THE SOURCE

July 2017 - vol. 22

Welcome to THE SOURCE, a service established by the SCAHRM Board of Directors.

When Disaster Hits, Where Does the Standard of Care Go?

Dawn Cushman, Esq.

Senior Attorney - R.J. Ryan Law, APC

A well-known idiom states, "No good deed goes unpunished."

One wonders whether the unknown author was referring to the legal liability exposure of healthcare providers after rendering emergency care to those in need. This author's experience defending healthcare providers in lawsuits arising out of services provided to those in desperate need during "routine" emergencies demonstrates that the legal system fails to shield and protect those whose only intention was to provide services consistent with or beyond what was to be expected under dire circumstances. How then can we expect the legal system to protect the healthcare profession from civil liability in critical times of national disaster?

In the last 10 years, multiple global and national disasters have occurred, including earthquakes, tsunamis, nuclear catastrophe, terrorist attacks, influenza pandemics, hurricanes, tornadoes and other types of natural and man-made calamities. These events are recognized as a "disaster" because they involve circumstances affecting hundreds of thousands of people at one time and overwhelm and paralyze local, county, state and even national resources for days, weeks and months.[1]

We watch in awe as lay persons and healthcare providers alike volunteer across state lines and national borders to offer assistance and care, without remuneration or glory. Yet, in the post-disaster aftermath, attention invariably turns to the issue of assessing liability and attributing blame.[2]

[1] See, S. Fink, "The Deadly Choices at Memorial," The New York Times (August 25, 2009), reciting various incidents involving Hurricane Katrina that "marooned" Memorial Medical Center in New Orleans.

[2] Following Hurricane Katrina, several healthcare practitioners were not only sued for civil damages but were charged with crimes in connection with the death of patients. *Id*. at p. 1. Grand jurors later refused to issue indictments for the charged crimes. But several civil lawsuits also were brought against practitioners and facilities. See, *LaCoste v. Pendleton Methodist Hosp., L.L.C.* (2007) 966 So. 2d 519, 526-527 and *Mineo v. Underwriters at Lloyds* (2008) 997 So. 2d 187, 190.

Continued next page…

This article will address one of the legal issues facing healthcare professionals as a result of national disasters.[3] The legal standard of care applicable to healthcare practitioners and facilities in "normal" emergencies[4] will be compared to and analyzed with the standard governing national disasters.

Due to the dramatic lack of human resources and other resources resulting from large-scale disasters, the standard of care governing the conduct of healthcare providers is "altered" from the norm and will allow responders to function outside their typical roles and functions. The "altered" standard of care is likely to be the yardstick by which the provision of medical services during national disasters or mass casualty events is measured and will likely serve the medical community well, providing needed protection from civil liability.

More state and federal legislation may be necessary to achieve optimum protection for all healthcare providers in national disasters.[5]

I. Immunity Principles.

A. Sovereign Immunity.

Governmental agencies, such as public health agencies and government-run hospitals, enjoy immunity from civil liability as a result of the sovereign immunity doctrine. Sovereign immunity derives from English law and was the immunity granted to kings. Its foundation is the fictional principle that "the King can do no wrong."[6] As a result, governmental entities cannot be sued unless the government gives its consent.

The United States and virtually all states "consent" to be sued under some form of Tort Claims Act, which allows for limited civil liability under expressly defined boundaries. Even so, sovereign immunity is immensely broad, affording state or federal governmental entities with statutory immunity regardless of whether or not a public health emergency is declared (i.e., immunity for discretionary actions taken to implement federal programs).[7] Therefore, any federal or state agency is likely to continue to be immune from suit in the event of a public health emergency.[8]

---

[3] Variations of the law between states and between nations preclude uniform answers in this article as to whether providers of emergency care are granted statutory immunity from liability in disasters. Public Health Emergency Legal Preparedness Checklist, Civil Legal Liability and Public Health Emergencies, p. 6 (The Center for Law & the Public's Health, December 2004).

[4] The term "normal" in this context means the regular type of medical malpractice cases that routinely confront healthcare risk managers on a day-to-day basis and includes cases that might fall within the day-to-day understanding of a medical "emergency." It does not include mass casualty events.

