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Risk Management in the Wake of Hurricane Katrina: Hospital Liability Associated with the Use of Volunteer Health Professionals During Emergencies

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RISK MANAGEMENT IN THE WAKE OF HURRICANES AND OTHER DISASTERS: HOSPITAL CIVIL LIABILITY ARISING FROM THE USE OF VOLUNTEER HEALTH PROFESSIONALS DURING EMERGENCIES

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INTRODUCTION

The impact of Hurricanes Katrina, Rita, and Wilma on the Gulf Coast states during the 2005 hurricane season illustrated the essential need for hospitals and other health care providers to prepare for and respond to emergencies. Hospitals in the paths of the storms across Louisiana, Mississippi, Alabama, and Florida were forced to evacuate some patients, temporarily act outside prevailing standards of patient care, and, in some cases, cease operations entirely. Additional hospitals that were unharmed by the physical destruction in these and many other states saw their patient populations swell as they absorbed hurricane evacuees, often as their community's primary source of health care services. The significant demands for medical care and complications associated with meeting patient needs underscore the critical nature of hospital preparedness as a part of comprehensive emergency response efforts.¹

A core component of hospital emergency planning is its ability to maintain quality standards of care during disaster responses. This ability hinges on multiple factors (e.g., access to medical supplies; functionality of hospital equipment, information systems, or other services; or destruction of physical structures), but may be most contingent on the availability of sufficient medical personnel. Hospitals need to be able to quickly and confidently ramp up staffing to meet surge capacity.² Additional medical providers are needed prior to, during, and following a disaster for hospitals to adequately function. Assuming the disaster is reasonably predictable, such as a hurricane, supplemental medical staff is needed in advance to help evacuate at-risk patients and prepare for emergency responses once the disaster hits. During the disaster, medical personnel may be deployed to care for existing patients and any new patients who were injured by the event. This can be a tremendous challenge in cases where the disaster literally destroys the hospital community's physical infrastructure (as was the case in New Orleans following Hurricane Katrina). Resulting temporary impairments of equipment and technological capabilities may necessitate more personnel to perform tasks like hand-pumping ventilators when there is no electricity.³ Hospitals face additional potential impacts related to an influx of new patients, the availability of fewer core

1. Adam Nossiter, *Hospital Conditions in New Orleans Worsen*, Aug. 31, 2005, <http://abcnews.go.com/Health/HurricaneKatrina/wireStory?id=1082512> (last visited Apr. 17, 2006); Press Release, Unconventional Concepts, Inc., London Attacks May Contain Clues for U.S. Emergency Preparedness, July 7, 2005, <http://www.pnnewswire.com/cgi-bin/stories.pl?ACCT=104&STORY=/www/story/07-07-2005/0004063208&EDATE=> (last visited Apr. 17, 2006).

2. Surge capacity is defined as "the number of critical casualties arriving per unit of time that can be managed without compromising the level of care." Asher Hirshberg et al., *How Does Casualty Load Affect Trauma Care in Urban Bombing Incidents? A Quantitative Analysis*. 58(4) J. TRAUMA 686, 691 (2005).

3. See, Nossiter, *supra*, note 1.

medical personnel, and the backlog created by rescheduling the procedures of existing patients. In cases of mass evacuation, many hospitals in an entire region may need additional medical personnel for weeks or months to sustain basic operations. At least two hospitals in the New Orleans area continue to seek significant additional medical personnel even two months after the impact of Hurricane Katrina.⁴

The real disaster facing hospitals in the aftermath of hurricanes or other emergencies is their potential failure to provide quality care or meet the essential needs of existing and new patients. These failures may implicate a host of liability concerns. In St. Bernard Parish, Louisiana, for example, owners of St. Rita's Nursing Home were indicted as a result of the deaths of thirty-four patients because of the facility's failure to comply with the Parish's mandatory evacuation order.⁵ Allegations that medical staff may have euthanized some patients at New Orleans' Memorial Medical Center in the days after the hurricane has led to an investigation by the Louisiana Attorney General's Office.⁶ Increasing staffing capabilities as a part of hospital emergency management planning is critical towards ensuring the availability of quality care for patients and mitigating the risk of liability to the hospital. While maximizing the use of existing core hospital personnel is a part of disaster response, meeting surge capacity inevitably requires the assistance of skilled and capable volunteer health professionals (VHPs),⁷ as addressed in Part I.

Deployment and use of VHPs during emergencies, however, raise other legal challenges for hospitals. Are VHPs, who may be deployed from other states, properly licensed to practice medicine in the host state? Do they have the necessary credentials to practice in a given hospital? What is the extent of their privileges

4. As of November 15, 2005, Ochsner Hospital and Touro Infirmary, two major health care facilities in the New Orleans area, were still requesting the assistance of hundreds of specialized health professionals through the Emergency Management Assistance Compact (EMAC). These facilities, whose staff had been greatly depleted in the aftermath of the hurricane, reported having to operate well below capacity due to insufficient medical personnel at their facilities. Personal communications from Ochsner Hospital and Touro Infirmary, EMAC Teleconference, Nov. 15, 2005 (on file with author).

5. CNN, *Nursing Home Owners Face Charges*, Sept. 13, 2005, <http://www.cnn.com/2005/US/09/13/katrina.impact/index.html> (last visited Nov. 18, 2005).

6. Carl Quintanilla, *Euthanasia Alleged at New Orleans Hospital*, Oct. 17, 2005, <http://msnbc.msn.com/id/9732216/> (last visited Nov. 18, 2005).

7. An essential element of emergency preparedness is the ability of a hospital to increase surge capacity and supplement its medical capabilities as part of an emergency response plan. A hospital's ability to accommodate a sudden flood of large numbers of patients requiring medical care determines its surge capacity. See, Daniel P. Davis et al., *Hospital Bed Surge Capacity In the Event of a Mass-Casualty Incident*, 20(3) PREHOSP. & DISASTER MED. 169 (2005), available at <http://pdm.medicine.wisc.edu/20-3%20PDFs/Davis.pdf>. Surge capacity refers to "the number of critical casualties arriving per unit time that can be managed without compromising the level of care." Hirshberg, *supra* note 2, at 691. In addition to bed and medical supply availability, the availability of properly qualified medical staff is an important aspect of surge capacity. See, *id.*

within the hospital? These concerns challenge hospitals because of the potential for liability related to negligent medical care given by improperly qualified health care professionals at their facilities. During non-emergencies, hospital administrators and staff work hard to prevent harms to patients through medical negligence. Their obligations to prevent these harms during emergencies are compounded by the disaster itself. Assessing liability is not easy, for example, when the standard of care during triage may change substantially in the context of an emergency.⁸ Regardless of these liability concerns, the need for VHPs to meet surge capacity during emergencies is clear because the alternative (i.e., improperly caring for patients because of a failure to use available VHPs) is untenable.

To assist hospitals and other medical providers in fulfilling patient needs during emergencies, federal and state governments have organized efforts to make qualified VHPs available to hospitals (and other providers) more rapidly. Volunteer medical personnel may be directly deployed by the federal government through initiatives such as the National Disaster Medical System (NDMS). Federal volunteer recruitment efforts related to the medical response to Hurricane Katrina in the Gulf Coast states resulted in over 33,000 responses.⁹ These efforts were, however, significantly criticized by states and localities because of significant delays in actual response.¹⁰

Alternatively, states are developing their own volunteer registries with federal funding and technical assistance. Following lessons learned from the terrorist attacks on September 11, 2001, the federal Public Health Security and Bioterrorism Preparedness and Response Act of 2002¹¹ authorized the Department of Health and Human Services (HHS) to create a state-based program to develop emergency systems for advance registration of volunteer health professionals (ESAR-VHP).¹² President Bush recently acknowledged the emergence of these state systems in his administration's plan to address pandemic flu.¹³ These state-based electronic systems seek to pre-qualify volunteers through advance verification of their

8. See, AGENCY FOR HEALTHCARE RESEARCH & QUALITY, ALTERED STANDARDS OF CARE IN MASS CASUALTY EVENTS: BIOTERRORISM AND OTHER PUBLIC HEALTH EMERGENCIES, available at <http://www.ahrq.gov/research/altstand/> (last visited Nov. 18, 2005) [hereinafter ALTERED STANDARDS OF CARE].

9. See, U.S. DEPT OF HEALTH & HUMAN SERV. HEALTH CARE PROFESSIONALS AND RELIEF PERSONNEL WORKER PAGE, <https://volunteer.ccrf.hhs.gov> (last visited Nov. 18, 2005).

10. *The Latest on Katrina's Aftermath, Bush Says Much Work Remains, Deflects Questions on Disaster Response*, CNN.com, Sept. 13, 2005, <http://www.cnn.com/2005/US/09/07/news.update/index.html> (last visited Mar. 31, 2006).

11. See, Pub. L. No. 107-188 (2002).

12. *Id.* at § 107.

13. *Bush Unveils \$7.1 Billion Plan to Prepare for Flu Pandemic*, CNN.com, Nov. 2, 2005, <http://www.cnn.com/2005/HEALTH/conditions/11/01/us.flu.plan/> (last visited Mar. 31, 2006).

credentials, licenses, accreditations, and hospital privileges of VHPs.¹⁴ Volunteers deployed through these systems are, in essence, pre-vetted.

Hospitals and other health care entities may access information from these systems during a public health emergency or mass casualty event to quickly privilege additional staff or verify a VHP's license or credentials.¹⁵ Thousands of additional VHPs were successfully deployed through these systems during Hurricanes Katrina, Rita, and Wilma, even though many states' systems are still in early stages of development.¹⁶ Additionally, the deployment of VHPs through volunteer systems may dispel some liability risks that hospitals face by improving their capacity to quickly, accurately, and satisfactorily check the qualifications of outside medical personnel.¹⁷ Yet, hospitals may still face civil liability for the use of VHPs under two major themes (as discussed in Part II): (a) *the doctrine of corporate negligence* (under which a hospital may be held liable for its own failures to adopt appropriate policies and procedures to protect patients); and (b) *vicarious liability* (through which a hospital may be held liable for the negligent actions of VHPs performed within the scope of their duties). These two themes are particularly important for hospital entities because, unlike individual volunteers during emergencies, they may not enjoy special immunity or indemnification protections through emergency laws or other mechanisms for liability regarding the provision of medical care.

