment by c. 309, in the introductory paragraph, substituted "Management" for "Services" at the end of the first sentence, and "emergency services" for "civilian" near the middle of the second sentence; in subdivision (1), inserted the present second sentence, in the present third sentence, substituted "life, implement emergency mitigation, preparedness, response or recovery actions; prescribe" for "life or other emergency mitigation, response or recovery; prescribe" and inserted "including," and in the present fourth sentence, inserted "to include those declaring a state of emergency and directing evacuation"; in subdivision (3), substituted "training and public information programs relative to emergency management and to take other preparatory steps including the partial or full mobilization of emergency management organizations" for "training programs and public information programs, and to take all other preparatory steps including the partial or full mobilization of emergency service organizations"; added "as needed" at the end of subdivision (6); deleted "and" at the end of subdivision (7); in subdivision (8), substituted "To request a major disaster declaration from the President, thereby certifying the need for federal disaster assistance and ensuring the expenditure" for "When necessary, to request predisaster federal assistance or the declaration of a major disaster and certify the need for federal disaster assistance and to give assurance of the expenditure" and added "and" at the end thereof; and added subdivision (9).

**THE 2004 AMENDMENTS.**—The 2004 amendments by cc. 773, effective April 12, 2004, and 1021, effective April 21, 2004, are identical, and inserted the next-to-last paragraph in subdivision (1).

**WAIVER OF REQUIREMENTS FOR LICENSURE OF HEALTH PROFESSIONALS.**—The Governor has authority under this section to waive the statutory and regulatory requirements related to the licensure of health professionals during

a state of emergency or declared disaster. See opinion of Attorney General to The Honorable John M. O'Bannon, III, Member, House of Delegates, 02-069 (11/13/02). .

**ENFORCEMENT OF QUARANTINE IN HEALTH EMERGENCY.**—The Governor, State Health Commissioner and Board of Health have the authority in a public health emergency to issue orders or regulations to enforce a quarantine. See opinion of Attorney General to The Honorable John M. O'Bannon, III, Member, House of Delegates, 02-069 (11/13/02). .

**CONTROL AND ALLOCATION OF SERVICES AND RESOURCES.**—The Governor has the authority to control and allocate services and resources, including state government and private medical personnel and supplies, under any state or federal emergency services program; however, the Commonwealth's authority to take private resources is limited by the constitutional requirement to provide just compensation. See opinion of Attorney General to The Honorable John M. O'Bannon, III, Member, House of Delegates, 02-069 (11/13/02). .

02-069

**MILITARY AND EMERGENCY LAWS: EMERGENCY SERVICES AND  
DISASTER LAW — MILITARY LAWS OF VIRGINIA.**

**CONSTITUTION OF VIRGINIA: EXECUTIVE (EXECUTIVE AND  
ADMINISTRATIVE POWERS) —BILL OF RIGHTS (LAWS SHOULD NOT BE  
SUSPENDED)-(TAKING OF PRIVATE PROPERTY).**

**HEALTH: ADMINISTRATION GENERALLY – DEPARTMENT OF HEALTH  
AND STATE HEALTH COMMISSIONER ¾ DISEASE PREVENTION AND  
CONTROL.**

**ADMINISTRATION OF GOVERNMENT: ADMINISTRATIVE PROCESS ACT.**

**Authority of Governor to suspend licensure requirements of health  
professionals, enforce quarantines, and control and allocate services and  
resources under federal and state emergency services programs in  
response to state of emergency. Requirement that Commonwealth provide  
just compensation for taking of private resources.**

The Honorable John M. O'Bannon, III  
Member, House of Delegates  
November 13, 2002

I am responding to your request for an official advisory opinion in  
accordance with § 2.2-505 of the *Code of Virginia*.

### **Issue Presented**

You ask whether the Governor, in responding to a public health  
emergency, has the legal authority (1) to suspend health  
professional licensure requirements, including those for out-of-state  
and retired health care professionals; (2) to enforce quarantines;  
and (3) to control and allocate private resources, including medical  
personnel and supplies, for emergency response.

### **Response**

It is my opinion that, in the event of a state of emergency, the  
Governor has the authority to suspend licensure requirements of  
health professionals, including those for out-of-state and retired  
health professionals, and to enforce quarantines. It is further my  
opinion that the Governor has the authority to control and allocate  
services and resources, including state government and private  
medical personnel and supplies, under any state or federal  
emergency services program. The Commonwealth's authority to

take private resources is limited by the constitutional requirement to provide just compensation.

## **Background**

You relate that the Health and Medical Subpanel of Governor Warner's Secure Virginia Panel has issued recommendations that have been accepted by the full panel. The Secure Virginia Panel is a replacement for the Virginia Preparedness and Security Panel that Governor James S. Gilmore created after the September 11, 2002, terrorist attacks.<sup>1</sup> One of the recommendations is to seek an official opinion from the Attorney General to determine if Virginia's laws are adequate to allow the Commonwealth to respond efficiently and effectively to a public health emergency resulting from terrorist activity. For the purposes of this opinion, I assume that the public health emergency resulting from terrorist activity is of the magnitude to compel the President of the United States to proclaim or declare a national emergency.<sup>2</sup> I further assume, for the purposes of this opinion, that such public health emergency meets the definition of a "man-made disaster" and constitutes an "emergency" as that term is defined in § 44-146.16(2).<sup>3</sup>

## **Applicable Law and Discussion**

The Commonwealth of Virginia Emergency Services and Disaster Law of 2000<sup>4</sup> sets forth the statutory framework for the Governor and the executive heads or governing bodies of the political subdivisions of the state to deal with emergency situations caused by natural and man-made disasters. Among the stated purposes of the Law, is to confer upon the Governor and the political subdivisions of the Commonwealth specific emergency powers.<sup>5</sup> It is also the

purpose of [the Law] and the policy of the Commonwealth that all emergency service functions of the Commonwealth be coordinated to the maximum extent possible with the comparable functions of the federal government, other states, and private agencies of every type, and that the Governor shall be empowered to provide for enforcement by the Commonwealth of national emergency services programs, to the end that the most effective preparation and use may be made of the nation's resources and facilities for dealing with any disaster that may occur.<sup>[6]</sup>



The Emergency Services and Disaster Law authorizes the Governor to declare a state of emergency "[w]henever, in the opinion of the Governor, the safety and welfare of the people of the Commonwealth require the exercise of emergency measures due to a threatened or actual disaster."<sup>7</sup> Section 44-146.17(1) gives the Governor broad authority to take action in the event of a disaster, "[t]o proclaim and publish such rules and regulations and to issue such orders as may, in his judgment, be necessary to accomplish the purposes of [the Law]."<sup>8</sup> Accordingly, the Governor has the authority to declare an emergency and waive state law when, in the Governor's opinion, the safety and welfare of the people of Virginia require the exercise of emergency measures.<sup>9</sup> The Governor, therefore, has authority under § 44-146.17 to waive the statutory and regulatory requirements related to the licensure of health professionals during a state of emergency or declared disaster.<sup>10</sup>

Besides the Governor's general ability to waive statutory and regulatory requirements immediately by executive order, health boards may engage in a more lengthy process of promulgating emergency regulations. Health care practitioners are required to be licensed in accordance with regulations promulgated by their respective boards.<sup>11</sup> Section 2.2-4011(A) authorizes the boards to promulgate emergency regulations in "a situation (i) involving an imminent threat to public health or safety." Each of the respective boards may, therefore, promulgate emergency regulations suspending licensure requirements in the event of a public health disaster. Section 2.2-4011(A) requires that "the agency shall state in writing the nature of the emergency and of the necessity for such action .... [S]uch regulations shall become effective upon approval by the Governor and filing with the Registrar of Regulations."

You also ask whether the Governor has the legal authority to maintain and enforce a quarantine. The State Health Commissioner has the authority, pursuant to § 32.1-43, "to require quarantine, vaccination or treatment of any individual when he determines any such measure to be necessary to control the spread of any disease of public health importance." In addition, the Board of Health

may promulgate regulations and orders to meet any emergency or to prevent a potential emergency caused by a disease dangerous to public health, including procedures specifically responding to any disease listed pursuant to § 32.1-35 that is determined to be caused by an agent or substance used as a weapon.<sup>[12]</sup>

The State Health Commissioner is further "vested with all the authority of the Board when it is not in session."<sup>13</sup>

Section 44-146.17(1) authorizes the Governor to "direct and compel evacuation of all or part of the populace from any stricken or threatened area ..., implement emergency mitigation, preparedness, response or recovery actions; ... and control ingress and egress at an emergency area, including the movement of persons within the area and the occupancy of premises therein." These powers may reasonably be interpreted to include quarantine under the Governor's authority to control the ingress, egress and movement of persons within an emergency area. The Governor, State Health Commissioner and Board of Health have the authority in a public health emergency to issue orders or regulations to enforce a quarantine.

You further ask whether the Governor has legal authority to control and allocate private resources, including medical personnel and supplies, for emergency response. As the chief executive officer of the Commonwealth, the Governor may direct state employees who are medically trained to participate in emergency response activities as part of their job responsibilities. Similarly, as the commander-in-chief of the armed forces of the Commonwealth, the Governor may direct the National Guard to provide such services.<sup>14</sup> The extent to which the Governor may order the National Guard's use of federal military assets, regularly used by the Guard, however, is subject to federal laws and regulations governing the use of such assets.<sup>15</sup>

Additionally, the Governor may call for privately employed personnel to assist in an emergency response situation. If volunteers are insufficient to meet emergency response needs, the Governor has the ability to require medically trained personnel to provide emergency response services. The Thirteenth Amendment to the Constitution of the United States prohibits "involuntary servitude, except as a punishment for crime." The Thirteenth Amendment does not, however, prevent the state from requiring service of its citizens for military or certain other civic duties.<sup>16</sup> Accordingly, the Governor may use his power as commander-in-chief of the state's military to call out, in addition to the National Guard, the unorganized militia.<sup>17</sup> Section 44-86 provides:

The commander in chief may at any time, in order to execute the law, suppress riots or insurrections, or repel invasion, or aid in any form of disaster wherein the lives or property of citizens are imperiled or may be imperiled, order out ... the whole or any part of the unorganized militia.<sup>[18]</sup>

Under § 44-86, the Governor has the power to order the deployment of "the whole or any part of the unorganized militia." This power includes the ability to call out privately employed medical personnel, as part of the state militia, to respond to a disaster situation.<sup>19</sup> "Whenever any part of the unorganized militia is ordered out, it shall be governed by the same rules and regulations ... as the National Guard or naval militia."<sup>20</sup> Moreover, "[w]hensoever the Governor orders out the unorganized militia or any part thereof, it shall be incorporated into the Virginia State Defense Force until relieved from service."<sup>21</sup>

