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Malpractice Immunity for Volunteer Physicians in Public Health Emergencies:

Adding Insult to Injury

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There is widespread concern among public health and emergency response officials that there could be a shortage of health care providers in a public health emergency. At least the following three factors could cause an inadequate supply of physicians, nurses, and other health care providers: (1) the severity of the emergency might greatly increase the demand for health services and outstrip the available supply; (2) health care providers might become unavailable because of their own high rates of illness, as was the case in the SARS epidemic; and (3) many health care providers might not report for duty for personal, family, or professional reasons.

One way of addressing the shortage is to encourage health care providers from unaffected areas or parts of the country to volunteer their services. A variety of measures have been enacted to facilitate the use of such volunteers. For example, the Emergency Management Assistance Compact,¹ signed by all 50 states, provides for licensing reciprocity, although in most states the provisions apply only to state and local government employees. Various federal laws, including the Volunteer Protection Act,² also are designed to encourage and regulate volunteers, including health professionals.³

Most states have enacted legislation immunizing business and non-profit entities that voluntarily assist governments during emergencies.⁴ A more comprehensive immunity provision is contained in section 11 of the Uniform Emergency Volunteer Health Practitioners Act (UEVHPA).⁵ Under this section, volunteer health practitioners are not liable for damages except in the case of willful, wanton, grossly negligent, reckless, or criminal conduct, or an intentional tort.⁶ As of November 2009, seven states had enacted the UEVHPA and bills to adopt the act were pending in nine other states.⁷ The immunity provision of the UEVHPA undoubtedly is based on the judgment that it would be unfair to impose liability on volunteer physicians and that the possibility of liability would likely discourage much-needed volunteers.

It is far from clear that substantial numbers of volunteer health professionals would be needed in every public health emergency. The “volunteer health corps” model is applicable primarily to a “doomsday scenario” in which most local health care providers are killed, incapacitated, or otherwise unavailable. This is rarely the case. For example, tragically, after the September 11th attacks, there was little need for *any* health care providers. It also could be argued that, regardless of the severity of the emergency, the volunteer health corps model would be relevant primarily in the immediate aftermath of the event and that restoring local providers and institutions should be the top priority for emergency response officials.

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This article leaves aside these policy questions, and it assumes the necessity of volunteer physicians and other health care providers in a public health emergency. The central premise of the article is that legislation immunizing volunteer physicians from malpractice liability is unnecessary and constitutes misguided policy. It asserts that laws granting volunteer physicians immunity in public health emergencies have the effect of discriminating against poor people, have the potential to be socially destabilizing, and could undermine public health interventions in an emergency. The article proposes alternatives to protect the interests of physicians, patients, and the public. Although the following discussion focuses on physicians, the same reasoning also applies to malpractice actions against other health care providers.

Altered Standards of Care

Immunity from medical malpractice liability in public health emergencies frequently comes under the rubric of “altered standards of care,”⁸ a broader term also incorporating treatment prioritization and allocation of scarce resources.⁹ In the context of malpractice liability, the need for “altered standards of care” assumes that traditional legal standards of care are inappropriate in an emergency. Certainly, it would be unreasonable for a court to apply an inflexible, “non-emergency” standard of care to hold a health care provider liable for harms suffered in an emergency by a patient who was treated without adequate diagnostic equipment, laboratory services, or front-line medications. If there were such an inflexible and unrealistic legal standard for medical care, it *ought* to be “altered” in an emergency.

Fortunately, and in stark contrast to suggestions by some “altered standards of care” advocates, the current standard of care applied to all medical malpractice cases is sufficiently flexible and situation-specific that it need not be altered. In all 50 states and the District of Columbia, the standard of care owed by a physician to a patient is that level of care that would be provided by a reasonably prudent physician in similar circumstances.¹⁰ As explained by the Supreme Court of Mississippi, the standard of care owed by a physician is “such reasonable diligence, skill, competence, and prudence as are practiced by minimally competent physicians in the same specialty or general field of practice throughout the United States, who have available to them the same general facilities, services, equipment, and options.”¹¹ Therefore, the general legal standard already would take into account if there were inadequate equipment or supplies, a lack of electricity, or other extenuating circumstances. In short, there is no need to “alter” the standard of care; the only thing that would be altered is the potential liability of physicians who fail to meet the standard.