Despite the potential for liability arising out of the use of VHPs, and the limited protections hospitals enjoy, hospitals may engage in several proactive strategies to effectively manage their risks. Part III summarizes these strategies in three main areas:

(1) *Planning and training to meet surge capacity.* One of the most effective strategies to limit liability is to prevent the conditions from which it may attach. Hospitals that engage in advance planning to meet surge capacity in response to emergencies, and require existing (and potential volunteer) health personnel to be trained in the methods of delivering quality care in the context of emergencies via triage, are

14. HEALTH RES. & SERV. ADMIN., DEP'T OF HEALTH & HUMAN SERV., EMERGENCY SYSTEM FOR ADVANCE REGISTRATION OF VOLUNTEER HEALTH PROFESSIONALS (ESAR-VHP)—LEGAL AND REGULATORY ISSUES 10 (2005), available at <http://www.hrsa.gov/esarvhp/legregissues/default.htm> (last visited Nov. 13, 2005) [hereinafter LEGAL AND REGULATORY ISSUES REPORT].

15. See, HEALTH RES. & SERV. ADMIN., DEP'T OF HEALTH & HUMAN SERV., EMERGENCY SYSTEMS FOR ADVANCE REGISTRATION OF VOLUNTEER HEALTH PROFESSIONALS (ESAR-VHP) PROGRAM INTERIM TECHNICAL AND POLICY GUIDELINES, STANDARDS, AND DEFINITIONS, v. 2, § 3.2.3, 25 (2005), available at <http://www.hrsa.gov/esarvhp/guidelines/default.htm> (last visited Mar. 31, 2006).

16. HEALTH RES. & SERV. ADMIN., DEP'T OF HEALTH & HUMAN SERV., BIOTERRORISM HOSPITAL PREPAREDNESS: EMERGENCY SYSTEM FOR ADVANCE REGISTRATION OF VOLUNTEER HEALTH PROFESSIONALS (ESAR-VHP)—PROGRAM STATUS, available at <http://www.hrsa.gov/esarvhp/>. (last visited Nov. 18, 2005).

17. LEGAL AND REGULATORY ISSUES REPORT, *supra* note 14, at 42.

taking meaningful, responsible steps toward significantly reducing their liability during emergencies;

(2) *Implementing strict credentialing procedures.* Volunteer registries like ESAR-VHP are designed to readily provide hospitals with access to available, pre-vetted VHPs for real-time responses to emergencies. This service is invaluable, but hospitals may also need to supplement these efforts through additional credentialing procedures designed to expeditiously validate the qualifications of VHPs specifically assigned to treat patients; and

(3) *Divesting responsibility for VHPs.* Statutory and other legal mechanisms do not fully insulate hospitals from all types of liability related to the use of VHPs during emergencies. However, hospitals can divest some of their responsibility through affirmative steps including specific informed consent forms for patients and specialized agreements with VHPs, their host hospitals, or other entities. Collectively, these proactive measures not only help reduce the potential for significant liability of hospitals in the use of VHPs during emergencies, but they can also improve patient care by facilitating the deployment of essential medical personnel when and where they are most needed.

I. THE INTERPLAY BETWEEN HOSPITALS AND VOLUNTEER HEALTH PROFESSIONALS DURING EMERGENCIES

Hospitals are complex institutions that provide a multitude of health services to the population. The cumulative, orchestrated efforts of administrators, supervisors, and a variety of skilled professionals are necessary for these institutions to function properly. A major emergency or disaster will inevitably test the capacity of a hospital's administrative structure and workforce to respond to the expanded health care needs of the affected populations. A predictable consequence of any significant public health emergency is the surge of dozens, hundreds, or even thousands of patients that may require immediate medical assistance in hospital settings. This influx of patients may tax the ability of local hospitals and other medical facilities to provide adequate care.¹⁸ The incorporation of new professionals into the operational structure of a hospital requires careful planning, adept management, and rigorous oversight, particularly during an emergency when circumstances may be stressful, novel, and chaotic. It is imperative that hospitals plan for these scenarios, assess potential areas of workforce shortage and surge capacity needs, and establish the means to increase the numbers of qualified health personnel available to meet surge capacity during various types of emergencies. The sections that follow explain the circumstances in which hospitals may need the

18. U.S. DEP'T OF HOMELAND SEC., FEDERAL RESPONSE PLAN, EMERGENCY SUPPORT FUNCTION #8: HEALTH AND MEDICAL SERVICES ANNEX, ESF 8-4 (Jan. 2003), available at <http://www.au.af.mil/au/awc/awcgate/frp/frpesf8.pdf> (last visited Mar. 31, 2006) [hereinafter ESF #8].

assistance of VHPs during emergencies, discuss the available mechanisms to link hospitals and VHPs, and describe the roles that VHPs may fill in various emergency scenarios.

A. Hospitals' Need for VHPs in Emergencies

To meet surge capacity, hospitals may draw upon their existing workforce, temporarily hired personnel, or VHPs. VHPs may be used in several different capacities during a public health emergency or mass casualty incident, depending on the nature of the incident. If the emergency involves large numbers of traumatic injuries, VHPs may be needed to supplement hospital staff resources that have been stretched thin or exhausted, to provide medical care for patients, or to offer mental health support for victims and their families. Natural disasters, like Hurricane Katrina, may result in injuries from trauma, dehydration, malnutrition, or exposure to toxic chemicals and contaminated water. Furthermore, if existing health care facilities are disabled, additional personnel may be needed to evacuate large numbers of patients or provide treatment under difficult circumstances with limited medical resources, creating a humanitarian aid crisis.¹⁹ Displaced patient populations will also need access to medications, medical supplies, equipment, and treatment.

The utilization of any outside personnel presents the hospital with management challenges and potential liability risks. Depending on the nature of the emergency, the hospital's existing workforce may be depleted or be completely overwhelmed. Irrespective of their specific training, VHPs may be asked to fill gaps in existing services. Consequently, VHPs may not be matched appropriately to the specific needs of health care entities, or may be asked to perform acts they are not well trained to do, raising concerns regarding civil liability.²⁰ These problems are compounded by the lack of a common system to coordinate volunteer responses at the state and local levels. During the hurricane response efforts in the Gulf Coast region, many states aligned through communications between their ESAR-VHP systems and with HRSA to coordinate the dissemination of VHPs to affected areas. These efforts contributed to more effective deployment and use of VHPs, although interoperability of these systems during a multi-jurisdictional emergency can still be improved. Some members of Congress suggested during the hurricane disasters that a nationally-coordinated system may help prevent duplication of efforts, waste of resources, and delays in emergency responses.²¹

19. Phillip Nieburg, Ronald J. Waldman, & Donald M. Krumm, *Hurricane Katrina: Evacuated Populations—Lessons from Foreign Refugee Crisis*, 353 N. ENG. J. MED. 1547 (2005); SUSAN F. MARTIN, ET AL., *THE UPROOTED: IMPROVING HUMANITARIAN RESPONSES TO FORCED MIGRATION 1* (2005).

20. For a complete discussion of civil liability implications, see Part II, *infra*.

21. Senator Obama introduced the Hurricane Katrina Emergency Health Workforce Act of 2005, S. Bill 1638, on September 8, 2005. The bill outlines a series of initiatives to provide for federal coordination of VHP deployment and additional legal protections for VHPs. See, Hurricane

While the use of VHPs can present management and liability challenges, there are several distinct advantages to their utilization during an emergency as opposed to existing or temporarily hired personnel. Hospital managers may need additional personnel from outside the emergency zone urgently to fill in and provide care to an expanding patient population that may require rapid treatment, access to medications, or even isolation (in cases of infectious conditions). Even if a hospital staff is generally functioning well during an emergency, specialized health professionals trained to treat patients with particular needs may still be needed. Incorporating VHPs into the hospital may be more efficient than trying to extend the utility of existing personnel or engaging in temporary hiring, provided that the appropriate systems are in place to assess and verify the professional competencies and qualifications of the VHPs.

B. Procedures for the Use of VHPs

Emergency management planning is an essential precursor to the use of VHPs in emergencies. Hospitals may request volunteers through multiple venues: federal volunteer networks, state ESAR-VHP programs, entities like the Medical Reserve Corps (MRC) or the American Red Cross, or pursuant to the state's Emergency Management Assistance Compact (EMAC) system. Depending on the scope of the disaster or emergency, VHPs may seek out hospitals and offer their services.²² The method of deployment will largely determine the scope of legal protections available to VHPs and their affiliations (e.g., whether they are considered a federal or state employee, an independent volunteer, or otherwise), and by extension, the civil liability exposure of the hospital utilizing them.²³ Three distinct sources—government deployments, private sector response, and spontaneous volunteers—help facilitate the deployment of VHPs during emergencies.

Government deployments of health volunteers typically involve activating teams of pre-registered emergency responders through federal, state, and local mechanisms to provide medical care or other needed assistance at the disaster site or other locations. At the federal level, deployments are governed by the National Response Plan (NRP)²⁴ and Emergency Support Function #8 (ESF-8), which

Katrina Emergency Health Workforce Act of 2005, S. 1638, 109th Cong. (2005), available at <http://thomas.loc.gov/cgi-bin/bdquery/D?d109:11:/temp/~bd0q2s::|/bss/d109query.html> (last visited Apr. 13, 2006). See also, JAMES G. HODGE, JR., CTR. FOR LAW & THE PUB. HEALTH, HURRICANE KATRINA RESPONSE: H.R. 3736—KATRINA VOLUNTEER PROTECTION ACT OF 2005, <http://www.publichealthlaw.net/Research/PDF/Katrina%20-%20HR%203736.pdf> (last visited Apr. 5, 2006) [hereinafter H.R. 3736 MEMORANDUM].