Section 44-146.17(1) lists measures the Governor may take to respond to a public health emergency, including those actions "as are in his judgment required to control, restrict, allocate or regulate the use, sale, production and distribution of food, fuel, clothing and other commodities, materials, goods, services and resources under any state or federal emergency services<sup>[22]</sup> programs." In addition, public agencies are directed

to utilize the services, equipment, supplies and facilities ... of the Commonwealth and the political subdivisions thereof to the maximum extent practicable consistent with state and local emergency operation plans. The officers and personnel of all such departments, offices, and agencies are directed to cooperate with and extend such services and facilities to the Governor and to the State Department of Emergency Management upon request.<sup>[23]</sup>

In 1997, pursuant to § 44-146.17(1), Governor George Allen promulgated, by executive order, the Commonwealth of Virginia Emergency Operations Plan.<sup>24</sup> The Emergency Operations Plan, as modified by the Secure Virginia Initiative set forth under executive order of Governor Mark R. Warner,<sup>25</sup> provides for state-level emergency operations in response to any type of disaster or large-scale emergency affecting the Commonwealth.<sup>26</sup> The purpose of the Plan is to assign duties and responsibilities to departments, agencies and support organizations, including volunteers, for disaster mitigation preparedness, response and recovery.<sup>27</sup> The Plan also provides that all health and medical-related professional societies and organizations and commercial health services may be requested to provide specific response teams or coordination capabilities during a declared emergency.<sup>28</sup>

The state and local plans currently in place provide for the mobilization of volunteer medical personnel and equipment necessary to address a public health emergency in a disaster situation. The costs of implementing such plans are disbursed from the Virginia Disaster Response Fund, a special fund account administered by the Coordinator of Emergency Management.<sup>29</sup>

The Governor's ability to control and allocate private resources pursuant to § 44-146.17(1), however, is tempered by the Virginia and United States Constitutions. Article I, § 11 of the Constitution of Virginia prohibits the General Assembly from passing any law "whereby private property shall be taken or damaged for public uses, without just compensation."<sup>30</sup> To the extent the control and allocation of resources exercised under § 44-146.17(1) amounts to a constitutional "taking," either temporary or permanent, the Commonwealth would be responsible to provide "just compensation" to the person whose property was acquired or used. In times of extreme emergency or declared disasters, time is of the essence in mobilizing public and private resources to respond to the emergency.<sup>31</sup> There does not appear to be a statutory mechanism, however, to ensure that any "taking" of private property by the Commonwealth during a state of emergency is properly recorded, accounted and reimbursed once the emergency subsides.

Funds are available in specified circumstances to cover the cost of emergency operations.<sup>32</sup> For example, disbursements may be made in specified circumstances from the Virginia Disaster Response Fund to cover the costs of response and recovery under § 44-146.18:1. Allotments may also be made to state agencies and localities to carry out disaster service missions and responsibilities in accordance with Department of Emergency Management<sup>33</sup>

guidelines under § 44-146.28(a). Funds may also be accepted from the federal government to pay "a portion of any disaster programs, projects, equipment, supplies or materials or other related costs"<sup>34</sup> under § 44-146.27(A)-(B). Further, the Governor and political subdivisions may accept gifts, grants or loans for purposes of emergency management under § 44-146.27(C). Additionally, the General Assembly may appropriate funds after the emergency through the normal appropriations process or special claims bills.

### Conclusion

Accordingly, it is my opinion that, in the event of a state of emergency, the Governor has the authority to suspend licensure requirements of health professionals, including those for out-of-state and retired health professionals, and to enforce quarantines. It is further my opinion that the Governor has the authority to control and allocate services and resources, including state government and private medical personnel and supplies, under any state or federal emergency services program. The Commonwealth's authority to take private resources is limited by the constitutional requirement to provide just compensation.

<sup>1</sup>See Exec. Order No. 7, 18:12 Va. Regs. Reg. 1707 (Feb. 25, 2002) (rescinding Exec. Order No. 85, 18:5 Va. Regs. Reg. 797 (Nov. 19, 2001), setting forth Secure Virginia Initiative, and creating Secure Virginia Panel).

<sup>2</sup>See, e.g., Proclamation No. 7463, 3 C.F.R. 263 (2002) (declaring existence of national emergency due to events of September 11, 2001, and utilizing provisions of federal emergency statutes); Exec. Order No. 13,223, 3 C.F.R. 785 (2002) (ordering reserves to active duty, suspending certain federal statutes, delegating certain authorities to Secretaries of Defense and Transportation); see also Exec. Order No. 83, 18:3 Va. Regs. Reg. 436 (Oct. 22, 2001) (on September 11, 2001, then Governor James S. Gilmore, III, verbally declared state of emergency pursuant to terrorist attack on Pentagon), *continued by* Exec. Order No. 19, 18:23 Va. Regs. Reg. 3116 (July 29, 2002) (ordering continuation of certain emergency declarations).

<sup>3</sup>Section 44-146.16 defines the following words as used in the Emergency Services and Disaster Law:

"(2) '*Man-made disaster*' means any condition following an attack by any enemy or foreign nation upon the United States resulting in substantial damage of property or injury to persons in the United States and may be by use of ... nuclear, radiological, chemical or biological means or other weapons or by ... terrorism, foreign and domestic ..., which threaten or cause damage to property, human suffering, hardship or loss of life;

"(2a) '*Emergency*' means any occurrence, or threat thereof, whether natural or man-made, which results or may result in substantial injury or harm to the population or substantial damage to or loss of property or natural resources and may involve governmental action beyond that authorized or contemplated by existing law because governmental inaction for the period required to amend the law to meet the exigency would work immediate and irrevocable harm upon the citizens or the environment of the Commonwealth or some clearly defined portion or portions thereof[.]"

<sup>4</sup>Va. Code Ann. §§ 44-146.13 to 44-146.28:1 (LexisNexis Repl. Vol. 2002).

<sup>5</sup>Section 44-146.14(a)(2).

<sup>6</sup>Section 44-146.14(b).

<sup>7</sup>Section 44-146.17(7).

<sup>8</sup>Moreover, § 44-146.17(1) provides that "no rule, regulation, or order issued under this section shall have any effect beyond June 30 next following the next adjournment of the regular session of the General Assembly." Section 44-146.17:1 provides that "[t]he Governor shall cause copies of any order ... proclaimed and published by him pursuant to § 44-146.17 to be transmitted forthwith to each member of the General Assembly." This reporting requirement ensures that the General Assembly is properly apprised of the Governor's actions during an emergency or disaster situation, and that an emergency, with its attendant concentration of power and authority in the Governor, cannot last indefinitely.

<sup>9</sup>See *Boyd v. Commonwealth*, 216 Va. 16, 19, 215 S.E.2d 915, 917 (1975); see also 1973-1974 Op. Va. Att'y Gen. 448, 449-50. "[A]ny suspension must last only as long as absolutely necessary.... Another important condition is that rights can only be suspended in the area affected by the emergency." 1 A.E. Dick Howard, *Commentaries on the Constitution of Virginia* 92 (1974). In the end, a court will be the final arbitrator of how the balance is struck between individual rights and the abridgement of those rights in times of emergency, disaster or war. *Id.* at 93. *But see* Va. Const. art. I, § 7 ("[A]ll power of suspending laws, ... without consent of the representatives of the people, ... ought not to be exercised.").

<sup>10</sup>In the context of a federally declared emergency, the United States Secretary of Health and Human Services has the power to temporarily waive or modify certain licensure requirements. Section 1135(b) of the Federal Public Health Security and Bioterrorism Preparedness and Response Act of 2002 authorizes the United States Secretary of Health and Human Services "to temporarily waive or modify ... in any emergency area ... during any portion of an emergency period, the requirements of titles XVIII, XIX, or XXI, or any regulation thereunder ... pertaining to—

"....

"(2) requirements that physicians and other health care professionals be licensed in the State in which they provide such services, if they have equivalent licensing in another State and are not affirmatively excluded from practice in that State or in any State ... included in the emergency area[.]"

Pub. L. No. 107-188, 116 Stat. 594, 627-28 (LexisNexis USCS Adv. Pamph. Aug. 2002) (to be codified at 42 U.S.C. § 1320b-5(b)).

<sup>11</sup>See, e.g., Va. Code Ann. § 54.1-2400(3) (LexisNexis Repl. Vol. 2002) (authorizing health regulatory boards "[t]o ... license qualified applicants as practitioners of the particular profession or professions regulated by such board[s]"). Section 54.1-2902 makes it "unlawful for any person to practice medicine, osteopathic medicine, chiropractic, podiatry, or as a physician's or

podiatrist's assistant" without a valid license, and § 54.1-3310 makes it "unlawful for any person to practice pharmacy ... unless licensed by the Board [of Pharmacy] as a pharmacist."

<sup>12</sup>Va. Code Ann. § 32.1-42 (LexisNexis Supp. 2002).

<sup>13</sup>Va. Code Ann. § 32.1-20 (LexisNexis Repl. Vol. 2001).

<sup>14</sup>"The Governor shall be commander-in-chief of the armed forces of the Commonwealth and shall have power to embody such forces to repel invasion, suppress insurrection, and enforce the execution of the laws." Va. Const. art. V, § 7; see also Va. Code Ann. § 44-8 (LexisNexis Repl. Vol. 2002) (parallel statutory authority); 1945-1946 Op. Va. Att'y Gen. 144, 147 ("This power may be used wherever a situation arises where, on account of obstructions, or threats of obstructions to the enforcement of the laws or obedience thereto, the functioning of the government or the health and safety of the people of the State are jeopardized.... The Governor is vested with absolute discretion in its use and in the selection of members of the militia he will embody .... He is the sole judge of whether an exigency exists which requires the aid of the militia and has full discretion as to the method of utilizing that aid. On the other hand, of course, if the facts leave no room for doubt that an emergency does not exist, the power cannot be exercised under a mere pretense that it does.").

<sup>15</sup>See 32 U.S.C. §§ 101 to 716 (2000).

<sup>16</sup>See 16A C.J.S. *Constitutional Law* § 483, at 542 (1984).

<sup>17</sup>The Governor may "order [the unorganized militia] out either by calling for volunteers or by draft [pursuant to § 44-89]." Section 44-87 (LexisNexis Repl. Vol. 2002).