[5] There are many important distinctions between a "natural disaster," public health emergency and mass casualty events. However, for the purpose of this article, the terms are being used synonymously unless otherwise indicated, to mean a major event resulting in massive injuries and casualty to human life.

[6] *Nevada v. Hall*, 440 U.S. 410, 414-415 (1979)

[7] Public Health Emergency Legal Preparedness Checklist, *supra*, p. 7.

[8] Some statutes have begun to address government immunity for disasters. For example, statutes already provide immunity against liability, except for willful misconduct, for the United States and for persons who prescribe, administer or dispense vaccine countermeasures for pandemics. Title 42 U.S.C. §§ 247d-6d, 247d-6e.

Continued next page…

Hospital facilities, hospital employees, and licensed practitioners will not, however, enjoy that type of sovereign immunity, even in the event of a public health emergency because sovereign immunity does not provide protection to non-governmental healthcare providers and facilities.

B. Good Samaritan Immunity Laws.

1. The Good Samaritan Rule.

Like sovereign immunity, the Good Samaritan Rule developed over the years through the evolution of "common law" – the law developed through written decisions rendered by judges and handed down for generations. Modern law consists of state and federal statutes, informed and interpreted through the use of common law.

The Good Samaritan Rule says that a bystander to an accident has no duty to provide aid to an injured person.[9] No matter how severe the injury, the passerby can ignore the emergency altogether, with no civil liability imposed as a result. Once the bystander volunteers to the aid the injured stranger, though, the Good Samaritan rule imposes a duty on that bystander to render aid reasonably.[10]

As a consequence, the Good Samaritan Rule became a means by which the judicial system imposed liability upon those who aided an injured person and caused injury through negligent or wrongful conduct.[11] The Good Samaritan rule "makes one person liable to another for breach of a duty voluntarily assumed by affirmative conduct, even when that assumption of duty is gratuitous."[12]

2. The Good Samaritan Statutes Providing Immunity.

In 1959, California became the first state to adopt a "Good Samaritan" statute providing statutory immunity to healthcare providers who in good faith render emergency care at the scene of an emergency.[13] The philosophy behind modern Good Samaritan statutes is to encourage and provide incentives to medical personnel to come to the aid of victims despite the less-than-ideal circumstances, in the face of often-inadequate facilities, sanitation and equipment.[14]

All 50 states have some form of Good Samaritan statute establishing varying degrees of immunity for healthcare providers.[15] Some courts construe the language of those laws broadly in favor of immunity, so that healthcare providers are encouraged to provide assistance without the looming fear of liability.[16] Other courts construe the Good Samaritan

---

9 *Velazquez v. Jiminez* (2002) 172 N. J. 240, 248.

10 *Velazquez v. Jiminez* (2002) 172 N. J. 240, 248.

11 See, *Thames Shipyard & Repair Co. v. United States* (1st Cir. 2003) 350 F.3d 247, 261.

12 *Good v. Ohio Edison Co.* (6th Cir. 1998) 149 F.3d 413, 420.

13 *Velazquez v. Jiminez* (2002) 172 N. J. 240, 248.*Id*. at p. 249.

14 *Velazquez v. Jiminez* (2002) 172 N. J. 240, 248.*Id*. at p. 250.

15 V. Sutton, "Analytical State Survey: Is There a Doctor (and a Lawyer) in the House? Why Our Good Samaritan Laws Are Doing More Harm Than Good for a National Public Health Security Strategy: A Fifty-State Survey, 6 J. Health & Biomed. L. 261, 268-269.

16 *Kearns v. Superior Court*, *supra*, 204 Cal.App.3d at p. 1329.

Continued next page…

laws narrowly against immunity so that injured persons have a remedy if they are injured from the volunteer's wrongful conduct.[17] No universal interpretation of Good Samaritan immunity exists and no standardized language is used in each statute.