Malpractice Actions Arising from Public Health Emergencies

Enacting laws establishing immunity for volunteer physicians might make sense if there were evidence that lawsuits have been or are likely to be filed alleging medical malpractice during public health emergencies. There is no such evidence, however. For example, in Canada, only two lawsuits were brought as a result of the SARS epidemic of 2003, and neither was a malpractice case. One lawsuit was brought by nurses and family members of nurses alleging that the government failed to take adequate steps to prevent the nurses from exposure to SARS in government hospitals. The Ontario Court of Appeals affirmed dismissal of the case.¹² A similar result was reached in a case brought by members of the public against the government.¹³ In the aftermath of Hurricane Katrina in 2005, three lawsuits were filed against cancer surgeon Dr. Anna Maria Pou by family members of patients at Memorial Medical Center in New Orleans, but the lawsuits allege she intentionally euthanized critically ill patients by administering lethal doses of morphine and midazolam.¹⁴ These highly unusual legal actions, which remain ongoing, would not be

precluded even under the UEVHPA because the plaintiffs have alleged intentional wrongdoing.

Immunity and Volunteer Physicians

An important assumption underlying efforts to enact immunity laws for volunteer physicians is that without such legislation physicians will be unwilling to volunteer. There is no evidence that immunity is needed to encourage altruistic physicians to volunteer in an emergency nor any evidence that granting malpractice immunity would be sufficient to get unwilling physicians to volunteer. The Institute of Medicine's 2009 letter report to Dr. Nicole Lurie, Assistant Secretary for Preparedness and Response of the Department of Health and Human Services, states: "Liability is a prevalent concern among healthcare providers and entities. This concern may be heightened when providing services during emergencies in which routine healthcare practices and responsibilities change."¹⁵ Although physician antipathy to malpractice liability is well known, neither the IOM Report nor the comments to section 11 of the UEVHPA provide any evidence of the connection between malpractice immunity and willingness to volunteer.

Regrettably, in every public health emergency since the Spanish Flu epidemic of 1918, substantial numbers of health care providers, including physicians, have refused to report for duty. According to Dr. Daniel Bausch of Tulane University School of Public Health and Tropical Medicine: "If you have an outbreak of, say, Ebola, most of the medical staff heads for the hills."¹⁶ In the context of a bioterrorism event, one study asked physicians if they would be willing to put themselves at risk of contracting a deadly illness to save others' lives. Only 40% of 526 responding physicians said they would be willing to put themselves at risk, and the survey might overestimate the response in an actual emergency, because there was no risk to responders in merely answering the question affirmatively.¹⁷

The problem of health care workers' reluctance to report for duty in a public health emergency is not unique to the United States. During the SARS epidemic, every jurisdiction with a significant number of SARS cases (Canada, China, Hong Kong, Singapore, Taiwan, and Vietnam) had to deal with the unwillingness of some health care providers to report for duty.¹⁸ In countries such as China, medical malpractice liability is not a major concern of physicians, thereby suggesting that other reasons are more important in determining whether a physician will report for duty.

Undoubtedly, the reasons for not reporting to work are varied and complex in all countries, as are the possible solutions. There is little evidence, however, that providing malpractice immunity for volunteer physicians would have any appreciable effect on expanding the number of volunteers. A further exploration of the personal, legal, and professional responsibility issues of health care providers in public health emergencies is beyond the scope of this article.¹⁹ In contemplating this phenomenon it is essential to recognize the selfless and heroic contributions of numerous physicians and other health care providers in a range of perilous situations.

Immunity and Public Policy

If few malpractice lawsuits are likely to be brought as a result of public health emergencies and if granting immunity to volunteer physicians could possibly increase the number of volunteers, then what is the harm in immunizing volunteer physicians? To answer this question, it is necessary to consider the consequences of granting immunity to volunteer physicians. The effect of immunizing volunteers is to create a distinction between non-volunteer and volunteer physicians. Non-volunteer physicians expect to be compensated for their services; they are treating patients with health care coverage or the financial means to

pay for their health care. If a patient is harmed by treatment not meeting the legal standard of care, the patient has a right to seek compensation by filing a medical malpractice action. By contrast, volunteer physicians are more likely to treat patients without health care coverage and without the means to pay for their care. These patients are epitomized by the people who were stranded in the Louisiana Superdome during Hurricane Katrina. Enacting laws immunizing volunteer physicians who are more likely to treat indigent patients preemptively adds legal insult before any possible medical injury. It sends a message that, unlike people with health care coverage, if non-paying patients are harmed by substandard medical care, they have no legal recourse.

