The Joint Subcommittee Studying the Feasibility of Offering Liability Protections to Health Care Providers Rendering Aid During a State or Local Emergency

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Richmond, Virginia

Overview.

The Joint Subcommittee to Study the Feasibility of Offering Liability Protections to Health Care Providers Rendering Aid During a State or Local Emergency held its second meeting of the 2007 interim in Richmond, Virginia, on September 27, 2007. The chairman, Delegate Phillip A. Hamilton, called the meeting to order and the members introduced themselves. Staff then presented a brief review of the subcommittee's first meeting, focusing on the presentations made to the subcommittee at that meeting. Staff then proceeded to respond to several questions raised by the members at the first meeting.

First, staff addressed the issue of liability protections available on military bases. Staff explained that servicemembers are precluded from bringing suits for injuries sustained while on active duty under the provisions of a United States Supreme Court case, *Feres v. United States,* 340 U.S. 135, 71 S. Ct. 153, 95 L. Ed. 152 (1950).

Staff then presented information concerning the prosecution of health care providers for decisions made during emergencies or disasters. Staff noted that concern regarding the criminalization of health care decisions resulted from the aftermath of Hurricane Katrina where Dr. Anna Pou was accused of euthanizing patients at New Orleans' Memorial Medical Center, although a grand jury decided not to pursue criminal charges. Staff explained that the medical community, particularly the American Medical Association (AMA), is actively involved in this area. The AMA has issued policies opposing the criminalization of medical judgment and the criminalization of health care decision making. The AMA has also promulgated a Model Act to Prohibit the Criminalization of Health Care Decision Making. Staff further noted that no state has apparently adopted this Model Act.

Presentations.

I. State of Emergency Declaration Process.

Michael Cline, State Coordinator of Emergency Management for the Virginia Department of Emergency Management (VDEM), made a presentation describing the process for emergency declarations. Mr. Cline stated that the Governor is the Director of Emergency Management and has the statutory authority to declare a state of emergency. Mr. Cline explained that the typical declaration process begins with a verbal recommendation that a state of emergency be declared made by the VDEM and based on

the input of the Virginia Emergency Response Team, which includes state agencies as well as representatives of the public and private sectors. In response to the oral recommendation, the Governor issues a verbal order. After input from state agencies, the VDEM, and occasionally the Virginia Department of Health (VDH), promulgate a written order which is reviewed by the Attorney General's office and other agencies that may be affected by the order and then by the Secretary of Public Safety before being issued by the Governor.

Mr. Cline explained that the only exception to this process is in the event that the disaster is expected, such as in the case of a forecasted severe winter storm. In such a case, the Governor would not issue a verbal declaration of a state of emergency and only the written declaration will be issued since the declaration is being made in anticipation of the disaster. Mr. Cline further explained that some state agencies, such as the Virginia Department of Transportation, can respond to a disaster to the extent of their existing authority without a state declaration of emergency. He noted, however, that the Virginia National Guard cannot be activated without a state declaration of emergency.

Finally, Mr. Cline clarified that the declaration of a state of emergency becomes effective upon the Governor's verbal order and that there is little time lapse between the issuance of the verbal order and the subsequent written order, the longest such lapse that Mr. Cline could recall being approximately 45 minutes.

II. Virginia Healthcare and Hospital Association.

Katharine M. Webb, Senior Vice-President of the Virginia Hospital and Healthcare Association (VHHA), made a presentation on the topic of providing care with limited resources. She noted that the VHHA first began to build a public/private partnership on this issue in 2001 when it established a working group of hospital leaders in 2001. Then in June of 2006, the VHHA convened a work group to begin addressing issues related to providing care in the face of normally adequate resources that are depleted by extraordinary demand during a disaster. This work group's membership included various hospital systems as well as other interested organizations and state representation from the VDH and the General Assembly.