<sup>18</sup>Pursuant to § 44-4, "[t]he unorganized militia shall consist of all able-bodied persons as set out in § 44-1, except such as may be included in §§ 44-2, 44-3, and 44-54.6 and except" as otherwise provided by law. Section 44-1 provides, in part, that "[t]he militia of the Commonwealth of Virginia shall consist of all able-bodied citizens of this Commonwealth and all other able-bodied persons resident in this Commonwealth who have declared their intention to become citizens of the United States, who are at least sixteen years of age and, except as hereinafter provided, not more than fifty-five years of age." Section 44-2 sets forth the composition of the National Guard. Section 44-3 sets forth the composition of the naval militia. Section 44-54.6 sets forth the composition of the Virginia State Defense Force. Such Force shall consist, in part, of "[s]uch persons of the unorganized militia who may be drafted to fill the force structure of the Virginia State Defense Force or who may be ordered out for active duty until released from such service." Section 44-54.6(2) (LexisNexis Repl. Vol. 2002).

<sup>19</sup>See 1945-1946 Op. Va. Att'y Gen. *supra* note , at 152 ("[T]he Governor may ... order out those militia members best qualified to meet the demands of the occasion.").

<sup>20</sup>Section 44-85 (LexisNexis Repl. Vol. 2002).

<sup>21</sup>Section 44-88 (LexisNexis Repl. Vol. 2002).

<sup>22</sup>"*Emergency services*' ... include, without limitation, fire fighting services, police services, medical and health services, rescue, engineering, warning services, communications, radiological, chemical and other special weapons defense, evacuation of persons from stricken areas, emergency welfare services, emergency transportation, emergency resource management, existing or properly assigned functions of plant protection, temporary restoration of public utility services, and other functions related to civilian protection." Section 44-146.16(3).

<sup>23</sup>Section 44-146.24.

<sup>24</sup>Exec. Order. No. 73, 13 Va. Regs. Reg. 3676 (Sept. 15, 1997).

<sup>25</sup>Exec. Order No. 7, *supra* note (requiring review of all current disaster, emergency management, and terrorism management plans, including Executive Order No. 73).

<sup>26</sup>Exec. Order No. 73, *supra* note , at 3676; Exec. Order No. 7, *supra* note , at 1707.

<sup>27</sup>1 Commonwealth of Virginia Emergency Operations Plan: Basic Plan at 1 (1997) (on file with Department of Emergency Management).

<sup>28</sup>*Id.* at G-1.

<sup>29</sup>See § 44-146.18:1. Under § 44-146.17(2), the Governor has the authority to "appoint a State Coordinator of Emergency Management."

<sup>30</sup>See also U.S. Const. amend. V ("nor shall private property be taken for public use, without just compensation").

<sup>31</sup>"Such a taking of private property by the government, when the emergency of the public service in time of war or impending public danger is too urgent to admit of delay, is everywhere regarded as justified, if the necessity for the use of the property is imperative and immediate, and the danger, as heretofore described, is impending, and it is equally clear that the taking of such property under such circumstances creates an obligation on the part of the government to reimburse the owner to the full value of the service. Private rights, under such extreme and imperious circumstances, must give way for the time to the public good, but the government must make full restitution for the sacrifice." *United States v. Russell*, 80 U.S. (13 Wall.) 623, 629 (1871).

<sup>32</sup>A federal declaration of disaster or national emergency may make available federal funds for emergency response services. See 42 U.S.C. § 5191 (2000) (requiring request for declaration of emergency by President to be made by Governor of affected state; situation must be severe and magnitude beyond state's capability to provide effective response; request must provide information regarding resources used, type of request, and extent of aid required); *id.* §§ 5192, 5193 (2000) (providing President with broad powers to direct federal agencies, with or without reimbursement, to provide resources, including personnel and equipment, for state and local emergency assistance; setting limits for funding of support efforts).

<sup>33</sup> See § 44-146.18(a) (continuing State Office of Emergency Services and State Department of Emergency Services as Department of Emergency Management).

<sup>34</sup> Section 44-146.27(A).



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# Concept of Operations for Triage of Mechanical Ventilation in an Epidemic

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## Abstract

The recent outbreak of severe acute respiratory syndrome and the growing potential of an influenza pandemic force us to consider the fact that despite great advances in critical care medicine, we lack the capacity to provide intensive care to the large number of patients that may be generated in an epidemic or multisite bioterrorism event. Because many epidemic and bioterrorist agent illnesses involve respiratory failure, mechanical ventilation is a frequently required intervention but one that is in limited supply. In advance of such an event, we must develop triage criteria that depend on clinical indicators of survivability and resource utilization to allocate scarce health care resources to those who are most likely to benefit. These criteria must be tiered, flexible, and implemented regionally, rather than institutionally, with the backing of public health agencies and relief of liability. This report provides a sample concept of operations for triage of mechanical ventilation in epidemic situations and discusses some of the ethical principles and pitfalls of such systems.

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**Keywords:** disaster, triage, ventilators, epidemics

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**T**he risk of epidemics continues to increase due to many factors, among them the threat of bioterrorism, the growing mobility of the world’s population, and many viruses, including influenza, that represent a threat to the population at large. The outbreak of severe acute respiratory syndrome that began in 2002 and the recent human cases of avian influenza, including the recently reported probable person-to-person transmission of avian influenza identified in Thailand,<sup>1–7</sup> are potent reminders that the population at large is vulnerable to agents both known and unknown.

Although advances in medical care since the last influenza pandemic in 1968–1969<sup>8</sup> have improved infectious disease patient outcomes, there has been a significant and ongoing contraction of inpatient beds. Inpatient capacity decreased by 38,000 beds (4.4%) nationwide between 1996 and 2000.<sup>9</sup> Emergency department (ED) overcrowding was reported by 91% of ED directors in

a recent national survey.<sup>10</sup> Intensive care unit (ICU) bed capacity contracted by 20% nationally between 1995 and 2001.<sup>11</sup> Often, beds may be available but are unstaffed due to a shortage of qualified nurses. This staffing shortage is expected to worsen over the next few years.<sup>12</sup> Despite great advances in the technology and science of critical care, the amount of “surge capacity” (resources in excess of those used on a daily basis) is minimal.

In a disaster involving traumatic or chemical injuries, at least some victims die at the scene, and historically only a minor percentage of the survivors are critically ill. However, victims of epidemics and biologic attacks do not die instantly, and deaths usually occur following hospitalization and critical care interventions. The time course for stabilization and recovery from infections is also prolonged as compared with that from trauma or chemical injury. The average ICU stay of a patient with severe acute respiratory syndrome in Toronto hospitals was 10.5 days<sup>13</sup> and the overall hospital length of stay in Singapore was 18 days.<sup>14</sup> Further, the inhalational anthrax cases of 2001 demonstrate that modern critical care can save lives previously regarded as “unsalvageable.” Before this experience, it was believed that symptomatic inhalational anthrax was fatal despite treatment, yet more than half of the victims survived with appropriate critical care.<sup>15</sup>

The combination of the efficacy of intensive care and decreased resources has placed us in a difficult situation. Although intensive care has greatly improved survival in recent decades, the overall lack of resources may mean that many patients of a modern pandemic may receive medical care similar to that provided to patients during the 1918 pandemic.<sup>16–18</sup>

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A related Commentary appears on page 195.

In no area are our limitations more concrete than the availability of mechanical ventilation. Should an epidemic or bioterrorism event occur that is confined to one area, augmentation of ventilators (and other health care supplies and staffing) from regional and federal resources is probable within 12–24 hours. The Centers for Disease Control and Prevention maintains a stockpile of ventilators for such contingencies. The National Disaster Medical System provides medical support for disasters, including movement of patients from a medically overwhelmed area to areas of the nation with adequate resources. Patient evacuation (particularly of uninfected patients) via the National Disaster Medical System could be an important tool in managing a local or regional event.<sup>19,20</sup> It is anticipated that while awaiting additional resources or patient movement, bag-valve-mask, bilevel pressure support, and other methods of ventilation could temporarily be used. Although any type of large-scale chemical, biologic, or conventional disaster may overwhelm these resources, it is more likely that an epidemic will be the event that forces widespread, systematic triage of resources.

If the epidemic is multisite, national, or international (e.g., pandemic influenza), it is unlikely that supplemental resources would be available. In this situation, triage of resources would be required to offer the “greatest good to the greatest number.” Although use of family members to manually ventilate intubated patients with a bag-valve system could be considered in select situations, this type of support would have limited utility unless the duration of intubation was relatively short. Although off-site care facilities have been proposed<sup>21</sup> to augment hospital care when the health care system is overwhelmed, even the provision of oxygen in these facilities is difficult, and mechanical ventilation for more than a few patients is impractical, if not impossible.<sup>22</sup>

In a recent drill, our 27-hospital regional compact (which maintains 4,857 beds, including 480 ICU beds) experienced a rapid and critical shortfall in ventilators when challenged with just more than 400 pneumonic plague cases. Despite a surge capacity between 2,500 and 3,500 beds in the area, there were only 16 ventilators available from vendors in our regional system. Modeling for a pandemic event involving 10% of our metropolitan population provides confirmation that our health care system will be pushed well beyond its usual boundaries (Table 1). Although all casualties in an epidemic will not present at once, the 1918 pandemic experience suggests that the initial wave of illness can be extremely rapid, over days

to a few weeks,<sup>18</sup> and it is unlikely that those in the hospital will recover rapidly and be discharged, creating bottlenecks, particularly in the ICU and ED. Due to this drill experience, a concept of operations for allocation of scarce resources and a tiered framework for restricting mechanical ventilation were developed.

## DEVELOPMENT OF CONCEPT OF OPERATIONS FOR ALLOCATION OF SCARCE RESOURCES

A concept of operations was developed at the regional/state level for adjusting standards of care during a disaster in which patient care resources are exceeded without potential for obtaining outside assistance in a timely manner (e.g., vaccines, treatments such as botulinum antitoxin, or ventilators).

1. Prior to an event occurring, the Minnesota Department of Health (DOH) convenes guideline development and guideline review groups to agree on a baseline framework for limiting care or adjusting standards of care to those appropriate for the scope of the disaster.
2. An event occurs, and the DOH recognizes that available health care resources are inadequate to allow usual standards of patient care.
3. The DOH requests a state declaration of emergency from the governor.
4. All available resources are used to mitigate stress on the health care system, including patient redistribution, with triage and adjusting standards of care considered as a last resort when no further resources can be obtained.
5. The DOH reconvenes the predetermined guideline development group to assess the situation and refine triage and treatment criteria based on the organism involved and its historical responses to interventions (medications, mechanical ventilation, and so on). This may occur in person or by telephone, depending on the urgency of the situation (Table 2).
6. The group modifies baseline triage criteria based on the specific event and recommends a new standard of care appropriate to the resources available.
7. The DOH convenes the guideline review group to assess the guidelines and provide feedback, modifications, and assent (Table 3).
8. The DOH assesses the need for off-site care facilities based on the event and the staff and supplies available.
9. The DOH meets with the governor's office to review the recommendations.
10. The governor issues an emergency order recommending standards of care based on the situation and ideally making those following this guidance “agents of the state,” providing them legal protections as if they were a state employee responding to a disaster. The governor also permits the establishment of off-site care facilities as needed.
11. The guideline development group continues to meet and update its recommendations based on the scope of the event and evolving knowledge of the pathogen and its response to medical management.