Most Good Samaritan statutes now provide that no person rendering emergency care in good faith, including those licensed to provide medical care, shall be liable for civil damages as a result of any wrongful act or omission in rendering that care.[18]

Yet less than half of the states provide a form of immunity for healthcare providers when responding to an emergency within the hospital setting.[19] In most states, immunity only applies to volunteers who (1) have no pre-existing practitioner-patient duty owed to the injured party; (2) are not compensated for their aid; and (3) happen upon the emergent situation by "chance."[20]

Therefore, no Good Samaritan statutory immunity exists in favor of the facilities or practitioners who are providing necessary emergency care from within the hospital at the time of a national disaster or mass public health crisis.[21]

II. The Standard Of Care Provides Protection From Civil Liability.

A. The Basic Standard of Care.

There is no "universal" expression of the standard of care applicable to healthcare providers. Every state uses different language. But basic principles exist regarding the standard of care, whether applicable to the physician, psychiatrist, nurse, clinician, hospital, or otherwise.

The basic principle behind the standard of care can be phrased, generally, as follows: A healthcare provider has a legal duty to exercise that degree of skill, diligence and judgment ordinarily employed by similarly-qualified, reasonably prudent practitioners in the same community under the same or similar circumstances.[22] This level of skill, diligence and judgment is referred to as "the standard of care."

---

17 *Velasquez v. Jimenez*, *supra*, 172 N.J. at p. 258.

18 See, New Jersey Rev. Stat. § 2A:62A-1; California Bus. & Prof. Code, §§ 2395, 2396. "Here, the statute clearly applies to a physician who, in good faith and without prior notice of the illness, renders emergency care without charging a fee." *Johnson v. Matviuw* (1988) 176 Ill.App.3d 907, 917.

19 V. Sutton, "Analytical State Survey," *supra*, 6 J. Health & Biomed. L. at p. 272 [identifying 24 states providing immunity for care at the hospital]; *Velazquez v. Jiminez* (2002) 172 N. J. 240, 248 [stating 7 states provide immunity for emergency care provided on facility premises].

20 "In sum, Good Samaritan immunity [under the New Jersey statute] encompasses only those situations in which a physician (or other volunteer) comes, by chance, upon a victim who requires immediate emergency medical care, at a location compromised by lack of adequate facilities, equipment, expertise, sanitation and staff. A hospital or medical center does not qualify under the terms of the Good Samaritan Act in its present form." *Velazquez v. Jiminez* (2002) 172 N. J. 240, 262. See also, *Colby v. Schwartz* (1978) 78 Cal.App.3d 885 and *Johnson v. Matviuw* (1988) 176 Ill.App.3d 907, 917-918.)

21 See *Neal v. Yang* (2004) 352 Ill.App.3d 820, 830 (Illinois appellate court). See also, V. Sutton, "Analytical State Survey," *supra*, 6 J. Health & Biomed. L. 261, at p. 292. Ms. Sutton advocates the development of a model Good Samaritan law that would ensure that fear of liability would not be an impediment to a national disaster, public health disaster or typical emergency.

22 *Nieves v. Hospital Metro-Politano* (D. Puerto Rico 1998) 998 F. Supp. 127, 136-137; *LaCoste v. Pendleton Methodist Hosp., L.L.C.* (2007) 966 So. 2d 519, 526-527 [Louisiana].

Continued next page…

The conduct of healthcare practitioners is not measured by the highest degree of care that can be provided. Rather, it is measured by the conduct a reasonably prudent healthcare practitioner would exercise under the circumstances. The foundation for the basic principle is "reasonableness."

When the act or omission by a healthcare practitioner is determined to be "unreasonable," the healthcare provider is considered to be negligent and will be held liable for civil damages. Where the conduct of the practitioner is determined to be reasonable, no civil liability exists.

The standard of care, then, provides the healthcare practitioner and/or the facility with one of the formidable shields in the arsenal that prevents the imposition of civil liability. Does that same shield exist in exigent circumstances and, if not, where does the standard of care go?

B. The Standard of Care Applicable To "Normal" Emergencies.

1. What Is An Emergency In A Non-Disaster Context?

The standard of care operating in the dire circumstances of a typical "emergency" situation appears to be articulated in the same or in a similar manner to the "normal" standard of care.