22. Many of the volunteers that appeared after the September 11, 2001 attacks and Hurricanes Katrina and Rita in 2005 arrived spontaneously, i.e. without any connection to the organized incident response system.

23. See, Part II, *infra*.

24. The NRP was developed by the Department of Homeland Security to establish "an all-

grants DHHS the authority to coordinate the health and medical components of the emergency response based on the need for assistance identified at the state or local levels.²⁵ The National Disaster Medical System (NDMS) coordinates 7,000-8,000 VHPs, organized into several different response groups,²⁶ including Disaster Medical Assistance Teams (DMAT).²⁷ Federal law permits individual federal agencies to deploy temporary health volunteers as part of an emergency response.²⁸ For example, over 33,000 people responded to DHHS' request for medical volunteers in response to Hurricane Katrina.²⁹ In addition, medical personnel deployed by MRC units³⁰ may assist in the establishment of mobile health care facilities and to provide care in existing facilities.³¹

States may mobilize volunteer teams through their own emergency preparedness laws and response plans.³² These teams can be deployed to other

hazards plan that provides the structure and mechanisms for national level policy and operational coordination for domestic incident management." U.S. DEP'T OF HOMELAND SEC., NATIONAL RESPONSE PLAN, 1 (Dec. 2004), available at http://www.dhs.gov/interweb/assetlibrary/NRP_FullText.pdf [hereinafter NATIONAL RESPONSE PLAN].

25. See generally, ESF #8, *supra* note 18 ("provid[ing] coordinated Federal assistance to supplement State and local resources in response to public health and medical care needs following a major disaster or emergency; or during a developing, potential medical situation.").

26. See, Robert F. Knouss, *National Disaster Medical System*, 116 PUB. HEALTH REP. 49, 50 (2001), available at http://www.publichealthreports.org/userfiles/116_SUP2/116049sup.pdf.

27. DMATs are teams of health professionals trained in emergency response, who can provide medical assistance at the site of the triggering event, before patients can be evacuated to health care facilities.

28. See, 42 U.S.C.A. § 217b (West 2003); JAMES G. HODGE & LANCE A. GABLE, HURRICANE KATRINA RESPONSE: LEGAL PROTECTIONS FOR TEMPORARY VOLUNTEERS UNDER A FEDERAL DECLARATION OF PUBLIC HEALTH EMERGENCY 1 (Sept. 2005), available at <http://www.publichealthlaw.net/Research/PDF/Katrina%20-%20Federal%20Temp%20Volunt.pdf>.

29. See, U.S. DEP'T OF HEALTH & HUMAN SERV., HEALTH CARE PROFESSIONALS AND RELIEF PERSONNEL WORKER PAGE, <https://volunteer.ccrf.hhs.gov/> (last visited Oct. 6, 2005).

30. MRC units are community-based units comprised of local medical and public health professionals willing to provide volunteer assistance "during times of community need." See, MED. RESERVE CORPS, THE OFFICE OF THE SURGEON GEN., U.S. DEP'T OF HEALTH & HUMAN SERV., ABOUT THE MEDICAL RESERVE CORPS, <http://www.medicalreservecorps.gov/page.cfm?pageID=5> (last visited Apr. 3, 2006). MRC units function predominantly at the local level and can be deployed by state or local governments to augment the public response to an emergency. *Id.*

31. During Hurricane Katrina, several MRC units were deployed to work in conjunction with the American Red Cross to provide medical care at federally established medical contingency stations for those in need of medical assistance following the hurricane. See, MED. RESERVE CORPS, THE OFFICE OF THE SURGEON GEN., U.S. DEP'T OF HEALTH & HUMAN SERV., MRC RESPONSE TO HURRICANES KATRINA AND RITA—INTERIM REPORT (Oct. 11, 2005), <http://www.medicalreservecorps.gov/page.cfm?pageID=1047>.

32. See, e.g., GOVERNOR'S DIV. OF EMERGENCY MGMT., TEX. DEP'T OF PUB. SAFETY, STATE OF TEXAS EMERGENCY MANAGEMENT PLAN, ANNEX H: HEALTH AND MEDICAL SERVICES, H-1 – H-2 (2002), ftp://ftp.cxdps.state.tx.us/dem/plan_state/state_annex_h.pdf. See generally, MED. RESERVE CORPS, OFFICE OF THE SURGEON GEN., U.S. DEP'T OF HEALTH & HUMAN SERV., GETTING STARTED: A GUIDE FOR LOCAL LEADERS 4 (2004), <http://www.medicalreservecorps.gov/pdf/MRCTASeries00.pdf> (providing a general guide to establishing and operating a Medical Reserve Corps unit) [hereinafter GETTING STARTED].

states pursuant to memoranda of understanding (MOU) between states, or through interstate compacts like EMAC, which govern emergency response efforts.³³ Local health departments also may engage in recruiting, mobilizing, and deploying volunteers. Often, local governments handle the deployment of first responders such as volunteer fire departments and EMS teams.³⁴ Likewise, private sector entities play an important role in deploying volunteers during public health emergencies and other disasters. Large, national volunteer organizations and consortia, such as the American Red Cross³⁵ and the National Voluntary Organizations Active in Disaster (NVOAD),³⁶ contribute manpower and expertise to emergency response efforts. Other volunteer organizations, such as Catholic Charities USA and the Salvation Army, also provide significant support.³⁷ Additionally, medical associations have organized their own disaster response teams.³⁸ Individual medical institutions may also assemble disaster response teams to provide assistance to state governments as a part of emergency response efforts.³⁹

33. See generally, CANADIAN INTERGOVERNMENTAL CONFERENCE SECRETARIAT, INTERNATIONAL EMERGENCY MANAGEMENT ASSISTANCE MEMORANDUM OF UNDERSTANDING (July 18, 2000), available at http://www.scics.gc.ca/cinfo00/85007918_e.html (providing “for the possibility of mutual assistance among the jurisdictions entering into [the] compact in managing any emergency or disaster when the affected jurisdiction or jurisdictions ask for assistance, whether arising from natural disaster, technological hazard, man-made disaster or civil emergency aspects of resources shortages.”) [hereinafter IEMAC]; Emergency Management Assistance Compact, Pub. L. No. 104-321 (1996) [hereinafter EMAC]. See also, Priscilla B. Fox, *Cross-Border Assistance in Emergencies: The New England/Eastern Canadian Model*, 11 NEW ENG. J. INT’L & COMP. L. 75 (2004), available at <http://www.nesl.edu/intjournal/vol11/fox.pdf>.

34. See, GETTING STARTED, *supra* note 32, at 4; E. Brooke Lerner et al., *Linkages of Acute Care and EMS to State and Local Public Health Programs: Application to Public Health Programs*, 11(4) J. PUB. HEALTH MGMT. & PRAC. 291, 292 (2005).

35. Under the NRP, the American Red Cross is responsible for “coordinating . . . mass care resources.” See, NATIONAL RESPONSE PLAN, *supra* note 24, at 3.

36. *Id.* at 11. (“NVOAD is a consortium of more than 30 recognized national organizations of volunteers active in disaster relief.”) See generally, NATIONAL VOLUNTARY ORGANIZATIONS ACTIVE IN DISASTERS, ANNUAL REPORT 2002, available at http://www.nvoad.org/articles/Annual_rep02.pdf (providing information regarding NVOAD’s structure, goals, and mission).

37. See, CATHOLIC CHARITIES USA, DISASTER RESPONSE, <http://www.catholiccharitiesusa.org/response/index.cfm?cfid=4603538&cftoken=69474944> (last visited Apr. 3, 2006); THE SALVATION ARMY, OUR ROLE IN DISASTER SERVICES, http://www.salvationarmyusa.org/usn/www_usn.nsf/vw-dynamic-arrays/8214F21A914E09CE80256FE80071ECF1?openDocument (last visited Apr. 3, 2006).

38. For example, the Orthopedic Trauma Association has established a mass casualty response team, composed of orthopedic traumatologists, which may be deployed as part of NDMS. See, Christopher T. Born & William G. DeLong, *Organizing the Orthopaedic Trauma Association Mass-Casualty Response Team*, 422 CLINICAL ORTHOPAEDICS & RELATED RES. 114, 115.

39. One example is the DMAT teams assembled by Johns Hopkins Medical Institutions (JHMI) within days of Hurricane Katrina to provide assistance in the response efforts. JHMI assembled two teams that were immediately sent to the Gulf Coast region to participate in the medical response at the request of the National Institutes of Health and the Maryland Department of Health and Human Services. These teams were organized by the institution’s Office of Critical

Virtually all hospitals have developed their own emergency response plans to coordinate personnel and resources. In many regions, hospitals have entered into agreements to share staff and provide reciprocal privileges to facilitate a coordinated medical response to a disaster.⁴⁰ These agreements are extremely helpful in coordinating the movement of essential health care personnel, but do not encompass the gamut of potential volunteer deployments. Hospitals must not only plan for the infusion of additional VHPs through organized systems, as discussed above, but also anticipate the arrival of numerous spontaneous volunteers during and after an emergency. Thousands of these individuals, who self-deploy to an emergency site or nearby health facilities to offer assistance without any prompting from or connection to organized volunteer networks, rushed to the Gulf coast region after Hurricanes Katrina and Rita. Many of them had no verification, beyond their own personal representations, of their licensure or capabilities to provide care, and as a result many were not fully utilized in response efforts.⁴¹ In many cases, emergency response coordinators were forced to develop ad hoc systems to immediately register and screen potential medical volunteers.⁴²

Proper credentialing and privileging of volunteers are critical for hospitals to determine how to best use particular volunteers and to ensure the provision of

Event Preparedness and Response and utilized to provide assistance in community hospitals and mobile health facilities. See E-mail from Gabor Kelen, Director of the Office of Critical Event Preparedness and Response, Johns Hopkins Medical Institutions, Director of the Johns Hopkins Department of Emergency Medicine, to Johns Hopkins University faculty, staff, and students (Sept. 16, 2005, 11:12 AM) (on file with author).