This could be accomplished within a short (hours to day) time frame, provided the groups have been convened previously and understand their mission.

Table 1  
Effects of Pandemic Influenza on a Metropolitan Health Care System

Metropolitan-area population	2,600,000 persons
Ten percent affected by pandemic influenza	260,000 persons
Twenty percent of those affected too sick to care for selves	52,000 persons
Twenty percent of those too sick to care for selves lack family or friends to provide care, or require hospitalization for complications	10,400 patients
Optimal surge capacity in current system (without accounting for staff absences and illness)	2,500–3,500 beds

**Table 2**  
Suggested Guideline Development Group Members

Department of Health commissioner or designee
Department of Health state epidemiologist
Department of Health Emergency Response/Office of Emergency Preparedness
Infectious disease physicians (2)*
Critical care physicians (2)*
Emergency physicians (2)*
Family practice physician
Pediatric infectious disease physician
Pediatric critical care physician

\* Should include the chapter representative or designee from the state specialty society.

The guideline development group is focused on developing evidence-based recommendations for clinical care relative to resources available. We had no other models to use in determining the composition of the group, but we desired a small group focused on critical care, emergency care, and infectious disease with representation of primary care and pediatric considerations. Further research may be needed to determine the optimum composition of these groups, but we have found that the size and membership of our group promotes discussion and consideration of many points of view. If other resources require rationing, a different composition of the group might be needed (e.g., botulinum antitoxin, vaccines). Mechanical ventilation was the first limited resource that our group considered.

The recommendations advanced by the development group were vetted by a wider group of both clinical and nonclinical members in the guideline review group. This review group should be focused on the practical implementation of the clinical guidelines, yet be balanced enough by citizen and elected members to ensure community views are represented and avoid a "tyranny of experts."<sup>23</sup> Decisions of the group should be made public and the functions and initial concept of operations discussed in advance of an incident. The Minnesota guideline review group, whose membership is still being modified, is composed in large part of members of the

Minnesota DOH Terrorism Task Force. The reception of the group to the concept of operations has been very positive. Our work with the groups, the DOH, the attorney general's office, and the governor's office is ongoing to further operationalize our conceptual model.

## DEVELOPMENT OF CRITERIA FOR RESTRICTION OF MECHANICAL VENTILATION

Development of triage criteria must reflect basic medical ethics principles. However, in a resource-poor environment, the traditional bioethical focus on patient autonomy (which assumes respect for the individuals' freedom to make decisions) shifts to a utilitarian or "distributive justice" model that attempts to do the "greatest good for the greatest number" with the resources available.<sup>24-26</sup>

We attempted to develop a tiered, scalable framework for restricting mechanical ventilation. Ideal attributes were determined from our drill experiences.

1. They should assist the individual physician by providing a guideline and policy basis for determining criteria for resource allocation or withdrawal, which will reduce the potential for each physician to have to design and defend individual strategies for individual cases and improve consistency.
2. They should be implemented on a regional, not institutional basis, with a government agency providing policy support for implementation.
3. Appropriate liability protections for providers and institutions cooperating with the public health directives should be assured in advance, or as part of an emergency order.
4. Aside from disease-specific criteria, restrictions should apply equally to all patients (e.g., both those infected and those who are hospitalized for other reasons).
5. Criteria should be implemented in a tiered or stepwise fashion, so that as resources are exhausted, another (stricter) tier of exclusion criteria is implemented in an attempt to provide the best care possible to those with the best chance of survival.
6. Whenever possible, tiers should be based on objective determinations of effectiveness of care affecting survival, and of resource utilization, rather than subjective determinations regarding the value of either the intervention or the value of the patient's life.<sup>27</sup>
7. The final tier should ideally provide a numeric assessment of survival probability. This figure may be then compared within and between institutions and regionally to allow resources to be shifted to equalize the care provided and also provide a "sliding scale" of care guidelines that may be adjusted depending on the demand on the resources (e.g., unable to provide mechanical ventilation to patients with score > X, tomorrow may change to score > Y).
8. The numeric scoring system should rely on as many clinical variables (rather than laboratory) as possible. It should be easily correlated with survival. It should be available in the public domain (e.g., nonproprietary). It should be easily adapted to Internet or personal digital assistant calculation programs. Ideally, it should involve simple calculations and few variables.

**Table 3**  
Suggested Guideline Review Group Members

Additional members in the categories noted under guideline development group
Respiratory therapists
Ethicists
State Attorney General and governor's legal counsel
State hospital association
State medical association
State nursing association
Hospital administrators, urban and rural
Local public health
Public safety and emergency management
Emergency medical services
Lay public members
Faith-based community members
Special interest groups: pediatrics, mental health, physical impairments groups
Political positions: select mayors, county commissioners, council members

To define existing work in this area, Ovid MEDLINE searches for available articles since 1966 were performed (to October 2004) utilizing combinations of the following search terms and key words: ventilation-mechanical, triage, critical care, disaster, emergency medical services, resource utilization and allocation, ethics, intensive care unit, distributive justice, emergency medicine, severity of illness index, and multiple organ dysfunction score. Searches were limited to human subjects and English-language articles. Citations of relevance were reviewed by the authors. Review of applicable article references and bibliographies was also conducted. Standard textbooks in critical care medicine were reviewed.

Although select papers have discussed triage in disaster settings, including those of terrorist origin,<sup>28–32</sup> to date no triage discussions have proposed objective methods to triage inpatient resources. The literature has also been silent on the operational withdrawal of resources from some patients to allow their application to patients with a higher survival probability during a disaster. Although there is no pure ethical difference between the withdrawal of treatment and withholding treatment, the emotional distress for the provider, the patient, and family members will be significantly greater when previously provided (and desired) treatments are withheld.<sup>33</sup> We found no formal constructs to apply to our triage criteria. Substantial critical care and prognostic literature was reviewed.

Three tiers of criteria were developed (Table 4). The first tier is solely related to respiratory failure with shock and multiple organ dysfunction. Second-tier criteria are related to high potential for death, prolonged ventilation, and high levels of resource utilization. These tier 2 criteria are invoked when tier 1 restrictions are inadequate to meet resource demands. The first and second tiers require no familiarity with scoring systems and depend mainly on respiratory failure and poor prognosis based on current and underlying disease. Third-tier criteria may involve additional restrictions or a numeric score and are invoked when determined necessary to maintain consistent standards of patient care and further restrict demand on resources. Any of the tiers may be modified during the event to account for disease-specific prognostic information.

The use of a predictive survival instrument in the final tier standardizes assessments and allows numeric comparisons of patients both within the institution and between institutions. This allows more efficient allocation of available resources to institutions in greatest need and provides as consistent a level of care (as possible) across the community and region. It also provides the physician with guidance for clinical care that is rational and quantitative rather than qualitative.

The standard of care that is applied in the setting of a large-scale disaster is a sliding scale of care appropriate

Table 4  
Three Tiers of Criteria

<p>Tier 1: Do not offer AND withdraw ventilatory support for patients with any one of the following:</p> <ol style="list-style-type: none"> <li>1. Respiratory failure requiring intubation <i>with</i> persistent hypotension (systolic blood pressure &lt;90 mm Hg for adults) unresponsive to adequate fluid resuscitation after 6–12 hours of therapy <i>and</i> signs of additional end-organ dysfunction (e.g., oliguria, mental status changes, cardiac ischemia)</li> <li>2. Failure to respond to mechanical ventilation (no improvement in oxygenation or lung compliance) and antibiotics after 72 hours of treatment for a bacterial pathogen (timeline may be modified based on organism-specific data)</li> <li>3. Laboratory or clinical evidence of <math>\geq 4</math> organ systems failing               <ol style="list-style-type: none"> <li>a. Pulmonary (adult respiratory distress syndrome, ventilatory failure, refractory hypoxemia)</li> <li>b. Cardiovascular (left ventricular dysfunction, hypotension, new ischemia)</li> <li>c. Renal (hyperkalemia, diminished urine output despite adequate fluid resuscitation, increasing creatinine level)</li> <li>d. Hepatic (transaminase greater than two times normal upper limit, increasing bilirubin or ammonia levels)</li> <li>e. Neurologic (altered mental status not related to volume status, metabolic, or hypoxic source, stroke)</li> <li>f. Hematologic (clinical or laboratory evidence of disseminated intravascular coagulation)</li> </ol> </li> </ol> <p>Tier 2: Do not offer AND withdraw ventilatory support from patients with respiratory failure requiring intubation with the following conditions (in addition to those in tier 1):</p> <p>Patients with pre-existing system compromise or failure including:</p> <ol style="list-style-type: none"> <li>1. Known congestive heart failure with ejection fraction &lt;25% (or persistent ischemia unresponsive to therapy and pulmonary edema)</li> <li>2. Acute renal failure requiring hemodialysis (related to illness)</li> <li>3. Severe chronic lung disease including pulmonary fibrosis, cystic fibrosis, obstructive or restrictive diseases requiring continuous home oxygen use before onset of acute illness</li> <li>4. Acquired immunodeficiency syndrome (AIDS), other immunodeficiency syndromes at stage of disease susceptible to opportunistic pathogens (e.g., CD4 &lt;200 for AIDS) with respiratory failure requiring intubation</li> <li>5. Active malignancy with poor potential for survival (e.g., metastatic malignancy, pancreatic cancer)</li> <li>6. Cirrhosis with ascites, history of variceal bleeding, fixed coagulopathy, or encephalopathy</li> <li>7. Acute hepatic failure with hyperammonemia</li> <li>8. Irreversible neurologic impairment that makes patient dependent for personal cares (e.g., severe stroke, congenital syndrome, persistent vegetative state)</li> </ol> <p>Tier 3: Specific protocols to be agreed upon by guideline development committee. Possibilities include:</p> <ol style="list-style-type: none"> <li>1. Restriction of treatment based on disease-specific epidemiology and survival data for patient subgroups (may include age-based criteria)</li> <li>2. Expansion of preexisting disease classes that will not be offered ventilatory support</li> <li>3. Applying Sequential Organ Failure Assessment scoring to the triage process and establishing a cutoff score above which mechanical ventilation will not be offered</li> </ol>
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to the resource demands of the event. A hospital attempting to manage a large influx of patients who require ventilator support during an epidemic may have to further ration resources in the face of increasing demand. This could potentially result in withdrawal of resources from an individual who might be stable, or even improving, but whose objective assessment indicates a worse prognosis than other patients who require the same resource (e.g., tier 3 criteria, where a score of X today might warrant a ventilator but, in the face of worsening shortages, might not be sufficient to justify continued ventilatory management tomorrow, or a patient who is already hospitalized when a disaster occurs, and whose resources are reapplied to a patient with a higher potential for a good outcome).