The Good Samaritan immunity statutes and other statutes related to emergencies provide us with definitions of an emergency that we can "borrow" to determine how the circumstances transpiring during an emergency affect the standard of care.

Some judicial decisions define "emergency" objectively as "an exigency" or "unforeseen complexity" that is so pressing in character that some kind of medical action must be taken by the healthcare provider.[23] Other cases define the term subjectively based on the volunteer's beliefs. If the volunteer considered, in good faith, the circumstances to be an emergency, then it is an emergency.[24]

The federal Emergency Medical Treatment and Active Labor Act ("EMTALA") defines an "emergency" to be a medical condition that manifests itself by acute symptoms of "sufficient severity" that the "absence of immediate medical attention could reasonably be expected to result in (i) placing the health of the individual . . . in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part." [25] As a consequence, courts find a normal "emergency" to exist where any inaction on the part of the medical practitioner would likely result in either "an immediate certainty of death" or "a high probability of a future risk of serious injury" to the person receiving treatment.[26]

---

[23] See, *Kearns v. Superior Court* (1988) 204 Cal.App.3d 1325, 1328.

[24] See *Thames Shipyard & Repair Co. v. United States*, 350 F.3d 247, 259 (1st Cir. Mass. 2003) (under the "emergency aid" exception to the warrant requirement, an emergency exists if safety officers have an objectively reasonable belief that a true emergency exists and there is an immediate need for assistance or aid).

[25] Title 42 U.S.C. § 1395dd(b)(1)(A); *Cruz-Queipo v. Hospital Espanol Auxilio Mutuo De Puerto Rico* (1st. Cir. 2005) 417 F.3d 67, 71.

[26] *Brazeal v. Henry Mayo Newhall Memorial Hospital* (1991) 234 Cal.App.3d 1329, 1338 ("Immediate intervention was imperative to avert a presently impending calamity.")

Continued next page…

In each of these examples, the "emergency" is determined not from the perspective of an "emergency" occurring in the community. Rather, the "emergency" is determined from a focus on the individual patient's medical condition and the perceived need for medical care. The question being asked at the time of a trial in these cases is: Does the person being aided have an "emergency" condition that requires immediate medical care?[27] If so, an emergency is said to exist.

2. What Is the "Emergency" Standard Of Care?

Cases addressing "normal" emergencies recognize that the volunteer's conduct is to be measured by the type of conduct that would be considered reasonable "under the same or similar circumstances." [28] Judicial decisions demand consideration of all attending circumstances of the emergency, including "the urgency of the situation and the concomitant need to act quickly.'"[29]

The standards applicable in emergencies was perhaps best expressed by the North Dakota Supreme Court in a non-medical context, stating that defendant's conduct was to be judged based on the circumstances existing at the time of the emergency:

> What [defendant] did in that awful fleeting moment cannot be judged by normal standards of care. In sudden, unheralded confrontation with disaster, there is no time for judicious balancing of alternatives. The course chosen in imperative haste, while mind and muscle are horror-stricken, must be given every charitable consideration.[30]

In other words, the measurement by which the defendant's conduct is judged takes into consideration the fact that a "sudden, unheralded confrontation with disaster" exists. Errors or mistakes that might fall below the "normal" standard of care will not give rise to liability in an "emergency" because the act or omission was "reasonable" or unavoidable under the circumstances.

Cases involving Coast Guard rescues – what most of us would consider an "emergency" situation – similarly recognize that the standard of care must be determined in the context of the unique circumstances of the rescue itself.[31] "Therefore, conduct that might ordinarily be

---

27 *Brazeal v. Henry Mayo Newhall Memorial Hospital* (1991) 234 Cal.App.3d 1329, 1338. "It would seem obvious that in determining whether a patient's condition constitutes such an emergency the trier of fact must consider the gravity, the certainty, and the immediacy of the consequences to be expected if no action is taken. However, beyond observing that these are the relevant considerations, the variety of situations that would qualify as emergencies under any reasonable set of criteria is too great to admit of anything approaching a bright line rule as to just how grave, how certain and how immediate consequences have to be."

28 *Velazquez v. Jiminez*, *supra*, 172 N. J. at p. 248.