40. The use of inter-facility Memoranda of Understanding (MOUs) to share staff and meet surge capacity needs is a common practice in the private sector. At least sixty-nine percent of urban hospitals have agreements with other hospitals to share resources in the event of bioterrorism. U.S. GEN. ACCOUNTING OFFICE, HOSPITAL PREPAREDNESS: MOST URBAN HOSPITALS HAVE EMERGENCY PLANS BUT LACK CERTAIN CAPACITIES FOR BIOTERRORISM RESPONSE, GAO-03-924, at 13 (Aug. 2003), available at <http://www.mipt.org/pdf/gao03924.pdf>. Often, shared staff members are paid as temporary employees at the facility where they are providing assistance; in other situations, their normal employer will pay their salary and receive reimbursement from the hospital that benefited from the shared services. For example, the District of Columbia Hospital Association maintains an agreement among its members to mutually assist hospitals in emergency management. This agreement addresses the logistics of personnel and equipment sharing and the transfer of patients. It also assigns credentialing responsibilities and legal liability to hospitals receiving assistance from others. See, D.C. HOSP. ASS'N, MUTUAL AID MEMORANDUM OF UNDERSTANDING 6-10 (Sept. 27, 2001), available at <http://www.dcha.org/EP/dchamou.pdf>.

41. Following the hurricanes, health professionals appeared at numerous shelters, medical clinics, hospitals, and mobile medical units to provide assistance and contacted state and federal emergency management coordinators about participating in the response. Associated Press, *Chaos Hinders Efforts to Treat Katrina Survivors*, MSNBC, Sept. 5, 2005, <http://www.msnbc.msn.com/id/9207678/>; Associated Press, *On an Old Baseball Field, Makeshift Medicine*, MSNBC, Sept. 3, 2005 <http://www.msnbc.msn.com/id/9189282/>.

42. *Id.*

quality medical care for patients in their facilities.⁴³ Legal and accreditation standards demand that health care facilities use credentialing and privileging to assess the qualifications of all professionals, including volunteers, who practice within their facilities.⁴⁴ During emergencies, credentialing and privileging must occur in an expedited fashion or may not be possible at all. Thus, advance registration systems will be an important resource to enable hospitals to engage in adequate expedited credentialing and privileging during emergencies. These systems can alleviate the burden on hospitals to verify a volunteer's qualities by providing pre-vetted information on VHPs within the system.

Recruitment of properly licensed and credentialed VHPs may necessitate drawing from a wide array of entities and jurisdictions, including obtaining assistance VHPs from across state lines. Therefore, the availability of cross-border recognition of medical licenses and practitioner certification may dictate the number of VHPs that can legally participate in the response efforts. Although license reciprocity provisions exist under the current emergency response system through state mutual aid agreements⁴⁵ and state laws,⁴⁶ there are no uniform legal mechanisms that apply to all VHPs in emergencies. Consequently, emergency planners may have difficulty recruiting VHPs from other states to mount a comprehensive and coordinated medical response.

II. THEMES OF CIVIL LIABILITY FACING HOSPITALS

The formal organization of VHPs during emergencies through governmental and private sectors facilitates the deployment of volunteers to hospitals during emergencies to meet surge capacity. These volunteer programs offer hospitals and other medical providers information and access to VHPs that are pre-vetted, and thus ostensibly qualified to function well in an exigent environment. Yet, during the hurricane response efforts in the Gulf Coast region, the specter of liability still muddied the effective utilization of VHPs. In some instances, hospital systems within and outside the region expressed liability concerns about the arrival of volunteers. Even though the risks of liability to hospitals may be greater in not utilizing VHPs to meet surge capacity (for example, if the failure to use qualified

43. See, JOINT COMMISSION FOR THE ACCREDITATION OF HEALTHCARE ORGANIZATIONS (JCAHO), COMPREHENSIVE ACCREDITATION MANUAL FOR HOSPITALS: THE OFFICIAL HANDBOOK (2004) [hereinafter JCAHO OFFICIAL HANDBOOK].

44. See, LEGAL AND REGULATORY ISSUES REPORT, *supra* note 14, at 29-30.

45. See, e.g., IEMAC, *supra* note 33; EMAC, *supra* note 33. See also, Fox, *supra* note 33, at 77.

46. Some states have enacted reciprocity legislation that is not tied to emergency declarations. Minnesota, Connecticut, West Virginia, and Illinois, for example, have enacted provisions allowing physicians holding licenses or permits from other states to provide care within the state when responding to an emergency. See, e.g., MINN. STAT. § 12.42 (2005); CONN. GEN. STAT. § 20-9(b)(3) (1999); W. VA. CODE § 30-3-13(b)(5) (2002); 20 ILL. COMP. STAT. 3305/16 (2004).

VHPs resulted in substantial reductions in care to patients), hospitals were cautious regarding the influx of VHPs.⁴⁷

In reality, hospitals' risks of liability concerning the use of VHPs exist. General tort principles holding persons responsible for harms caused to others after a breach of duty apply to hospitals as well as individuals.⁴⁸ Unlike individuals, however, hospitals may be held liable not only for their own acts and failures, but also for those of their health care workers. Hospitals owe duties of care to their patients that stem from the relationship that is formed when the patients present for care.⁴⁹ Patients arrive at a hospital with reasonable expectations that the hospital and its staff will provide adequate, competent, and quality care.⁵⁰ During an emergency, a patient's expectation may change as standards of care may be altered,⁵¹ but the duty to provide some level of care remains. If patients' reasonable expectations are not met, either due to the hospital's mistakes or those of its health care workers, hospitals may risk liability for resulting harms.

Of course, the need to provide quality care does not obligate the hospital to ensure the safety of their patients against all acts of physician negligence and misconduct.⁵² Especially during emergencies, courts will not likely hold hospitals accountable later for failures to sustain quality levels of care equivalent to pre-emergency standards. Rather, hospitals must provide the patient a degree of reasonable care in accordance with his or her known conditions.⁵³ This standard is met when reasonable efforts are made to oversee the actions of the health professionals practicing within the hospital.⁵⁴ Yet, emergency situations, such as Hurricane Katrina, may hinder the hospital's ability to adequately oversee health care workers (including VHPs) and the workers' ability to provide adequate care.⁵⁵ Both of these limitations could potentially lead to patient injury and expose

47. See, James G. Hodge, Jr., Lance A. Gable, & Stephanie Calves, *The Legal Framework for Meeting Surge Capacity Through the Use of Volunteer Health Professionals During Public Health Emergencies and Other Disasters*, J. OF CONT. HEALTH L. & POL. (forthcoming 2006).

48. *Bost v. Riley*, 262 S.E.2d 391, 396 (N.C. App. 1980).

49. *Id.*

50. *Id.*; see also, *Moore v. Bd. of Trustees*, 495 P.2d 605, 608 (Nev. 1972).

51. See, ALTERED STANDARDS OF CARE, *supra* note 8.

52. *Decker v. St. Mary's Hosp.*, 619 N.E.2d 537, 541 (Ill. Ct. App. 1993).

53. *Id.*

54. *Bost*, 262 S.E.2d at 396.

55. It is predictable that the standard of care to which hospitals are held as a supervisory authority is altered during emergency situations. See, ALTERED STANDARDS OF CARE, *supra* note 8. If hospitals are generally not expected to direct, control, or oversee treatment in the emergency room due to the necessity for split-second decision making (See, *Greene v. Rogers*, 498 N.E.2d 867 (Ill. 1986), cited in *Gilbert v. Frank*, 599 N.E.2d 143 (Ill. App. Ct. 1992)), then it may also be unreasonable to expect that they continue to exercise their supervisory powers during an emergency or disaster, during which the entire hospital is essentially converted into an "emergency" room.

hospitals to risks of liability under two major themes: (1) corporate negligence and (2) vicarious liability, each of which is discussed in the sections below.

A. Corporate Negligence

Corporate negligence theory can be used to hold a hospital liable on the basis of its own acts or failures to act, and not merely for the negligence of its employees. The theory is based on the assumption that hospitals are responsible for the general care and treatment of their patients⁵⁶ and have an affirmative duty to supervise the care its employees provide.⁵⁷ Corporate negligence liability is incurred by more than just an act of negligence by an individual for whom the hospital is responsible. Rather, liability results when the hospital itself breaches the duties that flow from the reception and treatment of patients.⁵⁸ In general, hospitals owe a duty to their patients to ensure that health care is only provided within their facilities by individuals who are competent and careful.⁵⁹ This duty includes the need to (1) provide adequate, safe facilities; (2) employ competent physicians; (3) oversee their employees' care; and (4) form and enforce policies ensuring quality patient care.⁶⁰

To sustain a finding of corporate negligence, courts typically require that a hospital deviated from its standard of care, had actual or constructive notice of the defects or actions causing harm to patients, and that its conduct was a substantial factor in causing the harm.⁶¹ In emergency situations where VHPs may be essential to meet surge capacity, fulfilling these duties is complicated. Nevertheless, hospitals may still be legally responsible for failing to provide some level of adequate care if they (1) do not have sufficient emergency management planning, (2) fall short in meeting surge capacity during the emergency, or (3) engage in improper staff selection, supervision, or administrative oversight.

Insufficient emergency management planning may be grounds for a finding of corporate negligence when the hospital does not implement plans to address the particular medical needs that exist during emergency situations. Disasters often cause widespread injury and illness and cut hospitals off from their usual resource channels.⁶² These consequences are devastating, but predictable. Hospitals must develop emergency management plans to address how they will obtain sufficient

56. See, *Pedroza v. Bryant*, 677 P.2d 166, 169 (Wash. 1984).

57. See, *Darling v. Charleston Comm. Mem. Hosp.*, 211 N.E.2d 253 (Ill. 1965).

58. See, *Edwards v. Brandywine Hosp.*, 652 A.2d 1382 (Pa. Super. Ct. 1995) (suggesting that a hospital, itself, breaches its independent duty to its patients when it knows or should know about the harm to its patients caused by the healthcare professionals practicing within).