Many scoring systems have been developed to predict mortality in intensive care environments.<sup>34</sup> These scoring systems offer an ability to compare critical illness between patients and to numerically compare illness severity between ICUs (and thus across or between institutions or regions). None of these systems are applicable to all patient populations, and none were developed as a triage tool; thus, their ability to predict mortality across populations does not translate into accuracy for individual patients, discouraging their use for day-to-day triage of ICU resources. However, disasters require different measures, and we believe that scoring systems allow a validated, objective approach to compare mortality predictions and thus, in a disaster, should be strongly considered despite their limitations.<sup>35,36</sup>

Some systems are proprietary (e.g., Acute Physiology and Chronic Health Evaluation III [APACHE III]), and many rely on complex variables and mathematical computations (Simplified Acute Physiology Score [SAPS], Logistic Organ Dysfunction [LOD] score, Modified Organ Dysfunction Score [MODS], and Morbidity Probability Model II [MPM II]).<sup>37–46</sup> Of the scoring systems that are currently available, the Sequential Organ Failure Assessment (SOFA) seems to be the most useful of the systems, generating a numeric score that offers good predictive accuracy based on a few clinical and simple (bilirubin, creatinine, platelet count) laboratory observations (Table 5).<sup>37–41</sup> SOFA scores can also be used over time to evaluate prognosis and response to therapy.<sup>37,38,40,41</sup>

Notably, SOFA (unlike MPM II) does not incorporate age-based criteria. Daniels would argue that the right of an individual to have the opportunity to reach the end of a natural life span would mean preferential triage of resources to the young rather than to those that had achieved a “natural life span.”<sup>47</sup> However, what constitutes a natural life span is open to discussion.

Although elders in general have lower survival rates and fewer quality-adjusted years of life than younger patients, there are marked differences in chronologic age versus biologic age. Surveys have found that neither the public<sup>48</sup> nor ICU practitioners<sup>49</sup> favor withholding care based on age alone. For those 13% of ICU practitioners who did favor an age limit, 85 years was the median age selected.<sup>36</sup> To the degree that biologically aged persons are more fragile and prone to developing organ system failure, these frailties will be reflected in their organ dysfunction scores.

Aside from tier 2, item number 10, no assessment of functional independence is made. This is likely to be the most difficult of factors affecting triage, because it relates to the demands that an individual would place on society after recovery. How performance of activities of daily living<sup>50</sup> or dependence scores<sup>51</sup> could be incorporated logically or ethically with physiologic scoring systems is an area that requires future discussion and research.

Finally, although use of a predictive framework is consistent with the view of ICU practitioners that social worth is of minimal consideration in decisions regarding ICU care, it fails to take into account quality of life, which was ranked as the most important factor affecting provision of ICU care. However, quality of life is very difficult to assess, because provider and patient interpretations of their condition may differ widely.<sup>49</sup>

## DISCUSSION

With the limitations present in our health care system today, we believe discussion of adjusting standards of care proportionate to the demands of a disaster or epidemic is critical. In developing and communicating our concept of operations and triage criteria, we do not believe that we have arrived at anything in our state besides a starting

Table 5  
Sequential Organ Failure Assessment<sup>39</sup>

Reprinted with kind permission from Springer Science and Business Media and the author, Dr. Vincent (Vincent JL, Moreno R, Takala J, et al. The SOFA [sepsis-related organ failure assessment] score to describe organ dysfunction/failure. *Intensive Care Med.* 1996;22:707–10).

NOTE. This table will not be available online but does appear in the February 2006 print issue of *AEM*.

\* Adrenergic agents are expressed as  $\mu\text{g/kg/min}$  for at least one hour.

point that needs further discussion, study, and refinement. We have thus far only looked at triage of ventilators, but this concept of operations theoretically can be applied to any resource in short supply. Mechanical ventilation and critical care are concrete resources that serve as good starting points for discussion, because there is at least some evidence to suggest which patients are likely to benefit and which are not, although the evidence is, at best, only indirectly related to triage applications.

The triage criteria must be regarded as guidelines, not standards. Individual clinicians have expressed the concern that they must have the ability to make decisions based on other criteria (e.g., preexisting functional capacity, prior wishes of patient regarding life-sustaining therapies, and so on) should they believe there is a need to deviate from the guidance in individual cases. We agree, although we believe that it would be unusual for a practitioner to decide to deviate substantially or systematically from a published emergency guideline, particularly one that could provide liability protection in what will certainly be a highly charged environment.

More important than the specifics of any tool (which will require modification based on the event) is the establishment of a process for making decisions to limit care so that in a time of crisis, a mechanism is in place to apply as much science as possible to these decisions and the persons involved are prepared for their roles.

According to the Society of Critical Care Medicine Ethics Committee, "triage policies should be disclosed in advance to the general public and, when feasible, to patients and surrogates on admission."<sup>36</sup> It cannot be anticipated that the families will agree with the decisions made; however, their disagreement and anger may be tempered by the fact that they viewed the underlying process as fair and understood it in advance, the so-called "fair process effect."<sup>52</sup>

It is difficult to acknowledge and discuss restrictions of care and the limitations of our health care system, but we have been gratified by the acceptance and careful consideration with which these issues have been received by our state groups and look forward to opening broader discussions and generating more public awareness of the issues. We hope that with some preliminary attention being paid to this issue at the federal level,<sup>31</sup> better definition of local, state, and federal roles and responsibilities will occur and operational planning will follow. Regardless of the federal role, there must be local discussions and understanding of resource limitations before an event. We hope that this report will serve as a stimulus for discussion and planning.

## CONCLUSIONS

As physicians and health care providers, we owe it to ourselves and to our patients to develop thoughtful and fair triage strategies in conjunction with members of the community before a crisis. Only in this way can we acknowledge our system limitations and develop contingency plans that can be practiced in advance of an incident, so that we may be trusted to do the greatest good for the greatest number with what we have to offer when disaster strikes.

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TITLE 44. MILITARY AND EMERGENCY LAWS  
CHAPTER 3.2. EMERGENCY SERVICES AND DISASTER LAW

**GO TO CODE OF VIRGINIA ARCHIVE DIRECTORY**

*Va. Code Ann. § 44-146.23 (2006)*

§ 44-146.23. Immunity from liability

A. Neither the Commonwealth, nor any political subdivision thereof, nor federal agencies, nor other public or private agencies, nor, except in cases of willful misconduct, public or private employees, nor representatives of any of them, engaged in any emergency services activities, while complying with or attempting to comply with this chapter or any rule, regulation, or executive order promulgated pursuant to the provisions of this chapter, shall be liable for the death of, or any injury to, persons or damage to property as a result of such activities. The provisions of this section shall not affect the right of any person to receive benefits to which he would otherwise be entitled under this chapter, or under the Workers' Compensation Act (§ 65.2-100 et seq.), or under any pension law, nor the right of any such person to receive any benefits or compensation under any act of Congress. For the purposes of the immunity conferred by this subsection, representatives of public or private employees shall include, but shall not be limited to, volunteers in state and local services who are persons who serve in a Medical Reserve Corps (MRC) unit or on a Community Emergency Response Team (CERT).

B. Any person owning or controlling real estate or other premises who voluntarily and without compensation grants a license or privilege, or otherwise permits the designation or use of the whole or any part or parts of such real estate or premises for the purpose of sheltering persons, of emergency access or of other uses relating to emergency services shall, together with his successors in interest, if any, not be liable for negligently causing the death of, or injury to any person on or about such real estate or premises or for loss of or damage to the property of any person on or about such real estate or premises during such actual or impending disaster.

C. If any person holds a license, certificate, or other permit issued by any state, or political subdivision thereof, evidencing the meeting of qualifications for professional, mechanical, or other skills, the person may gratuitously render aid involving that skill in the Commonwealth during a disaster, and such person shall not be liable for negligently causing the death of, or injury to, any person or for the loss of, or damage to, the property of any person resulting from such gratuitous service.

D. No person, firm or corporation which gratuitously services or repairs any electronic devices or equipment under the provisions of this section after having been approved for the purposes by the State Coordinator shall be liable for negligently causing the death of, or injury to, any person or for the loss of, or damage to, the property of any person resulting from any defect or imperfection in any such device or equipment so gratuitously serviced or repaired.

E. Notwithstanding any law to the contrary, no individual, partnership, corporation, association, or other legal entity shall be liable in civil damages as a result of acts taken voluntarily and without compensation in the course of rendering care, assistance, or advice with respect to an incident creating a danger to person, property, or the environment as a result of an actual or threatened discharge of a hazardous substance, or in preventing, cleaning up, treating, or disposing of or attempting to prevent, clean up, treat, or dispose of any such discharge, provided that such acts are taken under the direction of state or local authorities responding to the incident. This section shall not preclude liability for civil damages as a result of gross negligence, recklessness or willful misconduct. The provisions of this section shall not affect the



right of any person to receive benefits to which he would otherwise be entitled under this chapter, or under the Workers' Compensation Act (§ 65.2-100 et seq.), or under any pension law, nor the right of any such person to receive any benefits or compensation under any act of Congress. The immunity provided by the provisions of this paragraph shall be in addition to, not in lieu of, any immunities provided by § 8.01-225.

**HISTORY:** 1973, c. 260; 1979, c. 193; 1984, c. 743; 2005, c. 474.

**NOTES:**

**THE 2005 AMENDMENTS.**—The 2005 amendment by c. 474 added the last sentence to subsection A; substituted "the Commonwealth" for "this Commonwealth" in subsection C; and made minor stylistic changes.

**LAW REVIEW.**—For comment, "'911' Emergency Assistance Call Systems: Should Local Governments Be Liable for Negligent Failure to Respond?," see 8 G.M.U. L. Rev. 103 (1985).

**A COURT MAY MODIFY THE SENTENCE OF A DEFENDANT** completing the Department of Corrections' Therapeutic Community Program only if such modification occurs within twenty-one days of entry of the sentencing order. See opinion of Attorney General to The Honorable Henry A. Vanover, Judge, Twenty-Ninth Judicial Circuit, 03-081 (10/6/03). .

**IN THE ABSENCE OF A FORMALLY DECLARED EMERGENCY AND WITHOUT SPECIFIC LEGISLATION,** the general test of whether sovereign immunity applies depends upon the capacity in which the private entity was acting and whether such acts are under the direction and control of the Commonwealth, based on the nature of, and the state's interest in, the function to be performed. See opinion of Attorney General to The Honorable John W. Marshall, Secretary of Public Safety, 03-078 (12/1/03). .