29 *Ibid*.

30 *Knudtson v. McLees*, *supra*, 443 N.W.2d at p. 906.

31 See *Korpi v. United States*, 961 F. Supp. 1335, 1347 (N.D. Cal. 1997) ("A rescue attempt must be considered in the light of the circumstances that faced the rescuers when they acted and not with the wisdom of an "armchair admiral" after the fact.")

Continued next page…

negligent may be non-negligent in the ***pressure cooker circumstances*** of a rescue."[32] When rescue personnel, like the Coast Guard, police or others "reasonably believe" that a person is in need of immediate aid, then "[t]he need to protect or preserve life or avoid serious injury is justification for what would be otherwise illegal absent an exigency or emergency."[33]

Thus, articulation of the standard of care applicable to "emergency" situations involves the same fundamental principles as the standard of care applicable to "normal" situations, with the possible qualification represented by the following bracketed phrasing: A healthcare provider [responding to an emergency] has a legal duty to exercise that degree of skill, diligence and judgment ordinarily employed by similarly-qualified, reasonably prudent practitioners in the same community under the same or similar [emergency] circumstances.

3. The Standard of Care In "Normal" Emergencies Is Individualized.

The standard of care appears to remain the same regardless of whether it is being applied to conduct rendered by practitioners during a routine medical situation or a "normal" emergency situation. But the focus is uniquely individualized for the particular patient being treated so that each patient presenting for treatment will receive care and attention. Practitioners make their decisions about necessary lab tests, diagnostic tests, medications, hygiene, needs, pain management and treatment "with only that individual (or the individual and family unit) in mind."[34] "Under normal conditions, current standards of care might be interpreted as employing appropriate health and medical resources to improve the health status and/or save the life and limb of ***each individual patient***."[35]

The individual's health status is paramount and the focus remains so throughout the management of the patient's care. Consequently, Emergency Departments in non-disaster situations will triage based on the immediacy of the patient's signs and symptoms, with treatment provided for those individual patients with the greater critical need for treatment at the time. The practitioner provides care throughout the patient's admission based on the focus of what medical care is needed to improve "this patient's" health status or what resources can be used at the facility or another facility to save the life and limb of "this patient."

With this primary focus, a practitioner or healthcare facility continues to have a legal duty to exercise that degree of skill, diligence and judgment ordinarily employed by similarly-qualified, reasonably prudent practitioners in the same community under the same or similar circumstances, regardless of whether "normal" conditions are operating or an "emergency" condition is operating.

---

[32] *Fondow v. United States* (D. Mass. 2000) 112 F. Supp.2d 119 [emphasis added], *Thames Shipyard & Repair Co. v. United States* (1st Cir. 2003) 350 F.3d 247, 261-262 [same].

[33] *Mincey v. Arizona*, 437 U.S. 385, 392-393 (1978).

[34] American Nurses Association, "Adapting Standards of Care Under Extreme Conditions: Guidance For Professionals During Disasters, Pandemics, and Other Extreme Emergencies," (March 2008), p. 10.

[35] California Department of Health Services, Development of Standards and Guidelines for Healthcare Surge During Emergencies [Draft], p. 7 (emphasis added).

Continued next page…

II. The "Altered" Standard Of Care In National Disasters.

A. What Is An "Emergency" In A Disaster?

Since September 11, 2001, the influenza pandemic and Hurricane Katrina, significant inroads have been made to improve preparedness for a mass casualty event.[36] Statutes were enacted addressing the provision of healthcare during an "emergency." These statutes define "emergency."

By statute, an "emergency" is defined as any instance where federal assistance is "needed to supplement State and local efforts and capabilities to save lives and to protect property and public health and safety, or to lessen or avert the threat of a catastrophe."[37] A "major disaster" is also defined and includes any "natural catastrophe" (including any hurricane, tornado, tsunami, earthquake, fire, explosion) "to warrant major disaster assistance . . . in alleviating the damage, loss, hardship or suffering caused thereby."[38] [39]

As a result of these declarations of emergency, the "legal landscape" is changed and alters to effectuate emergency responses by healthcare practitioners.[40] The entire focus of an emergency is redirected. No longer is the designation of an emergency related to an individual patient's medical condition. Rather, the entire focus of an emergency in a major national disaster is one directed toward entire communities affected, with the design "to save lives and to protect property and public health and safety." It is a public focus, not a private focus.