59. *Aldoroty v. HCA Health Serv. of Kan., Inc.*, 962 P.2d 501 (Kan. 1998).

60. *Thompson v. Nason Hosp.*, 591 A.2d 703 (Pa. 1991).

61. *Rauch v. Mike-Mayer*, 783 A.2d 815, 827 (Pa. Super. 2001).

62. See, James G. Hodge, Jr. et al, *Volunteer Health Professionals and Emergencies: Assessing and Transforming the Legal Environment*, 3(3) BIOSECURITY AND BIOTERRORISM 216, 217 (2005).

resources to treat patients during a disaster situation.⁶³ Even if the hospital has engaged in advance emergency planning, it may be held liable for any resulting deficiencies in care if it cannot effectively implement its plan's components.⁶⁴ Communication-based, organizational, or supervisory failures that prevent hospitals from properly implementing their emergency plans to serve patients during an emergency may all lead to findings of liability under corporate negligence.⁶⁵

Hospitals may also face liability for their inability to meet surge capacity during an emergency situation.⁶⁶ In response to an increased demand for treatment after a hurricane or other disaster, hospitals that do not or cannot call upon adequate numbers of staff may not be able to provide reasonable care to their new and existing patients.⁶⁷ Failing to effectively utilize existing federal or state VHP systems to meet surge capacity may be grounds for corporate negligence liability when VHPs available through these systems would have helped the hospital provide adequate treatment for new and existing patients.⁶⁸ Improper or delayed use of VHP systems may also lead to hospital liability for breaches of the duty to provide a reasonable standard of care for patients.⁶⁹ Finally, the inability to meet surge capacity may also violate the federal Emergency Medical Treatment and Active Labor Act (EMTALA).⁷⁰ EMTALA requires hospitals to screen and stabilize within their capabilities all patients who present for emergency care, even during disasters.⁷¹ Nonconformance with EMTALA requirements is a separate ground for hospital liability via a federal cause of action.⁷²

Courts have also held hospitals liable under the theory of corporate negligence for an individual physician's negligence if it was the result of deficiencies in staff

63. See, e.g., JCAHO OFFICIAL HANDBOOK, *supra* note 43.

64. See, *Ranch*, 783 A.2d at 827; *Welsh v. Bulger*, 698 A.2d 581 (Pa. 1987).

65. See, Barry R. Furrow, *Forcing Rescue: The Landscape of Health Care Provider Obligations to Treat Patients*, 3 HEALTH MATRIX 31, 63 (1993).

66. See, Daniel P. Davis, et al., *Hospital Bed Surge Capacity In the Event of a Mass-Casualty Incident*, 20(3) PREHOSP. & DISASTER MED. 169 (2005), available at <http://pdm.medicine.wisc.edu/20-3%20PDFs/Davis.pdf>.

67. Meeting surge capacity includes providing an adequate supply of qualified medical staff, beds, and medical supplies. See, Asher Hirshberg et al., *How Does Casualty Load Affect Trauma Care in Urban Bombing Incidents? A Quantitative Analysis*, 58(4) J. TRAUMA 686, 691 (2005).

68. This finding derives from hospital accreditation standards set forth under the Joint Commission for Accreditation of Healthcare Organizations (JCAHO) that implicates additional concerns under corporate negligence liability for failing to provide adequate facilities or care. See, JCAHO OFFICIAL HANDBOOK, *supra* note 43; see also, *Carter v. Hucks-Folliss*, 505 S.E. 2d 177 (N.C. App. 1998) (establishing propriety of considering hospital's failure to comply with JCAHO standards as some evidence of negligence).

69. See, *Marks v. Mandel*, 477 So.2d 1036 (Fl. App. 3d Dist. 1985) (indicating that hospital emergency room's failure to provide thoracic surgeon for patient in timely fashion constituted enough evidence for the jury to rule on a corporate negligence question).

70. 42 U.S.C.A. § 1395(d)(d) (2005).

71. *Id.*

72. See, *Godwin v. Mem'l Med. Ctr.*, 25 P.3d 273, 278 (N.M. App. 2001).

selection or supervision practices.⁷³ A hospital's duty of care extends to exercising reasonable effort in selecting and retaining qualified medical professionals on its staff.⁷⁴ Accordingly, hospitals utilizing VHPs must ensure that these professionals are properly licensed, credentialed, and privileged.⁷⁵ If hospitals do not properly investigate the qualifications of their VHPs, they may be held liable for creating a foreseeable risk of harm to patients who may be treated by incompetent health professionals.⁷⁶

To determine whether a hospital has adequately vetted the licensing, credentialing, and privileging of its staff members, courts typically require that it has exercised "reasonable care."⁷⁷ Even though emergency situations require hospital personnel to act quickly and decisively, hospitals who do not verify the qualifications of their VHPs with reasonable care may face liability for negligent staff selection.⁷⁸ Although ESAR-VHP and other volunteer systems ascertain a VHP's credentials prior to mobilization,⁷⁹ hospitals may still face liability for negligent credentialing or privileging if they fail to verify that the VHP has been properly vetted.⁸⁰ For liability to attach it must be proven that but for the hospital's lack of care in the selection or retention of the health care provider, the provider would not have been granted staff privileges and the patient would not have been injured.⁸¹ In the context of VHPs, it is unclear what evidence courts might use to

73. See, *Rauch v. Mike-Mayer*, 783 A.2d 815, 827 (Pa. Super. 2001). Note that the hospital's corporate negligence liability for a staff member's negligence is direct liability for its own administrative failures, rather than the vicarious liability that would attach based upon the professional's status as an employee or agent of the hospital. See Section II B, *infra*.

74. *Pedroza v. Bryant*, 677 P.2d 166, 168 (Wash. 1984).

75. See, *Robinson v. Duszynski*, 243 S.E.2d 148, 151 (N.C. App. 1978).

76. See, *Megrelishvili v. Our Lady of Mercy Med. Ctr.*, 291 A.D.2d 18 (N.Y.A.D. 1 Dept., 2002). The hospital's VHP system administrator may also be found liable for his or her failure to adequately or properly utilize the system.

77. *Rule v. Lutheran Hospitals & Homes Sec.*, 835 F.2d 1250 (Neb. App. 1987); see also, *Mills v. Angel*, 995 S.W.2d 262 (Tex. Appl. Texarkana 1999). Cf., *Wellstar Health Systems, Inc. v. Green*, 572 S.E.2d 731, 733 (Ga. App. 2002) in which the court found that the provision of an otherwise alleged "competent" practitioner, with no further indication of having satisfied licensure requirements, was not sufficient to shield the hospital from liability.

78. See, *Lopez v. Cent. Plains Reg'l Hosp.*, 859 S.W.2d 600 (Tex. App. Amarillo, 1993) (recognizing that hospital's duty to exercise reasonable care in staff selection gives rise to cause of action for negligent credentialing); *Goodstein v. Cedars-Sinai Med. Ctr.*, 78 Cal. Rptr. 2d 577 (2d Dist. 1998) (holding that hospital may be liable to patient for negligence of physician if hospital's failure to ensure competence of staff through appropriate selection and review procedures creates an unreasonable risk of harm to patients).

79. Cf., LEGAL AND REGULATORY ISSUES REPORT, *supra* note 14.

80. See, *Johnson v. Misericordia Comm. Hosp.*, 294 N.W. 2d 501 (Wis. App., 1980) (finding hospital liable for negligent staff selection when it failed to "scrutinize a physician's credentials" before approving his application for privileges and that failure to adhere to its own bylaws and credentialing policies was breach of separate duty owed to patients).

81. See, *Rose v. Garland Community Hosp.*, 87 S.W.3d 188 (Tex. App. 2002).

judge a hospital's investigative efforts during disasters.⁸² Courts have previously looked at what steps are taken to ascertain credentials based on the information available to the hospital at the time of the health care provider's approval.⁸³

Finally, courts have also held hospitals liable for the negligence of individual health professionals when the resulting injuries could have been prevented through adequate supervision.⁸⁴ When a hospital knows or should have known about a staff member's inadequate care and fails to take action to prevent injury, corporate negligence liability may attach.⁸⁵ Although the hospital's supervisory capacity may be compromised during emergencies, failures to review treatment practices could subject it to liability for resulting injuries caused by an individual VHP's negligence.⁸⁶ Even if a hospital has supervisory measures in place for VHPs, deficiencies in these measures can sustain liability if the deficiencies prevent the hospital from uncovering incompetent care.⁸⁷ For example, if a hospital's nurses are charged with checking a patient's condition and their failure to do so results in patient injury or death, the hospital may face corporate negligence liability for inadequate supervision of staff.⁸⁸ Courts are reluctant to hold hospitals liable for an employee's negligence when existing supervisory procedures were sound and would not have yielded evidence of any wrongdoing.⁸⁹ However, if other circumstances should have put the hospital on notice that the employee was likely to provide insufficient care, hospital liability may follow.⁹⁰

82. JCAHO guidelines detail the licensing, privileging, and credentialing practices that hospitals should follow when utilizing VHPs during an emergency, so it is likely that courts will use those suggested policies to evaluate hospitals' actions. *See, Carter v. Hucks-Folliss*, 505 S.E. 2d 177, 177 (N.C. App. 1998) (establishing propriety of considering hospital's failure to comply with JCAHO standards as some evidence of negligence).

83. *See, e.g., Purcell v. Zimbelman*, 500 P.2d 335 (Ariz. Ct. App. 1972); *Tucson Med. Ctr., Inc., v. Misevch*, 545 P.2d 958 (Ariz. 1976).

84. *See, Moore v. Bd. of Trustees of Carson-Tahoe Hosp.*, 495 P.2d 605 (Nev. 1972) (recognizing a hospital's responsibility for the care provided by its staff and potential liability for injuries resulting from its careless supervision); *Oehler v. Humana Inc.*, 775 P.2d 1271 (Nev. 1989).