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TITLE 2.2. ADMINISTRATION OF GOVERNMENT  
SUBTITLE II. ADMINISTRATION OF STATE GOVERNMENT  
PART B. TRANSACTION OF PUBLIC BUSINESS  
CHAPTER 40. ADMINISTRATIVE PROCESS ACT  
ARTICLE 2. REGULATIONS

## GO TO CODE OF VIRGINIA ARCHIVE DIRECTORY

*Va. Code Ann. § 2.2-4011 (2006)*

## § 2.2-4011. Emergency regulations; publication; exceptions

A. Regulations that an agency finds are necessitated by an emergency situation. For the purposes of this subsection, "*emergency situation*" means a situation (i) involving an imminent threat to public health or safety or (ii) in which Virginia statutory law or the appropriation act or federal law or federal regulation requires that a regulation be effective in 280 days or less from its enactment, and the regulation is not exempt under the provisions of subdivision A. 4. of § 2.2-4006. In such cases, the agency shall state in writing the nature of the emergency and of the necessity for such action and may adopt the regulations. Pursuant to § 2.2-4012, such regulations shall become effective upon approval by the Governor and filing with the Registrar of Regulations. The regulations shall be limited to no more than twelve months in duration. During the twelve-month period, an agency may issue additional emergency regulations as needed addressing the subject matter of the initial emergency regulation, but any such additional emergency regulations shall not be effective beyond the twelve-month period from the effective date of the initial emergency regulation. If the agency wishes to continue regulating the subject matter governed by the emergency regulation beyond the twelve-month limitation, a regulation to replace the emergency regulation shall be promulgated in accordance with this article. The Notice of Intended Regulatory Action to promulgate a replacement regulation shall be filed with the Registrar within sixty days of the effective date of the emergency regulation and published as soon as practicable, and the proposed replacement regulation shall be filed with the Registrar within 180 days after the effective date of the emergency regulation and published as soon as practicable.

B. Emergency regulations shall be published as soon as practicable in the Register.

C. The Regulations of the Marine Resources Commission shall be excluded from the provisions of this section.

**HISTORY:** 1975, c. 503, § 9-6.14:9; 1977, cc. 450, 459; 1981, c. 387; 1982, c. 425; 1983, c. 295; 1984, c. 5; 1985, c. 602, § 9-6.14:4.1; 1986, c. 615; 1987, cc. 375, 652; 1988, cc. 364, 424, 498, 723, 765, 820; 1989, cc. 54, 71, 299, 478; 1990, cc. 721, 968; 1991, cc. 80, 294, 344; 1992, cc. 200, 409, 488, 592, 793, 829; 1993, cc. 537, 669, 898; 1994, cc. 237, 577, 649, 740, 743, 801, 938; 1995, cc. 103, 499, 516; 1996, cc. 51, 152, 158, 189, 205, 279, 320, 345, 573, 590, 598, 638, 705, 735, 818, 1012; 1997, cc. 87, 88, 109, 212, 390, 439, 567, 624, 785, 806, 845, 850, 861, 868; 1998, cc. 39, 619, 784; 1999, cc. 412, 421, 433, 603; 2000, cc. 382, 400, 924, 1011; 2001, c. 844.

**NOTES:**

EDITOR'S NOTE.—Acts 2004, Sp. Sess. I, c. 4, Item 322 H, as amended by Acts 2005, c. 951, effective for the biennium ending June 30, 2006, provides: "H. The Department of Medical Assistance Services shall have the authority to amend the Medallion II waiver to allow the Department to carve out dental services provided to children under the age of 21, and for adults as defined in 12 VAC 30-50-190, from Medicaid managed care. In addition, the Department shall have the authority to amend the State Plans for Titles XIX (Medical Assistance) and XXI (Family Access to Medical Insurance Security) of

the Social Security Act, as required by applicable statute and regulations to provide dental services to individuals enrolled in these programs on a fee-for-service basis, and to revise the prior authorization requirements for dental services in accordance with industry standards. The Department of Medical Assistance Services shall enact emergency regulations to effect this provision within 280 days or less from the enactment of this act. The Department of Medical Assistance Services may consider outsourcing such dental services to children under age 21, and for adults as defined in *12 VAC 30-50-190*, to an administrative services program."

Acts 2004, Sp. Sess. I, c. 4, Items 324 G and H, as amended by Acts 2005, c. 951, effective for the biennium ending June 30, 2006, provide: "G. The Department of Medical Assistance Services shall have the authority to amend the Family Access to Medical Insurance Security Plan and related regulations to cover additional medical services for special education students and to revise referral and prior authorization requirements for services provided to special education students by school division providers. The Department shall have authority to enact emergency regulations under § 2.2-4011 of the Administrative Process Act, to effect this provision.

"H. The Department of Medical Assistance Services shall have the authority to amend the Family Access to Medical Insurance Security Plan and related regulations to establish separate payment rates for state and local government providers based on an evaluation of costs incurred. The Department shall have authority to enact emergency regulations under § 2.2-4011 of the Administrative Process Act, to effect this provision."

LAW REVIEW.—For survey of Virginia administrative law for the year 1974-1975, see *61 Va. L. Rev. 1632 (1975)*. For survey of Virginia administrative law for the year 1976-77, see *63 Va. L. Rev. 1366 (1977)*. For article, "Legislative and Executive Veto of Rules of Administrative Agencies: Models and Alternatives," see *24 Wm. & Mary L. Rev. 79 (1982)*.

EDITOR'S NOTE.—The case below was decided under former corresponding provisions.

*EVEN THOSE REGULATIONS EXEMPTED FROM PROMULGATION PROCESS MUST GO THROUGH ADOPTION PROCEDURE.* *Johnston-Willis, Ltd. v. Kenley*, 6 Va. App. 231, 369 S.E.2d 1 (1988).

SUSPENSION OF REQUIREMENTS FOR LICENSURE OF HEALTH PROFESSIONALS.—Health boards may promulgate emergency regulations suspending licensure requirements for health professionals in the event of a public health disaster. See opinion of Attorney General to The Honorable John M. O'Bannon, III, Member, House of Delegates, 02-069 (11/13/02). .

USER NOTE: For more generally applicable notes, see notes under the first section of this part, article, chapter, subtitle or title.

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TITLE 32.1. HEALTH  
CHAPTER 2. DISEASE PREVENTION AND CONTROL  
ARTICLE 3. DISEASE CONTROL MEASURES

**GO TO CODE OF VIRGINIA ARCHIVE DIRECTORY**

*Va. Code Ann. § 32.1-42 (2006)*

§ 32.1-42. Emergency rules and regulations

The Board of Health may promulgate regulations and orders to meet any emergency or to prevent a potential emergency caused by a disease dangerous to public health, including, but not limited to, procedures specifically responding to any disease listed pursuant to § 32.1-35 that is determined to be caused by an agent or substance used as a weapon or any communicable disease of public health threat that is involved in an order of quarantine or an order of isolation pursuant to Article 3.02 (§ 32.1-48.05 et seq.) of this chapter.

**HISTORY:** 1979, c. 711; 2002, c. 768; 2004, cc. 773, 1021.

**NOTES:**

**EDITOR'S NOTE.**—Acts 2004, cc. 773 and 1021, cl. 2, provide: "That the Board of Health shall promulgate regulations to implement the provisions of this act to be effective within 280 days of its enactment."

**THE 2002 AMENDMENTS.**—The 2002 amendment by c. 768 inserted "including procedures specifically responding to any disease listed pursuant to § 32.1-35 that is determined to be caused by an agent or substance used as a weapon."

**THE 2004 AMENDMENTS.**—The 2004 amendments by cc. 773, effective April 12, 2004, and 1021, effective April 21, 2004, are identical, and inserted "of Health," "but not limited to" and added the language beginning "or any communicable disease" at the end.

01-117

**HOUSING: UNIFORM STATEWIDE BUILDING CODE.**

**COMMON LAW, STATUTES AND RULES OF CONSTRUCTION:  
GENERAL PROVISIONS.**

**State Building Code supersedes design elements in Suffolk city ordinance requiring use of specific building materials and finishes in construction of all buildings.**

The Honorable Martin E. Williams  
Member, Senate of Virginia  
November 19, 2001

You ask whether the third paragraph of § 36-98 of the *Code of Virginia*, as amended by the 2001 Session of the General Assembly,<sup>1</sup> supersedes all residential architectural design feature requirements of an ordinance adopted by the City of Suffolk.

You relate that, in September 1999, the City of Suffolk adopted a comprehensive ordinance, entitled the Unified Development Ordinance, in an attempt to regulate development in the city.<sup>2</sup> You advise that the ordinance contains certain residential architectural design features which are required for single family homes constructed in a planned development zone.<sup>3</sup> Furthermore, you advise that the ordinance contains a listing of residential architectural design features which the City is attempting to enforce on all single family residential projects built in the city.<sup>4</sup> The portion of the subject ordinance about which you specifically inquire requires that "[e]xterior materials and finishes such as brick, stone, wood, clapboard, cedar shake, stucco, drivet or similar material shall be provided on all exterior elevations on not less than fifty (50%) percent of all buildings".<sup>5</sup> For the purposes of this opinion, you ask that I assume that you are referring to projects involving single family residential construction.

Section 36-98, a portion of the Uniform Statewide Building Code<sup>6</sup> ("Building Code"), directs and empowers the Board of Housing and Community Development "to adopt and promulgate a Uniform Statewide Building Code," and expressly provides that "[s]uch building code shall supersede the building codes and regulations of the counties, municipalities and other political subdivisions and state agencies." Prior opinions of the Attorney General conclude that the Building Code supersedes all building and maintenance codes and regulations of counties,

municipalities, political subdivisions and state agencies that have been or may be enacted or adopted.<sup>7</sup> The dominant purpose of the Building Code is "to protect the health, safety and welfare of the residents of this Commonwealth."<sup>8</sup> Another important purpose of the Building Code is to provide for "the safety of ultimate construction."<sup>9</sup>

The third paragraph of § 36-98 pertains to the effect of the Building Code on local ordinances, and provides:

Such [Building] Code also shall supersede the provisions of local ordinances applicable to single family residential construction that (a) regulate dwelling foundations or crawl spaces, (b) require the use of specific building materials or finishes in construction, or (c) require minimum surface area or numbers of windows; however, such Code shall not supersede proffered conditions accepted as a part of a rezoning application, conditions imposed upon the grant of special exceptions, special or conditional use permits or variances, or land use requirements in airport or highway overlay districts, or historic districts created pursuant to § [15.2-2306](#), or local flood plain regulations adopted as a condition of participation in the National Flood Insurance Program.