C. "Altered" Statutory Obligations.

Statutory obligations are suspended or "altered" during a national disaster. Once the emergency is declared, statutory requirements can be waived or modified, including certification requirements under Medicare, the use of unlicensed healthcare providers, and the waiver of sanctions under the EMTALA, 42 U.S.C. § 1320b-5(b)(3).[41]

While the waiver of these statutory obligations does not provide the healthcare practitioner or the hospital with immunity from liability, the effect of these provisions is to "alter" the manner in which healthcare is provided. For example, a waiver of sanctions under EMTALA does not relieve a hospital

---

[36] Altered Standards of Care in Mass Casualty Events. Prepared by Health Systems Research Inc., AHRQ Publication No. 05-0043 (April 2005).

[37] Title 42 U.S.C. § 5122(1).

[38] Title 42 U.S.C. § 5122(2).

[39] Under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, Title 42 U.S.C. § 1521 et seq., and the National Emergencies Act, Title 50 U.S.C. § 1601 et seq., an emergency or disaster is one that is declared by the President of the United States. Similarly, the Secretary of the Department of Health and Human Services may declare a "public health emergency." (Title 42 U.S.C. § 247d.) Also, many states are now authorizing their respective governors to declare a public health emergency. (Turning Point, Collaborating for a New Century in Public Health, "Model State Public Health Act, a Tool for Assessing Public Health Laws" (September 2003), Article VI Public Health Emergencies, p. 41.)

[40] Health Systems Research, Inc., "Mass Medical Care With Scarce Resources," AHRQ Publication No. 07-0001 (February 2007), Chap. III, p. 27.

[41] Many other state and federal statutes are now in effect that address obligations under a public health emergency or major disaster. This article cannot address all of these statutes.

Continued next page…

from its obligation to provide patient's with a medical screening exam. But the hospital may be able to delay or postpone the exam.[42] Thus, the legal landscape is altered by the mass casualty event.

C. The "Altered" Standard Of Care.

One source has defined the "altered" standard of care applicable in mass casualty events as follows: "The Standard of Care during a Healthcare Surge is defined as: 'the degree of skill, diligence and reasonable exercise of judgment in furtherance of optimizing *population outcome* during a healthcare surge event that a reasonably prudent person or entity with comparable training, experience or capacity would have used under the circumstances."[43]

In one sense, the "altered" standard of care as expressed above is not altered at all. As with the "normal" standard of care, the healthcare provider's conduct continues to be measured against what a reasonably prudent practitioner or facility would do under the same or similar circumstances. Thus, no alteration of the standard of care exists. But a paradigm shift occurs.

No longer is the focus on the individual patient. Under the foregoing definition of the standard of care, the paradigm is now to "optimize population outcome." The decision-making that occurs during a mass casualty event shifts in such a manner that "the clinical goal is the greatest good for the greatest number of individuals."[44]

First and foremost, the goal of both state and federal statutes for declaring a major disaster is to keep the affected healthcare system functioning so that the healthcare providers can deliver an acceptable quality of care to preserve as many lives as possible. But as with any "emergency" circumstance, what once might be considered negligent under "normal" circumstances is no longer considered so under the "altered" standard of care. By the very nature of the national disaster, there are insufficient resources to meet the demand. By the very nature of the national disaster, the focus is no longer the individual patient but the mass of patients in the community.

Under normal circumstances, hospitals are staffed by an adequate number of nursing and ancillary staff and a reasonably prudent hospital would not generally allow a non-physician to perform functions requiring properly-licensed physicians such as the diagnosis of a patient. These actions taken outside the scope of professional nursing, under routine circumstances would subject the nurse and the hospital to legal liability.