85. *Rauch v. Mike-Mayer*, 783 A.2d 815, 827 (Pa. Super. 2001).

86. *See, Lo v. Provena Covenant Med. Ctr.*, 796 N.E.2d 607 (App. Ct. 4th Dist. 2003) (recognizing that hospital has independent duty to review and supervise patients' care).

87. *See, e.g., Johnson v. St. Bernard Hosp.*, 35 Ill. Dec. 364 (Ill. App. 1. Dist., 1979).

88. *Darling v. Charleston Cmty. Mem'l Hosp.*, 211 N.E. 2d 253 (1965).

89. *See, Brown v. DePuy AcroMed, Inc.*, 801 N.Y.S. 2d 681 (N.Y.A.D. 4 Dept. 2005) (holding that hospital committed no corporate negligence when doctor implanted defective screws in patient's spine, since hospital took no part in choice of screws).

90. *See, e.g., Megrelishvili v. Our Lady of Mercy Med. Ctr.*, 291 A.D.2d 18 (N.Y.A.D. 1 Dept., 2002); *Ward v. Lutheran Hosps. & Homes Soc. of Am., Inc.*, 963 P.2d 1031 (Alaska 1998) (ruling that hospital's knowledge of prior malpractice suit or disciplinary proceedings against physician is sufficient proof that hospital should have known a physician would act negligently).

B. Vicarious Liability

In addition to the liability via corporate negligence, hospitals are also at risk of liability based directly on the VHP's individual negligence. Under the theory of vicarious liability, the negligent acts of a health care provider may be directly imputed to the hospital in which the care is given.⁹¹ The theory of respondeat superior provides for vicarious liability when a negligent health care provider is an employee or an agent of the hospital and has acted in the course of his employment. This may seem to preclude vicarious liability for a volunteer's negligence because the individual may not be considered an employee or even an agent of the hospital. However, courts in some states have used the theory of ostensible agency to hold hospitals vicariously liable for injuries to patients who seek care through a hospital's emergency room, and not from any particular physician.⁹² Thus, a hospital may potentially be liable for a VHP's negligent treatment of patients if (1) an employment or agency relationship is found,⁹³ or (2) patients look to the hospital rather than a particular provider for care.⁹⁴

The legal theory of respondeat superior looks to the existence of a formalized employment or agency relationship. It extends liability to employers based on an assumption that the employer has control over the actions of its employees.⁹⁵ The level of control exerted by the employer will determine the extent of this liability.⁹⁶ Typically, only negligent acts undertaken within the "scope of employment" are subject to liability.⁹⁷ Although demonstrating an agency relationship may appear relatively simple, courts have set a high standard for its determination. Whether a particular physician or other health care provider is considered an employee or agent depends on the nature of his contractual agreement,⁹⁸ including the method of payment, scheduling,⁹⁹ training status,¹⁰⁰ staff privileges,¹⁰¹ and degree and

91. LEGAL AND REGULATORY ISSUES REPORT, *supra* note 14, at 51.

92. *Abraham v. Dulit*, 679 N.Y.S.2d 707 (N.Y. App. Div. 1998); *see also*, *Johnson v. Jamaica Hosp. Med. Ctr.*, 21 A.D. 3d 881 (N.Y. App. Div. 2005). *Cf.*, *Cooper v. Sisters of Charity of Cincinnati*, 272 N.E.2d 97 (Ohio 1971), an action for wrongful death where the plaintiff alleged that the physician was acting on behalf (i.e., as an agent) of the hospital. On appeal, the court noted that the physician was not under the control of the hospital and that the practice of medicine in a hospital was not sufficient to create an agency by estoppel. Absent a showing of induced reliance, the court affirmed the holding of the trial court which denied imputing liability to the hospital.

93. *See*, LEGAL AND REGULATORY ISSUES REPORT, *supra* note 14, at 51.

94. *See, id.* at 51-52.

95. *See, id.* at 51.

96. *See, id.*

97. *See, id.*

98. *Vanaman v. Milford Mem'l Hosp.*, 272 A.2d 718 (Del. 1970).

99. *Cooper v. Binion*, 598 S.E. 2d 6 (Ga. Ct. App. 2004).

100. *Capps v. Valk*, 369 P.2d 238 (Kan. 1962).

101. *Vanaman*, 272 A.2d at 718; *Pogue v. Hosp. Auth. of DeKalb County*, 170 S.E.2d 53 (Ga. Ct. App. 1969); *but see*, *Torrence v. Kusminsky*, 408 S.E.2d 684, 692 (W. Va. 1991) ("Where a

magnitude of control the hospital exercises over the provider's practices.¹⁰² Most courts will not hold a hospital liable for the negligence of its health care providers based on an employment or agency relationship if the contract specifically negates such a status.¹⁰³ Conversely, even where a provider is on the hospital's medical staff, an employment or agency relationship may not necessarily follow.¹⁰⁴

Hospitals may still be subject to vicarious liability for the actions of VHPs under the theory of ostensible or apparent agency if the patient looks to the hospital, rather than an individual physician, to provide care.¹⁰⁵ To demonstrate this type of relationship between the health care provider and the hospital, (1) the patient must reasonably rely on the belief that the health care provider is an agent or employee of the hospital, and (2) the hospital must affirmatively hold out the provider as an employee or agent, or knowingly permit the provider to project herself as such.¹⁰⁶ Ostensible agency is particularly relevant in emergency situations.¹⁰⁷ In the case of a medical emergency, the public is "justifiably unaware of and unconcerned with the technical complexities"¹⁰⁸ that define the employment

hospital makes emergency treatment available to serve the public as an integral part of its facilities, the hospital is estopped to deny that the physicians and other medical personnel on duty providing treatment are its agents. Regardless of any contractual arrangements with so-called independent contractors, the hospital is liable to the injured patient for acts of malpractice committed in its emergency room, so long as the requisite proximate cause and damages are present.".)

102. *See*, *Qayyum v. Morehouse Gen. Hosp.*, 874 So. 2d 371 (La. Ct. App. 2004).

103. *Cf.*, *Darling v. Charleston Comm. Hosp.*, 211 N.E.2d 253 (Ill. 1965). In *Darling*, the contract between a hospital and a physician specifically denied that the physician was to be considered an "employee," precluding liability on the basis of vicarious liability. However, the hospital was still ultimately found liable under a different theory, that of corporate negligence. Thus the employment contract is not a "cure-all."; *see also*, *Cooper*, 598 S.E. 2d at 6.

104. *Jacoves v. United Merch. Corp.*, 11 Cal. Rptr. 2d 468 (Cal. Ct. App. 1992); *Nagengast v. Samaritan Hosp.*, 621 N.Y.S.2d 217 (N.Y. App. Div. 1995) (holding that mere affiliation with a hospital and the granting of admitting privileges are not sufficient in themselves to impose liability on a hospital on the basis of a physician's negligence); *see also*, *Cooper*, 598 S.E. 2d at 6.

105. *Henderson v. Marx*, 674 N.Y.S.2d 247 (N.Y. App. Div. 1998) (holding that a hospital may still be held vicariously liable where the physician was not a hospital employee given that the patient sought treatment from the hospital itself); *Abraham v. Dulit*, 679 N.Y.S.2d 707 (N.Y. App. Div. 1998).

106. *Baptist Mem'l Hosp. Sys. v. Sampson*, 969 S.W.2d 945 (Tex. 1998); *Robers v. Condell Med. Ctr.*, 801 N.E.2d 1160 (Ill. App. Ct. 2003). *See also*, *Simmons v. St. Clair Mem'l Hosp.*, 481 A.2d 870, 874 (Pa. Super. 1984) (holding that a hospital may be liable for the physician's actions when (1) the patient looks to the hospital rather than the individual physician to provide him with care, and (2) the hospital holds the physician out as its employee); *Burless v. W. Va. Univ. Hosps., Inc.*, 601 S.E.2d 85, 93 (W.Va. 2004); *Mejia v. Cmty. Hosp. of San Bernardino*, 122 Cal. Rptr. 2d 233, 236 (Cal. App. 4th Dist. 2002); *Petrovich v. Share Health Plan of Ill., Inc.*, 719 N.E.2d 756, 765 (Ill. 1999); *Capan v. Divine Providence Hosp.*, 430 A.2d 647, 649 (Pa. Super. 1981).

107. *See*, *Torrence v. Kusminsky*, 408 S.E.2d 684, 692 (W. Va. 1991); *Adamski v. Tacoma Gen. Hosp.*, 579 P.2d 970, 979 (Wash. App. 1978); *Mduba v. Benedictine Hosp.*, 384 N.Y.S.2d 527, 529-30 (A.D. 1976).

108. *Clark v. Southview Hosp. & Family Ctr.*, 628 N.E.2d 46, 53 (Ohio 1994), *cited in* *McGill v. Newark Surgery Ctr.*, 756 N.E.2d 762, 773 (Ohio Ct. Comm. Pl. 2001).

relationships between the hospitals and its medical professionals.¹⁰⁹ Given the very nature of an emergency, which emphasizes the need for rapid receipt of care, the public “has every right to assume and expect that the *hospital* is the medical provider it purports to be.”¹¹⁰ During disaster responses, few patients presenting for care will specifically request an individual physician. Instead, patients may arrive at the hospital with the expectation that they will receive some general medical assistance that the hospital can provide. Under this branch of vicarious liability, if a VHP is recruited to meet surge capacity during the emergency, his or her negligence can expose the hospital to some risks for liability. Thus, this theory serves to equalize the balance of information and provide the patient with an outlet for recovery related to negligent medical care.