A rule of statutory construction requires the presumption that, when new provisions are added to existing legislation by an amendatory act, a presumption normally arises that a change in the law was intended.<sup>10</sup> In addition, two bodies of law which pertain to the same subject matter are said to be *in pari materia*.<sup>11</sup> Where possible, the two should be harmonized in order to give effect to both.<sup>12</sup> "If both the statute and the ordinance can stand together and be given effect, it is the duty of the courts to harmonize them and not nullify the ordinance."<sup>13</sup> Of course, consistent with Dillon's Rule, the local ordinance must be supported by adequate enabling legislation.<sup>14</sup>

When the state in the exercise of its police power enacts certain laws, however, a political subdivision may in the exercise of its delegated police powers legislate on the same subject.<sup>15</sup> The exercise of this power by a locality cannot, however, be inconsistent with state law.<sup>16</sup> An ordinance is inconsistent with state law if state law preempts local regulation in the area, either by expressly prohibiting local regulation or by enacting state

regulations so comprehensive that the state may be considered to occupy the entire field.<sup>17</sup> Section 1-13.17 precludes a local governing body from enacting ordinances "inconsistent with" state law.<sup>18</sup> It is beyond doubt that § 1-13.17 can have the effect of invalidating local ordinances under appropriate circumstances.<sup>19</sup>

The design element contained in the Suffolk city ordinance, requiring that "[e]xterior materials and finishes such as brick, stone, wood, clapboard, cedar shake, stucco, drivet, or similar materials shall be provided on all exterior elevations on not less than fifty (50%) percent of all buildings,"<sup>20</sup> clearly mandates the use of specific building materials or finishes in construction. The third paragraph of § 36-98 unambiguously "supersede[s] the provisions of local ordinances applicable to single family residential construction ... requir[ing] the use of specific building materials or finishes in construction." The third paragraph of § 36-98 is clearly "so comprehensive that the state may be considered to occupy the entire field." Consequently, I must conclude that design elements of the Suffolk city ordinance quoted above are preempted by the provisions of the third paragraph of § 36-98.

<sup>1</sup>2001 Va. Acts ch. 525, at 588.

<sup>2</sup>Suffolk, Va., Unified Development Ordinance (Jan. 26, 2000) [hereinafter Suffolk Ordinance].

<sup>3</sup>*See id.* art. 4, § 31-410.

<sup>4</sup>*See id.* table 410-2.

<sup>5</sup>*Id.* at 4-55.

<sup>6</sup>Va. Code Ann. §§ 36-97 to 36-119.1 (Michie Repl. Vol. 1996 & Supp. 2001).

<sup>7</sup>*See Op. Va. Att'y Gen.*: 1986-1987 at 221, 221; 1985-1986 at 184, 184; *see also* Fairfax County v. M. & S., Inc., 222 Va. 230, 279 S.E.2d 158 (1981).

<sup>8</sup>Section 36-99(A) (Michie Supp. 2001). "The Building Code shall prescribe building regulations to be complied with in the construction of buildings and structures, and the equipment therein as defined in § 36-97, and shall prescribe regulations to insure that such regulations are properly maintained, and shall also prescribe procedures for the administration and enforcement of such regulations. The provisions thereof shall be such as to protect the health, safety and welfare of the residents of this Commonwealth, provided that buildings and structures should be permitted to be constructed at the least possible cost consistent with recognized standards of health, safety, energy conservation and water conservation and barrier-free provisions for the physically handicapped and aged." *Id.*

<sup>9</sup>VEPCO v. Savoy Const. Co., 224 Va. 36, 44, 294 S.E.2d 811, 817 (1982) (quoting Jan. 2, 1980, trial court judge op.).

<sup>10</sup>Wisniewski v. Johnson, 223 Va. 141, 144, 286 S.E.2d 223, 224-25 (1982); *see also* Op. Va. Att’y Gen.: 1996 at 61, 61; 1990 at 156, 157; 1986-1987 at 272, 273.

<sup>11</sup>*See* Op. Va. Att’y Gen.: 1983-1984 at 135, 135; 1982-1983 at 343, 344; 1981-1982 at 273, 274.

<sup>12</sup>Prillaman v. Commonwealth, 199 Va. 401, 405, 100 S.E.2d 4, 7 (1957).

<sup>13</sup>King v. County of Arlington, 195 Va. 1084, 1091, 81 S.E.2d 587, 591 (1954).

<sup>14</sup>City of Virginia Beach v. Hay, 258 Va. 217, 221, 518 S.E.2d 314, 316 (1999) (holding that, under Dillon’s Rule, local governing bodies have only those powers expressly granted by legislature, those powers fairly or necessarily implied from expressly granted powers, and those powers which are essential and indispensable. Where legislature grants power to local government but does not specify method of implementing power, local government’s choice as to how to implement conferred power will be upheld, provided method chosen is reasonable).

<sup>15</sup>Ticonderoga Farms v. County of Loudoun, 242 Va. 170, 175, 409 S.E.2d 446, 449 (1991); *King*, 195 Va. at 1088, 81 S.E.2d at 590.

<sup>16</sup>"When the council ... of any city ... [is] authorized to make ordinances, ... it shall be understood that the same must not be inconsistent with the Constitution and laws of ... this Commonwealth." Va. Code Ann. § 1-13.17 (Matthew Bender Repl. Vol. 2001); *see* 1995 Op. Va. Att’y Gen. 85, 86.

<sup>17</sup>*See King*, 195 Va. at 1087, 81 S.E.2d at 590; 1983-1984 Op. Va. Att’y Gen. 86, 87; *see also* Hanbury v. Commonwealth, 203 Va. 182, 185, 122 S.E.2d 911, 913 (1961).

<sup>18</sup>Loudoun County v. Pumphrey, 221 Va. 205, 269 S.E.2d 361 (1980).

<sup>19</sup>*Id.*; Wayside Restaurant, Inc. v. City of Virginia Beach, 215 Va. 231, 208 S.E.2d 51 (1974); *Kisey*, 212 Va. at 693, 187 S.E.2d at 168; *King*, 195 Va. at 1087, 81 S.E.2d at 590.

<sup>20</sup>Suffolk Ordinance, *supra* note 2, art. 4, § 31-410, table 410-2, at 4-55.



**COUNTIES, CITIES AND TOWNS: CERTAIN LOCAL GOVERNMENT OFFICERS.**

**City of Hopewell may not hire employees on temporary basis, pursuant to written contracts, rather than hire such employees for indefinite period of time.**

Mr. Edwin N. Wilmot  
City Attorney for the City of Hopewell  
March 8, 2000

You ask whether the City of Hopewell may hire employees on a temporary basis, pursuant to written contracts, rather than hire such employees for an indefinite period of time.

It is your opinion<sup>1</sup> that § 15.2-1503 of the *Code of Virginia* permits the City of Hopewell to hire an employee on a temporary basis for a term not to exceed one year. You note that the charter for the City of Hopewell vests authority in the city to exercise all powers conferred upon cities.<sup>2</sup> You, therefore, conclude that the language in § 15.2-1503(A), which permits localities to hire employees "for temporary service not to exceed one year or except as otherwise provided by general law or special act," is applicable to your request.

Title 15.2 contains several provisions addressing aspects of the employer/employee relationship in local government. Section 15.2-1500(A) specifically provides that "[e]very locality shall provide for all the governmental functions of the locality, including, without limitation ... the employment of ... employees needed to carry out the functions of government." Section 15.2-1503(A) provides that employees hired by a locality "shall be without definite term, unless for temporary services not to exceed one year or except as otherwise provided by general law or special act."

Chapter V of the Hopewell City Charter pertains to the position of city manager. Section 2 provides, in part:

The city manager shall appoint for an indefinite term and remove, subject to the provisions of this charter and except as herein provided, the heads of all departments and all other officers, (except executive officers), and employees of the city.<sup>[3]</sup>

"[T]he plain, obvious, and rational meaning of a statute is always to be preferred to any curious, narrow, or strained construction."<sup>4</sup> Statutes should not be construed to frustrate their purpose.<sup>5</sup> In addition, the use of the word "shall" in a statute generally implies that its terms are intended to be mandatory, rather than permissive or directive.<sup>6</sup> A fundamental rule of statutory construction is that statutes which relate to the same subject matter should, to the extent possible, be read together, the object being to give effect to

the legislative intent of each statute.<sup>7</sup> An equally fundamental rule of construction is that a specific or special statute supersedes a general statute insofar as there is a conflict.<sup>8</sup> Finally, when a statute creates a specific grant of authority, the authority exists only to the extent specifically granted in the statute.<sup>9</sup>

Chapter V, § 2 of the Hopewell charter pertains specifically to the hiring of employees by the City of Hopewell. Section 2 requires the city manager to appoint employees "for an *indefinite term*."<sup>10</sup> A charter provision that establishes the powers of a local government is special legislation authorized by Article VII, § 2 of the Constitution of Virginia (1971),<sup>11</sup> and will prevail over general law, absent an indication of legislative intent to the contrary, in the event of a conflict between the two.<sup>12</sup> Words used in a statute are to be given their common meanings unless a contrary legislative intent is manifest.<sup>13</sup> The term "indefinite" generally means "having no exact limits : indeterminate in extent or amount : not clearly fixed ... : not narrowly confined or restricted ... : continuing with no immediate end being fixed : unlimited."<sup>14</sup>

Applying the required rules of statutory construction and the above definition to this inquiry, I must conclude that the City of Hopewell may not hire employees on a temporary basis, pursuant to written contracts, rather than hire such employees for an indefinite period of time. Section 15.2-1503(A) is the general statute pertaining to the hiring of temporary employees by all local governments within the Commonwealth. The specific provisions of the Hopewell charter supersede the general provisions of § 15.2-1503(A).

Accordingly, I must conclude that the City of Hopewell is not authorized to fill a city position with a temporary employee.<sup>15</sup>

<sup>1</sup>Section 2.1-118 requires that any request by a city attorney for an opinion from the Attorney General "shall itself be in the form of an opinion embodying a precise statement of all facts together with such attorney's legal conclusions."

<sup>2</sup>"The city shall have and may exercise all powers which are now or may hereafter be conferred upon or delegated to cities under the constitution and law of the Commonwealth and all other powers pertinent to the conduct of the city government ...." 1950 Va. Acts ch. 431, at 828, 830 (quoting ch. II, § 1).

<sup>3</sup>*Id.* at 837.

<sup>4</sup>*Turner v. Commonwealth*, 226 Va. 456, 459, 309 S.E.2d 337, 338 (1983).

<sup>5</sup>See 1982-1983 Op. Va. Att'y Gen. 309, 311 (illogical result frustrates purpose of statute).