Ms. Webb explained that the focus of the work group was on the ability of hospitals to continue to provide care during extraordinary events when faced with limited resources. The work group began its efforts by researching the appropriate laws in order to understand, correct and validate the concerns of health care providers. After this research was completed, the work group developed a Critical Resource Shortage Planning Guide. Ms. Webb stated that this Guide focuses on the allocation of scarce resources during an emergency situation and establishes a process for hospitals to follow in planning for the provision of care in the face of scarce resources. The Guide rests on four assumptions: (1) that hospitals will be responsible for making decisions regarding resource shortages at the institution and health system level; (2) that hospitals will need to allocate resources during a shortage in a way that does the greatest good for the greatest

number; (3) that resource shortage plans should fall within the hospital's existing incident command system; and (4) that the Guide only applies during emergencies and disasters.

In addition to the development of the Guide, Ms. Webb expressed her belief that legislation is still necessary in order to protect health care providers as care rendered during a disaster will be different than what would be provided under normal circumstances. Ms. Webb listed five legislative principles needed for comprehensive protection of health care providers: (1) protections embrace an all hazards approach and apply to both natural and man-made disasters; (2) protections apply to all health care providers, including hospitals; (3) protections are not limited to volunteers; (4) protections apply both pre- and post-declaration of a state of emergency; and (5) protections apply to all care provided during the emergency or disaster.

III. Liability Insurance and Liability Protections.

J. Christopher LaGow, J.D., who represents the Property Casualty Insurers Association of America, briefly spoke on the relation of liability protections and insurance. Mr. LaGow expressed his support for liability protections, such as the Good Samaritan statute, as they further the public policy of encouraging the provision of emergency care. However, Mr. LaGow indicated that there is a lack of any quality studies regarding the impact of such protections on paid claims or insurance premiums. In response to questioning from the members, Mr. LaGow did state that he believed that the degree of contingency planning a hospital did in preparation for disasters may be a factor in determining its premiums. He also stated that he believed that such risk management considerations are already taking place. This position was contradicted by subcommittee member Steven Gravely who stated that no insurance carrier has incorporated disaster management in making its risk assessment.

IV. Health Care Provider Liability Protections in Other Jurisdictions.

Staff then made a brief presentation regarding health care liability protections in other states. Staff noted that almost every state has its own version of a Good Samaritan statute as well as civil defense/emergency services laws. Staff observed that other states' Good Samaritan statutes are relatively similar to Virginia's and likewise provide that care must be rendered without compensation at the scene of an accident or emergency before the liability protections may be invoked. Staff also noted that at least six states--California, Indiana, Louisiana, Maryland, Michigan, and Minnesota--have civil defense/emergency services laws that expressly afford liability protections for health care providers. All except one of these statutes require that a declared state of emergency exist before they will apply. Indiana also requires that a declaration of emergency exist, but provides that the statute's liability protections cover the provision of health care that occurred prior to the declaration.

Public Comment.

The chairman requested that Steve Pearson, who represents the Virginia Trial Lawyers Association, speak during the public comment period. Mr. Pearson expressed his belief that the issue of health care provider liability being addressed by the subcommittee already fits into the current legal framework in Virginia involving the standard of care. Mr. Pearson stated that issues such as the provision of health care in the face of resource shortages or by providers outside the scope of their expertise would all come before the jury as part of the question of whether the standard of care used was appropriate. Mr. Pearson also emphasized his opposition to broad grants of immunity, including immunity that would apply during time periods prior to the declaration of a state of emergency.

In response to questioning from the members, Mr. Pearson acknowledged differences between the statutory standard of care and Model Jury Instructions' standard of care. He did not, however, believe that there is any need to conform the statutory definition to the Model Jury Instructions and expressed his opinion that there is no history of any problems with juries in Virginia understanding that when they consider the standard of care, they must consider the circumstances in which such care was provided as it is their duty to consider relevant evidence.

Mr. Pearson also addressed questions from the members concerning claims brought against health care providers for failing to plan for emergencies, such as some of the claims filed in the wake of Hurricane Katrina or the SARS outbreak in Canada. While he could not speak as to specific differences between the laws of Virginia, Louisiana and Canada, Mr. Pearson stated that the laws of Virginia would lead to predictable, reasonable results in such cases. He also stated it would be difficult to prevent people from engaging in such litigation, as people would try to find ways around any limitation on their ability to succeed on a particular claim.