In the case of VHPs who assist temporarily during disaster or emergency responses, the method by which they are recruited may affect their particular status as an employee or agent of the hospitals they support. As discussed in Part I, VHPs may arrive at a hospital as federal or state government workers or as private sector actors through organized systems like ESAR-VHP, private organizations (e.g., MRC, American Red Cross), or even spontaneously.¹¹¹ Each of these methods may define the VHP’s status differently and establish a distinct relationship between the VHP, the state or federal government, and the hospital.¹¹² VHPs that arrive spontaneously, outside of the hospital’s specific solicitation for help, may not initially be considered employees of the hospital, even assuming they are assigned some function upon arrival. However, depending on how they are utilized, they may have the appearance of being an agent of the hospital, thus raising liability concerns. Physicians dispatched via state programs may also have the appearance of agency with their recipient hospital hosts. In many cases, the hospitals’ view and administration of these VHPs, regardless of the circumstances of the VHPs’ arrival, may be authoritative as to their employee or agency status. Thus, the route by which VHPs arrive to provide care, and how the hospitals receive them, may affect their legal status as employees or agents, and ultimately the risk of vicarious liability for the hospitals in which they temporarily practice.

C. Liability Protections for Hospitals as Compared to VHPs

Hospital concerns about potential liability risks under theories of corporate negligence and vicarious liability could be allayed if their liability were eliminated or curtailed during emergencies, as is the case for many individual volunteers. However, few legal protections exist to completely exempt hospitals from

109. *McGill*, 756 N.E.2d at 773.

110. *Clark*, 628 N.E.2d at 53 (emphasis added).

111. *See*, Part I.B *supra*.

112. *Id.*

negligence liability related to the administration, use, and actions of VHPs. Laws and regulations at the federal and state levels typically provide significant legal protections for VHPs responding during an emergency, but these legal protections rarely extend to hospitals and other organizational entities providing health care and services. Disparities between available legal protections for volunteers and for hospitals are rooted in the evolution of these protections. Most of the legal protections available to volunteers were implemented to encourage individual, altruistic behavior during emergency situations and to protect those who volunteer their time and effort to assist others from liability or other harms. Hospitals and other health care facilities, which are required by law and expected by society to provide quality care regardless of the situation, are not always viewed as needing similar incentives.¹¹³ However, some hospitals may enjoy state liability protections in their roles as government entities or emergency care providers through specific grants of immunity during public health emergencies, thus gaining sovereign immunity because of their status as public institutions. In addition, Congress is currently seeking to further limit health care liability during hurricanes and other disasters.¹¹⁴ These provisions may serve to reduce the hospitals' liability risks in certain situations but are collectively sparse in application.

The scope of liability protections for hospitals is much narrower than that of VHPs, but hospitals are not devoid of safeguards. VHPs may receive licensure reciprocity, extended workers' compensation coverage, and immunity from civil liability by virtue of their participation in an organized emergency response effort.¹¹⁵ Several categories of legal provisions may grant civil liability protections to individual volunteers, including Volunteer Protection Acts,¹¹⁶ Good Samaritan laws,¹¹⁷ and emergency response provisions.¹¹⁸ Although these particular provisions typically do not extend to health care entities,¹¹⁹ there are several notable exceptions. In Oregon, for example, designated emergency health care centers enjoy immunity as state agents for any claims arising out of the provision of uncompensated medical care in response to a declared emergency.¹²⁰ Minnesota law allows its governor to grant immunity to organizations and individuals providing health care services

113. See, DAN B. DOBBS, *THE LAW OF TORTS* (2000).

114. See, *Katrina Volunteer Protection Act of 2005*, H.R. 3736, 109th Cong. (2005) (the bill has passed in the House, and is currently in the Senate awaiting a vote); *Hurricane Katrina Emergency Health Workforce Act of 2005*, S.B. 1638, 109th Cong. 2005.

115. See, James G. Hodge, Jr., et al., *Volunteer Health Professionals and Emergencies: Assessing and Transforming the Legal Environment*, 3(3) *BIOSECURITY & BIOTERRORISM* 216 (2005).

116. *Federal Volunteer Protection Act of 1997*, Pub. L. No. 105-19 (1997); 42 USC § 14501 et. Seq. (2004); see also, VA. CODE. ANN. § 44-146.23 (2005).

117. See, e.g., MO. ANN. STAT. § 537.037 (West 2005).

118. See, e.g., TEX. GOV'T CODE ANN. § 421.061 (2005).

119. *Id.*

120. See, OR. REV. STAT. §§ 401.5.5, 401.657, 401.667 (2003).

during a declared emergency when good faith acts or omissions cause harm during emergency care, advice, or assistance.¹²¹ In Hawai'i, the Department of Health is statutorily empowered to enter into agreements with health care providers, including health care entities, to control disease epidemics requiring more physical or personnel resources than the department itself can provide.¹²² When acting pursuant to such an agreement, these health care entities are not liable for any personal injuries or property damage resulting from the performance of their duties, absent willful misconduct.¹²³

Emergency response laws often adopt a more expansive approach to legal protections—in some cases all responders, even those that receive compensation, may qualify for legal protections. Still, the vast majority of these provisions exclude liability protections for entities and organizations providing health care services. States that have incorporated relevant provisions of the Model State Emergency Health Powers Act (MSEHPA) may protect hospitals from liability if they are under contract with the state or providing medical assistance at the state's request during a state-declared public health emergency.¹²⁴ MSEHPA details steps for states to declare a public health emergency and bestows upon the state special powers, including liability immunization, once it has done so.¹²⁵ During a state-declared public health emergency, hospitals could thus be insulated from many types of liability arising out of their use of VHPs pursuant to the MSEHPA.

Hospitals and other health care entities may also receive some protection from civil liability claims pursuant to sovereign immunity or targeted statutory provisions. Sovereign immunity protects government entities, and in some cases government contractors, from civil liability by essentially removing the legal routes through which they may be sued. Under the broadest conception, these entities are thus effectively immune from any civil action. Hospitals run by or affiliated with the state government may benefit from this protection. Some courts consider city- or county-run hospitals state entities and therefore immunize them from potential liability.¹²⁶ Other courts have ruled that hospital administration is a corporate

121. MINN. STAT. § 12.61 (2005). These protections do not apply in cases of "malfeasance in office or willful or wanton actions." *Id.*

122. HAW. REV. STAT. § 325-20 (2004).

123. *Id.*

124. MODEL STATE EMERGENCY HEALTH POWERS ACT (MSEHPA) § 804(b) (Ctr. for Law & the Pubs. Health at Georgetown and Johns Hopkins Univs. 2001), available at <http://www.publichealthlaw.net/Resources/Modellaws.htm> (last visited May 15, 2005). Note that as of June 30, 2005, thirty-seven states had incorporated MSEHPA's provisions. *Id.*

125. *Id.*

126. *See, Cabelka v. Comanche County Hosp.*, 87 P.3d 1101 (Okla. Civ. App. Div. 3 2003); *see also, Liberty Nat. Life Ins. Co. v. Univ. of Ala. Health Servs. Found.*, 881 So. 2d 1013 (holding that operation of hospital by state university grants sovereign immunity). *But see, O'Brien v. Rockingham County*, 120 A. 254 (N.H. 1923) (distinguishing between counties and incorporated towns or cities in terms of the nature of governmental and corporate powers they possess and

undertaking and thus not within the realm of state action or protected by sovereign immunity.¹²⁷

While most states have retained sovereign immunity for government-affiliated institutions, some states have greatly reduced or even eliminated this protection. Washington State, for example, has completely abrogated sovereign immunity for state actions.¹²⁸ As a result, the state and its affiliated employees and institutions face significant exposure to civil liability. Although the state does provide indemnification for damages against emergency responders, it does not indemnify hospitals or other institutions.

Though potentially beneficial, sovereign immunity is curbed in many states through tort claims acts (TCAs). TCAs effectively waive sovereign immunity for government actors and agents acting within their official capacities.¹²⁹ The scope of states' TCAs varies widely, including elements effecting complete abolition of sovereign immunity protections, reserving total immunity for specific actors, and retaining immunity protections with only limited exceptions.¹³⁰ Public hospitals must investigate their state courts' application of sovereign immunity protections and the scope of any applicable TCAs to determine whether the doctrine might protect them from potential liability.

The broad spectrum of immunity protections that states provide health care entities during emergencies is illustrated by the diverse legislation existing in the three Gulf Coast states most affected by Hurricane Katrina. In Louisiana, state legislation immunizes hospitals and health care entities from liability resulting from injury or damage to people or property during a state-declared emergency, except in cases of gross negligence or willful conduct.¹³¹ However, the legislation includes no specific provision addressing hospital liability for actions of VHPs, so it is unclear whether courts will interpret this language to include hospital immunity for VHP negligence. Public hospitals in Mississippi are protected through immunity provisions for state and political subdivision employees or agents during a state-

upholding sovereign immunity only for county-run hospitals). Irrespective of which governmental entity runs a hospital, courts are usually reticent to recognize sovereign immunity when the hospital or its agent has acted with willful or wanton negligence.

127. See, *Odom v. Lane*, 588 S.E.2d 548 (N.C. App. 2003) (holding that hospital operation is proprietary function and not a service typically provided by the government, thus foreclosing any governmental immunity for hospital); see also, *Thomas v. Hosp. Auth. of Clarke County*, 440 S.E.2d 195 (Ga. 1994).