<sup>6</sup>See *Andrews v. Shepherd*, 201 Va. 412, 414-15, 111 S.E.2d 279, 281-82 (1959); see also *Schmidt v. City of Richmond*, 206 Va. 211, 218, 142 S.E.2d 573, 578 (1965); Op. Va. Att'y Gen.: 1998 at 56, 58; 1996 at 178, 178; 1991 at 238, 240; 1989 at 250, 251-52; 1985-1986 at 133, 134.

<sup>7</sup>See *Commonwealth v. Sanderson*, 170 Va. 33, 195 S.E. 516 (1938).

<sup>8</sup>See *City of South Norfolk v. Dail*, 187 Va. 495, 499, 47 S.E.2d 405, 406 (1948); *Commonwealth v. Sanderson*, 170 Va. at 40, 195 S.E. at 519; *Commonwealth v. R. & P. R. R. Co.*, 81 Va. (6 Hansbrough) 355 (1886); see also *City of Roanoke v. Land*, 137 Va. 89, 119 S.E. 59 (1923) (local ordinance adopted under general charter powers that conflicts with specific statute empowering court to grant or refuse pawnbroker license to applicant is void); Op. Va. Att'y Gen.: 1987-1988 at 276, 277; 1985-1986 at 65, 68.

<sup>9</sup>See 2A Norman J. Singer, *Sutherland Statutory Construction* § 47.23 (5<sup>th</sup> ed. 1992 & Supp. 1999); Op. Va. Att'y Gen.: 1992 145, 146; 1989 at 252, 253; 1980-1981 at 209, 209-10.

<sup>10</sup>1950 Va. Acts ch. 431, *supra* note 2, at 837 (emphasis added).

<sup>11</sup>"The General Assembly may also provide by special act for the ... powers of any county, city, town, or regional government ...." Art. VII, § 2.

<sup>12</sup>See *Pierce v. Dennis*, 205 Va. 478, 138 S.E.2d 6 (1964); *Petersburg v. General Baking Co.*, 170 Va. 303, 196 S.E. 597 (1938); Op. Va. Att'y Gen.: 1983-1984 at 140, 141; 1978-1979 at 35.

<sup>13</sup>See Op. Va. Att'y Gen.: 1998 at 91, 93; 1990 at 233, 234; 1989 at 155, 155.

<sup>14</sup>Webster's Third New International Dictionary of the English Language 1147 (1993).

<sup>15</sup>You ask a second question regarding whether such hiring of temporary employees must be made open for application from all interested applicants. Since I conclude that the city may not hire employees on a temporary basis, pursuant to a written contract, it is unnecessary to respond to your second inquiry.

1 of 1 DOCUMENT

CODE OF VIRGINIA

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\*\*\* CURRENT THROUGH THE 2005 REGULAR SESSION, Acts 2005, cc. 1 to 951 \*\*\*  
\*\*\* ANNOTATIONS CURRENT THROUGH JANUARY 1, 2006 \*\*\*

TITLE 2.2. ADMINISTRATION OF GOVERNMENT  
SUBTITLE II. ADMINISTRATION OF STATE GOVERNMENT  
PART B. TRANSACTION OF PUBLIC BUSINESS  
CHAPTER 40. ADMINISTRATIVE PROCESS ACT  
ARTICLE 2. REGULATIONS

**GO TO CODE OF VIRGINIA ARCHIVE DIRECTORY**

*Va. Code Ann. § 2.2-4006 (2006)*

**STATUS: CONSULT SLIP LAWS CITED BELOW FOR RECENT CHANGES TO THIS DOCUMENT LEXSEE**  
2006 Va. ALS 719 — See section 1.  
LEXSEE 2006 Va. ALS 632 — See section 1.

§ 2.2-4006. Exemptions from requirements of this article

A. The following agency actions otherwise subject to this chapter and § 2.2-4103 of the Virginia Register Act shall be exempted from the operation of this article:

1. Agency orders or regulations fixing rates or prices.
2. Regulations that establish or prescribe agency organization, internal practice or procedures, including delegations of authority.
3. Regulations that consist only of changes in style or form or corrections of technical errors. Each promulgating agency shall review all references to sections of the Code of Virginia within their regulations each time a new supplement or replacement volume to the Code of Virginia is published to ensure the accuracy of each section or section subdivision identification listed.
4. Regulations that are:
  - a. Necessary to conform to changes in Virginia statutory law or the appropriation act where no agency discretion is involved;
  - b. Required by order of any state or federal court of competent jurisdiction where no agency discretion is involved;  
or
  - c. Necessary to meet the requirements of federal law or regulations, provided such regulations do not differ materially from those required by federal law or regulation, and the Registrar has so determined in writing. Notice of the proposed adoption of these regulations and the Registrar's determination shall be published in the Virginia Register not less than 30 days prior to the effective date of the regulation.
5. Preliminary program permit fees of the Department of Environmental Quality assessed pursuant to subsection C of § 10.1-1322.2.
6. Regulations of the Pesticide Control Board adopted pursuant to subsection B of § 3.1-249.51 or clause (v) or (vi) of subsection C of § 3.1-249.53 after having been considered at two or more Board meetings and one public hearing.
7. Regulations of the regulatory boards served by (i) the Department of Labor and Industry pursuant to Title 40.1

and (ii) the Department of Professional and Occupational Regulation or the Department of Health Professions pursuant to Title 54.1 that are limited to reducing fees charged to regulants and applicants.

8. The development and issuance of procedural policy relating to risk-based mine inspections by the Department of Mines, Minerals and Energy authorized pursuant to §§ 45.1-161.82 and 45.1-161.292:55.

9. General permits issued by the (a) State Air Pollution Control Board pursuant to Chapter 13 (§ 10.1-1300 et seq.) of Title 10.1 or (b) State Water Control Board pursuant to the State Water Control Law (§ 62.1-44.2 et seq.), Chapter 24 (§ 62.1-242 et seq.) of Title 62.1 and Chapter 25 (§ 62.1-254 et seq.) of Title 62.1, (c) Virginia Soil and Water Conservation Board pursuant to the Virginia Stormwater Management Act (§ 10.1-603.1 et seq.) of Title 10.1, and (d) the development and issuance of general wetlands permits by the Marine Resources Commission pursuant to subsection B of § 28.2-1307, if the respective Board or Commission (i) provides a Notice of Intended Regulatory Action in conformance with the provisions of subsection B of § 2.2-4007, (ii) following the passage of 30 days from the publication of the Notice of Intended Regulatory Action forms a technical advisory committee composed of relevant stakeholders, including potentially affected citizens groups, to assist in the development of the general permit, (iii) provides notice and receives oral and written comment as provided in subsection F of § 2.2-4007, and (iv) conducts at least one public hearing on the proposed general permit.

10. The development and issuance by the Board of Education of guidelines on constitutional rights and restrictions relating to the recitation of the pledge of allegiance to the American flag in public schools pursuant to § 22.1-202.

11. Regulations of the Board of the Virginia College Savings Plan adopted pursuant to § 23-38.77.

12. Regulations of the Marine Resources Commission.

13. Regulations adopted by the Board of Housing and Community Development pursuant to subsection D of § 36-99.

B. Whenever regulations are adopted under this section, the agency shall state as part thereof that it will receive, consider and respond to petitions by any interested person at any time with respect to reconsideration or revision. The effective date of regulations adopted under this subsection shall be in accordance with the provisions of § 2.2-4015, except in the case of emergency regulations, which shall become effective as provided in subsection B of § 2.2-4012.

C. A regulation for which an exemption is claimed under this section or § 2.2-4002, or 2.2-4011 and that is placed before a board or commission for consideration shall be provided at least two days in advance of the board or commission meeting to members of the public that request a copy of that regulation. A copy of that regulation shall be made available to the public attending such meeting.

**HISTORY:** 1985, c. 602, § 9-6.14:4.1; 1986, c. 615; 1987, cc. 375, 652; 1988, cc. 364, 424, 498, 723, 765, 820; 1989, cc. 54, 299, 478; 1990, cc. 721, 968; 1991, cc. 80, 294, 344; 1992, cc. 200, 409, 488, 592, 793; 1993, cc. 537, 669, 898; 1994, cc. 237, 577, 649, 740, 743, 801; 1995, cc. 103, 499, 516; 1996, cc. 51, 152, 158, 189, 205, 279, 320, 345, 573, 590, 598, 638, 705, 735, 818, 1012; 1997, cc. 87, 88, 109, 212, 390, 439, 567, 624, 785, 806, 845, 850, 861, 868; 1998, cc. 39, 619, 784; 1999, cc. 412, 421, 433, 603; 2000, cc. 382, 400, 924, 1011; 2001, c. 844; 2003, c. 436; 2005, c. 102.

#### NOTES:

**CROSS REFERENCES.**—As to the Virginia Respite Care Grant Fund being exempt from the Administrative Process Act, see § 2.2-717. As to the purchase of continued health insurance coverage by the surviving spouse and any dependents of an active local law-enforcement officer, firefighter, etc., through a plan sponsor, see § 2.2-1206. As to guidelines for the award of Virginia Investment Performance Grants, see § 2.2-5101. As to the allocation and awarding of grants under the Virginia Investment Partnership Grant Fund, see § 2.2-5104.

**EDITOR'S NOTE.**—Acts 2005, c. 102, cl. 2, provides: "That the Governor shall make new appointments for each of the three at-large members of the Board in accordance with the provisions of this act on July 1, 2005. The new appointments of the at-large members of the Board shall go into effect upon the expiration of the current members' terms in January 2006, and the terms shall be staggered as follows: one member for a term of two years; one member for a term of three years; and one member for a term of four years. The Governor shall designate the term to be served by each appointee at the time of appointment and may reappoint the existing at-large members of the Board."

Acts 2005, c. 102, cl. 3, provides: "That the Director of the Department of Conservation and Recreation shall amend the

Stormwater Management Regulations by removing the out-of-date Best Management Practices (BMP) nutrient removal efficiency information and adding it into the Virginia Stormwater Management Handbook guidance document where it shall be more effectively updated for public use."

THE 2003 AMENDMENTS.—The 2003 amendment by c. 436 substituted "30" for "thirty" throughout the section; and added subdivision A 13.

THE 2005 AMENDMENTS.—The 2005 amendment by c. 102 substituted "(c) Virginia Soil and Water Conservation Board pursuant to the Virginia Stormwater Management Act (§ 10.1-603.1 et seq.) of Title 10.1, and (d)" for "and (c)" in subdivision A 9; and substituted "§ 2.2-4002, or 2.2-4011" for "§ 2.2-4002, or § 2.2-4011" in subsection C.

#### NOTES APPLICABLE TO ENTIRE ARTICLE

MICHIE'S JURISPRUDENCE REFERENCES.—For related discussion, see *1A M.J. Administrative Law*, §§ 9 — 12.