In conclusion, Mr. Pearson reiterated his belief that current Virginia law affords sufficient liability protections to health care providers to ensure an effective emergency response. He also stated that increased education for the medical community regarding current Virginia law would help ease the medical community's concerns about their potential liability.

Three other people made comments to the subcommittee. First, Beverly Soble of the Virginia Health Care Association expressed her preference that the subcommittee extend any liability protections it may choose to recommend to all health care providers, including nursing homes and assisted living facilities. She expressed her opinion that such facilities would likely assist with any surge in the provision of health care associated with an emergency.

Second, Scott Johnson, who represents the Medical Society of Virginia, stated his preference that the protections already afforded to health care providers in Va. Code § 8.01-225.01 be extended to include natural disasters, in addition to the man-made disasters that are already covered by that statute. He further expressed his support that any recommendation of the subcommittee include liability protections that cover both

pre- and post-declaration of emergency time periods. Finally, Mr. Johnson advocated several changes to Virginia's Good Samaritan statute, including that persons rendering services under that statute be permitted to be reimbursed for their actual expenses and expanding that statute's scope so the protections are not limited to care provided at the scene of an emergency.

Finally, Dr. Lisa Kaplowitz, Deputy Commissioner for Emergency Preparedness and Response for the VDH, stated that physicians who would be willing to respond to a disaster are worried about the risk that they may be subjecting themselves to by doing so. Dr. Kaplowitz said that such concerns could be ameliorated if the physicians were aware that they were afforded greater liability protections. She expressed her skepticism that greater physician education concerning the currently available liability protections would be sufficient.

Member Discussion and Recommendations.

The members then proceeded to discuss several legislative alternatives that had been prepared by staff. As a way of framing their discussion, the chairman utilized the legislative principles contained in Ms. Webb's presentation on behalf of the VHHA.

The first principle put to the subcommittee was who should be covered. It was decided by the subcommittee that any liability protections should extend to all health care providers, and not be limited to institutional providers, such as hospitals.

The second principle was whether to adopt an all hazards approach. The subcommittee determined that any liability protections should cover both natural and man-made disasters. In furtherance of this decision, the subcommittee decided that, if possible, the current definitions of these types of disasters contained in the Virginia Code should be condensed into one single definition of "disaster." Alternatively, Delegate Hull also requested that an amendment to the term natural disaster be made to clarify that disease outbreaks would be covered.

The third principle considered by the subcommittee was the issue of volunteers. The subcommittee decided that volunteer health care providers be allowed to recover their actual expenses incurred during the rendition of care.

The fourth principle that the subcommittee addressed was when the liability protections should apply. The subcommittee determined that the protections should apply both before and after the declaration of a state of emergency.

The fifth and final principle was the application of any liability protections to all care provided during a disaster or emergency. The subcommittee decided that no dual standard of care should apply during an emergency or disaster.

The subcommittee also approved the fifth legislative draft prepared by staff which amended the exceptions to the definition of a patient found in Va. Code § 8.01-581.1 to

add a reference to Va. Code § 44-146.23, the liability provision of the Emergency Services and Disaster Law, in addition to the already existing reference to the Good Samaritan statute.

The subcommittee also decided to attempt to broaden the Good Samaritan statute to expand its application from care rendered at the scene of the accident or emergency to care rendered in response to an accident or emergency.

In preparation for the subcommittee's next meeting, the chairman directed staff to draft legislation consistent with the subcommittee's decisions on these legislative principles and its other decisions. This legislation will be discussed at the subcommittee's next meeting. The chairman also directed staff to research the existing liability protections for emergency medical technicians and whether they will be covered by the draft legislation.

Next Meeting.

The joint subcommittee's next meeting will be held on October 16, 2007, at 10:00 A.M. in House Room D of the General Assembly Building in Richmond, Virginia.