But in a major national disaster, where nursing and physician availability is limited or otherwise affected, the normally accepted scope of practice is expanded to allow for the greatest volume of care to be provided "under the circumstances." The standard of care still requires care to be provided in a reasonable manner but "reasonable" might include allowing unlicensed, uncredentialed

---

[42] Troutman Sanders, "EMTALA Compliance in Disaster Circumstances," Prepared for Virginia Hospital and Healthcare Association (March 2, 2007), p. 13.

[43] California Department of Health Services, Development of Standards and Guidelines for Healthcare Surge during Emergencies [Draft], p. 7.

[44] American Nurses Association, "Adapting Standards of Care Under Extreme Conditions: Guidance For Professionals During Disasters, Pandemics, and Other Extreme Emergencies," (March 2008), p. 10.

Continued next page…

physicians licensed in other states and countries to assist in the provision of care. In short, the existence of a major disaster allows for appropriate and reasonable allocation of scarce resources.

Some say that the "normal" standard of care requires "defensive" medicine so that tests are performed on individual patients to "leave no stone unturned" in analyzing a patient's condition. The "normal" standard of care, with its individual focus, does not allow for competing needs of other patients. In a major national disaster, the rationing of equipment, medications, supplies, testing and other resources becomes a necessity. Under a public health emergency, "one person's condition may be allowed to deteriorate while another victim's more pressing medical needs are addressed . . ."[45]

Triage during a major disaster becomes altered. In normal times, Emergency Departments in hospital facilities triage patients regularly but with that individual focus for managing the patient's condition. The analysis includes categories for the individual's condition in terms of priority and (1) the patient's need for resuscitation; (2) an emergency with a critical illness or severe pain; (3) urgent care with a need for care within a 30-minute or 60-minute window; or (4) a non-urgent need for care. The idea behind triage in the ED setting is to treat the most vulnerable person first.

But in a major disaster, the new focus is on public care and the greatest number of persons saved and managed. Well-established standards allow for categories for immediate care, delayed care, minor injuries or "exclusion criteria."[46] The exclusion criteria include patients with a high risk of death or a minimal likelihood of a favorable outcome. It is to be anticipated that, given the limited resources, the last category of individuals might be relegated to receiving palliative care while the other available resources would be allocated to those more likely to survive in order to "do the most good." As the system of care starts to recover and additional resources, equipment and supplies become available, triage services begin to manage the more gravely injured.

This idea of withholding treatment, while knowing there may be a negative outcome, treads a difficult legal and moral line for many people.[47] Yet, these tough decisions are likely to be mandated during a major crisis and the "altered" standard of care exists to provide protection for healthcare providers against claims for liability arising out of the medical care and treatment provided during public health emergencies.

III. Unresolved Legal Issues Abound.

Much remains to be done in this altered legal landscape. Legal issues abound in this arena.[48]

The ability of plaintiffs' lawyers to circumvent statutory and case law protections afforded healthcare providers is never-ending and may continue to rear its ugly head in the aftermath of any mass casualty event.

---

[45] E. Weeks, "Symposium: Shaping A New Direction For Law And Medicine: An International Debate on Culture, Disaster, Biotechnology and Public Health, etc. 10 DePaul J. Health Care Law 251 (2007), p. 4.

[46] Altered Standards of Care in Mass Casualty Events. Prepared by Health Systems Research Inc., AHRQ Publication No. 05-0043 (April 2005).

[47] National Academy of Sciences, "Crisis Standards of Care: Summary of a Workshop Series," http:/www.nap.edu/catalog/12787.htlm., p. 54, quoting Sheryl Starling of the California Department of Public Health.

[48] See, Swendiman and Jones, "The 2009 Influenza Pandemic: Selected Legal Issues," Congressional Research Service, www.crs.gov.

Continued next page…

For example, Louisiana had certain statutory prerequisites available to protect healthcare providers from certain types of malpractice claims yet several lawsuits attempted to, and did, bypass those protections following Hurricane Katrina.[49]

In one Katrina wrongful death lawsuit, statutory prerequisites were bypassed through the assertion of cleverly-phrased, non-medical malpractice claims. The lawsuit did ***not*** assert claims that the patient died because healthcare providers or the facility failed to meet the standard of care for the diagnosis and treatment of the patient. Rather, plaintiffs alleged that the hospital facility was improperly designed, constructed and maintained because it lacked sufficient emergency power to sustain life support systems and allowed flood waters to enter the structure, endangering the patients.[50] The issue was not medical malpractice law but premises liability law.