Although, at this writing, Congress is still debating whether all Americans should have a right to health care, the courts have long held that the ability to bring an action for medical malpractice should not depend on the insurance status of the patient. In the celebrated case of *Tunkl v. Regents of the University of California*,²⁰ as a condition of receiving care, indigent patients entering UCLA Medical Center were required to sign a document releasing the hospital from malpractice liability under the theory that the hospital was providing charity care. When the legality of the release was challenged in a malpractice action brought by an indigent patient, the hospital argued that the law should recognize a distinction between paying and non-paying customers. In emphatically rejecting this argument, the California Supreme Court held that the release was void as against public policy: "To immunize the hospital from negligence as to the charitable patient because he does not pay would be as abhorrent to medical ethics as it is to legal principle."²¹ This same principle militates against enactment of statutory immunity for volunteer physicians.

Another possible justification for immunity is that because indigent patients are much less likely to sue for medical malpractice,²² the concern about differential legal rights is moot. To resolve this issue, it is necessary to consider the context of a public health emergency. In an extreme situation, there could be shortages in public services; insufficient food, water, and sanitation facilities; quarantine of exposed individuals; and even the triage of medical care. To deal effectively with this societal stress there must be a community sense of social solidarity. Public policy that needlessly and thoughtlessly proclaims that people differ in their legal rights during a public health emergency will undermine the efforts of public health officials and government leaders to gain compliance with public health orders and to maintain social solidarity. Thus, the potential benefit of immunity laws is unproven and likely to be small, whereas the potential costs to the public's health and welfare could be great.

Alternatives

Several approaches may be considered in attempting to balance removing any malpractice disincentive from potential volunteer physicians while providing compensation for patients harmed by acts of medical negligence. The problems with granting immunity to volunteer physicians have been previously addressed. Another approach is for Congress to enact "a comprehensive immunity provision that addresses liability for all health care providers, whether they be paid or unpaid, private or public sector workers, individuals, or entities."²³ This proposal has the advantage of eliminating the piecemeal protections at the federal and state levels, and it also does not discriminate between the recipients of voluntary and compensated care. It would apply "only in very limited circumstances that involve large-scale health threats and require the treatment of hundreds or thousands of patients."²⁴ The proposal might be an appropriate response to a "doomsday scenario," but it does not address the typical public health emergency. In addition, politically it might prove difficult to limit the broad immunity to truly exceptional circumstances.

Another suggestion is for physicians to use informed consent documents that detail the effects of the public health emergency on the provision of medical services.²⁵ Besides the issue of impracticality in an emergency, it is unlikely that courts would look upon such documents any more favorably than the releases indigent patients were required to sign at UCLA Medical Center.²⁶ An additional possibility is to establish compensation pools, which would provide payment to individuals wrongfully injured in the course of an emergency.²⁷ Although such a system might be valuable under some circumstances, the terms of its implementation would have to be carefully designed. Adopting yet another approach, Tennessee enacted a version of the UEVHPA that declared approved volunteers to be state employees and therefore compensation for the negligence of volunteer health practitioners would be available under the state tort claims act.²⁸

Perhaps the simplest and most effective way to reassure voluntary physicians that their extraordinary service will not result in liability while maintaining the legal rights of individuals who might be harmed by an act of malpractice is for the government to pay for the malpractice insurance of volunteer physicians or to indemnify physicians for any claims arising from their service. As noted earlier, the potential for malpractice lawsuits by indigent patients treated in an emergency is quite low, thereby making the governmental financial obligation small. At the same time, there is a significant symbolic value to both physicians and the public from this approach. Determining the legal rights of all patients under the same legal principles affirms that the standard of care and the potential remedies in the event of malpractice do not depend on the status of the physician or the patient's ability to pay for medical care.

Conclusion

There are numerous complex issues surrounding the provision of emergency services, including health care. This limited commentary is not intended to be a comprehensive review of the field. In particular, the article does not address the broad issue of whether granting some type of immunity to various public and private entities and individuals in a public health emergency is essential to ensure an adequate level of voluntary assistance. The article also does not describe or evaluate in detail the various options to limit the liability of volunteer physicians and other health care providers in a public health emergency. It merely argues that one possible approach to one problem embodied in a uniform act — malpractice immunity for volunteer physicians — should not be adopted. Granting immunity solely to volunteer physicians is unnecessary, unwise, unjust, and likely to result in unintended consequences to public health emergency response.

It has been less than five years since the appalling scenes of post-Katrina New Orleans, where socially and economically vulnerable people were literally left behind by public health and emergency response agencies.²⁹ In light of this recent history, it is indefensible to enact legislation granting immunity to volunteer physicians when the effect is to establish and announce a system of unequal legal rights for the next public health emergency.

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