Similarly, plaintiffs did not allege that the doctors and other healthcare providers failed to meet the standard of care in failing to properly and timely transfer the patient to an alternate facility. Instead, plaintiffs alleged corporate hospital negligence because the facility "failed to implement an evacuation plan, failed to have a facility available to receive transferred patients, and failed to have a plan in place in case of a mandatory evacuation."[51]

Thus, there will be times in this new legal landscape where even the "altered" standard of care may have no application and may offer no protections because the theories of medical malpractice have been bypassed altogether.

"The ultimate solution to this problem lies with Congress through amendment to the law."[52] Analyzing the legal, acceptable standard of care and analyzing how the standard of care may change during a mass casualty event requires more work.[53] More is necessary to ensure that healthcare professionals and facilities are guarded against claims for liability arising out of the provision of medical care in less-than-ideal, exigent circumstances.

"'There is a need to have clear legal recognition that these alternative standards exist and that practitioners are authorized to follow them."[54]

It is hoped that this article will contribute to increased awareness in the medical and legal communities that a disaster creates circumstances taxing to all infrastructure. The good news is that when disaster hits, the standard of care goes nowhere – it remains the same. Healthcare providers can be assured that there is a standard of care operating in the disaster, with an altered focus to "optimize population outcome," and continuing to provide a shield against civil liability.

---

49 See, *Lafonta v. Hotard Coaches, Inc.* (2007) 969 So. 2d 686, 689 (La.App. 4 Cir. 2007 and *LaCoste v. Pendleton Methodist Hosp., L.L.C.* (2007) 966 So. 2d 519.

50 *LaCoste v. Pendleton Methodist Hosp., L.L.C.* (2007) 966 So. 2d 519, 522.

51 *Id*. at p. 526-527.

52 Troutman Sanders, "EMTALA Compliance in Disaster Circumstances," *supra*, p. 18.

53 National Academy of Sciences, "Crisis Standards of Care: Summary of a Workshop Series," http:/www.nap.edu/catalog/12787.htlm., p. 53.

54 *Id*. at p. 55.

Continued next page…

About the Author:

Ms. Cushman is an attorney practicing in California for more than 37 years, and is a Certified Specialist in Appellate Law. She received her B.A. degree from San Diego State University (1976) and her law degree from California Western School of Law (1979). Ms. Cushman has submitted over 100 briefs to the appellate courts, resulting in approximately 10 published appellate court decisions on subjects including medical staff privileges, statute of limitations, causation, expert discovery, elimination of punitive damages, wrongful termination in employment and insurance bad faith.

Ms. Cushman is a Senior Attorney with R.J. Ryan Law, APC, in Glendale, California containing members with a combined experience of over 60 years representing hospitals, physicians, skilled nursing facilities and other healthcare providers in matters involving medical malpractice, staff privileges, elder abuse and employment law. Ms. Cushman has been a member of the Southern California Association for Healthcare Risk Management since 2003. She was a member of the Editorial Review Board for the ASHRM Journal of Healthcare Risk Management. She also regularly lectures on civil procedure, summary judgment motions, and appellate procedure as well as sexual harassment litigation, discriminatory employment practices and wrongful termination litigation in the healthcare field.

* *

As long as we have your current e-mail address, you will receive the SOURCE via email throughout the year. If you do not wish to receive this publication, or if you change or delete your e-mail address, please e-mail us at info@scahrm.org. In addition, if you have any items you feel would be ideal to add to the SOURCE in the future, please e-mail Carole Lambert, Chair of the SCAHRM Communications Committee at clambert@capphysicians.com.

SCAHRM has prepared THE SCAHRM SOURCE for informational purposes only and it is not legal advice. Transmission of the information is not intended to create, and receipt does not constitute, an attorney-client relationship. Subscribers and readers should not act upon this information without seeking professional counsel. If you want legal advice, you must consult a lawyer.