128. WASH. REV. CODE § 4.92.090 (2005).

129. LEGAL AND REGULATORY ISSUES REPORT, *supra* note 14, at 45-46.

130. *Id.*

131. CTR. FOR LAW & THE PUBS. HEALTH, HURRICANE KATRINA RESPONSE: LEGAL PROTECTIONS FOR VHPs IN ALABAMA, LOUISIANA AND MISSISSIPPI, <http://www.publichealthlaw.net/Research/PDF/Katrina%20-%20AL%20LA%20MS%20Legal%20Protections.pdf> (last visited Apr. 5, 2006).

declared emergency.¹³² Despite the existence of substantial protections for public hospitals under these circumstances, private hospitals in Mississippi may still face liability. Moreover, public hospitals may still face substantial liability risk for VHP negligence related to actions occurring outside a declared emergency. Alabama provides liability protection to hospitals engaged in emergency management activities. These protections do not, however, extend to vicarious liability for the actions of volunteers.¹³³

As opposed to immunizing health care entities from liability, states could offer hospitals indemnification for civil liability judgments or settlements resulting from care provided during declared emergencies.¹³⁴ Indemnification shifts the economic loss of a court judgment from one party to another, in this case from the hospitals to the states. However, most state legislation providing indemnity for liability judgments arising out of public health emergencies is meant to shield individual VHPs rather than hospitals or other health care entities.¹³⁵

In addition to state legislation that may offer immunity or indemnification to hospitals utilizing VHPs, pending federal legislation exemplifies potential Congressional action that could affect the liability hospitals face regarding VHP use. The Hurricane Katrina Volunteer Protection Act¹³⁶ seeks to immunize from liability any person or entity who causes injury or loss while voluntarily giving aid to any individual affected by Hurricane Katrina, provided that their action did not violate any state or federal law and was not willful, wanton, or criminal.¹³⁷ This legislation would provide liability protection to VHPs and the hospitals in which they are working but narrowly tailors its immunity to liability arising out of Katrina relief efforts.¹³⁸ Senate Bill 1638,¹³⁹ still pending in the U.S. Senate Health, Education, Labor and Pensions Committee, would have a more lasting effect on liability resulting from the use of VHPs during future emergencies, but it fails to explicitly extend immunity to hospitals or other health care entities.¹⁴⁰ In the face of the House bill's narrow application and the Senate bill's silence as to hospital liability for VHP negligence, it seems unlikely that currently pending federal legislation will eliminate hospitals' liability risks.

132. *Id.*

133. *Id.*

134. *See*, LEGAL AND REGULATORY ISSUES REPORT, *supra* note 14, at 52.

135. *See, id.* at 44.

136. Katrina Volunteer Protection Act of 2005, H.R. 3736, 109th Cong. (2005) (the bill has passed in the House, and is currently in the Senate awaiting a vote).

137. H.R. 3736 MEMORANDUM, *supra* note 21.

138. Moreover, because laws cannot constitutionally take effect *ex post facto*, this legislation would only immunize hospitals and VHPs from liability for acts occurring after its passage. *Id.*

139. Hurricane Katrina Emergency Health Workforce Act of 2005, S.B. 1638, 109th Cong. 2005 (introduced before the U.S. Senate on September 8, 2005 and referred to the Committee on Health, Education, Labor and Pensions on the same date).

140. *See*, H.R. 3736 MEMORANDUM, *supra* note 21.

Overall, the legislative provisions existing and pending on the state and federal levels provide little liability protection for hospitals utilizing VHPs during emergencies. Despite the extensive immunity and indemnity provisions drafted with VHPs in mind, hospitals still suffer from a dearth of liability protections for their use of those volunteers. Hospitals and other health care organizations may potentially be exposed to civil liability during emergencies for their own acts and the acts of their employees, agents, and volunteers even when the VHP who committed the acts may be individually immune.¹⁴¹ Individual states' immunity and indemnity provisions may effect a slight reduction of hospital liability risk in certain situations, but none negate hospitals' risks completely. Hospitals must look to other measures to proactively reduce their risks in the use of VHPs.

III. PROACTIVE STRATEGIES FOR HOSPITALS TO MANAGE LIABILITY RISKS

Assessing hospital risks of liability for patient harms relating to the use of VHPs during emergencies is complex. Liability themes like corporate negligence, vicarious liability, and EMTALA violations have very real applications in non-emergency circumstances. As the legal landscape changes with the formal declaration of emergencies, will these themes pervade during disasters to the same extent that they do during non-emergencies? Will patients, who are potentially harmed by a VHP's delivery of health care services, find success through judicial or other remedies for negligent actions (or failures to act) of hospitals or their agents? Alternatively, will courts reject these claims because care was provided under exigent circumstances? Will federal or state legislatures bail hospitals out of rising liability costs via indemnification? Answers to these and other questions in the context of a large scale public health emergency are difficult to predict. Yet, existing legal themes, inadequate liability protections, and recent lessons from the Gulf Coast region suggest that hospitals must be wary of their potential for liability associated with the use of VHPs.

Hospitals may seek legislative or regulatory reforms to clarify their responsibilities or broker better protections (akin to what individual volunteers enjoy in most states). Such options always exist, but are rife with political and practical complications. At the core of these complications is the recognition that hospitals cannot dispense of their community obligations to provide quality health care services. Liability theories are grounded in the notion that injured individuals have some recourse for their damages through persons or entities that are at fault. To encourage physicians and other health care workers to volunteer during emergencies, government has created numerous protections from liability for

141. These issues are discussed at length in Part II, *infra*.

VHPs.¹⁴² Similar protections for hospitals may be less palatable within communities.

Unlike individual volunteers who can temporarily relocate to assist during an emergency, hospitals, such as those in New Orleans, may find themselves stuck at the center of a disaster, providing care to as many patients as possible. Other hospitals may be far removed from the scene of a disaster, yet absorbing new waves of patients from other facilities. The emergency itself, such as an epidemic avian flu outbreak, may evolve to impact hospitals in specific regions, effectively transferring patient burdens from region to region. In each scenario, hospital systems are relied on to provide care to thousands of existing and new patients. This need to provide care may be characterized as a *duty* of government-run hospitals or the *business* of private sector operations. In either sector, it is quintessentially an ethical obligation of hospitals. Stronger liability protections for hospitals may be viewed as diminishing this obligation to the detriment of individual patients. Conversely, failing to provide better liability protections may present some hospitals with the undesirable choice of having to cease operations during emergencies. VHPs may still be needed anyway to staff field hospitals or establishments taken over by government, but the ideal scenario is to welcome VHPs into an existing, organized, functioning health care environment. Most accredited hospitals, even during emergencies, offer a better environment for VHPs seeking to treat patients than hastily-organized clinics. Proposals for alternative actions for hospitals to take to reduce their liabilities will not be quickly resolved. In the interim, a better option for hospitals is to engage in several proactive strategies to effectively manage their risks. These include: (1) planning and training to meet surge capacity; (2) implementing strict credentialing procedures; and (3) divesting responsibility for VHPs, as explained below.

A. Planning and Training to Meet Surge Capacity

In emergencies and non-emergencies, one of the most effective strategies to limit liability in hospital settings is to prevent the conditions under which it may arise. Effective planning can be a preventative remedy for the ills of liability. As part of national bioterrorism preparedness efforts, public and private sector hospitals across the nation have developed emergency management plans to sustain essential operations during emergencies. HRSA has provided millions of dollars to facilitate hospital planning through its National Bioterrorism Hospital Preparedness Program.¹⁴³ Hospitals that engage in advance planning to meet surge capacity in response to emergencies should specifically recognize the need for VHPs by

142. See, Part II.C. *supra*.

143. HEALTH RES. & SERVS. AGENCY, NATIONAL BIOTERRORISM HOSPITAL PREPAREDNESS PROGRAM, available at <http://www.hrsa.gov/bioterrorism/> (last visited Apr. 5, 2006).

identifying the methods, resources, and ways that VHPs will be recruited, utilized, and supervised. Among the personnel resources for hospitals' use are a range of organized volunteer registries, like ESAR-VHP, as discussed in Part II.B. The primary objective is to plan in advance for the real-time use of VHPs to ensure the delivery of adequate care during emergencies. Hospitals should also be informed of their role in emergency responses through the Federal Response Plan and state and local emergency response plans. This type of planning and coordination may lessen potential liability threats by (1) organizing prospective VHPs to enhance patient treatment and (2) providing an essential reference for the standards of care that hospitals must adhere to during emergency responses.

Establishing policies and procedures through effective planning, however, is not enough. To further avoid risks of liability in the use of VHPs, hospitals must be prepared to implement these policies in accordance with the standards of practice in the field. This requires ongoing, meaningful training programs for all employees responsible for emergency management. Training must address the various elements of the hospital's plan, including the use and administration of volunteer registries, as well as the hospital staff's supervision of VHPs once they arrive. Training cannot ensure readiness for all disasters, but it helps establish roles, responsibilities, and leadership among hospital management, medical personnel, and staff. These qualities contribute to the type of environment in which VHPs may be effectively utilized.

B. Implementing Additional Credentialing Procedures

Volunteer registries like ESAR-VHP are designed to readily provide hospitals with access to available, pre-vetted VHPs for real-time responses to emergencies. This service is invaluable. Hospitals do not have adequate time to independently recruit, validate, and assign VHPs during emergencies. They simply need medical personnel fast. Yet, in their haste, hospitals must be cautious of the potential for inaccuracies in VHP registration data. Their failure to cross-check the credentials of assigned VHPs may expose them to liability. Regrettably, emergency situations present opportunities for impostors to attempt to impersonate qualified medical personnel and provide some level of treatment to patients. In addition to the criminal acts of a select few, hospitals may mistakenly assign VHPs to functions or duties that the volunteers are not professionally trained to handle. Resulting lapses in the provision of patient care would be inexcusable even during emergencies. Hospitals should thus be prepared to supplement volunteer registries' efforts to check the qualification of VHPs through additional, on-site credentialing and privileging procedures. These procedures must be able to expeditiously validate the qualifications of VHPs specifically assigned to treat patients directly within the hospital. Specific hospital staff should be pre-designated with responsibility for

verifying VHP credentials through ESAR-VHP or other resources during emergencies.

In setting policies and procedures regarding the use of volunteer registries and VHPs, hospitals must look to their current policies and federal, state, and local laws to determine the specifics of their exposure to liability. Policies should be designed to avoid specific liability sources. Standards from the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) for disaster privileging may serve as an important guide for appropriate credentialing procedures for VHPs.¹⁴⁴ Hospital personnel who are routinely responsible for granting staff privileges should review the policies and protocols for granting disaster privileges to ensure that they meet quality of care standards. This may include establishing minimum procedural requirements for any VHPs granted hospital privileges during emergencies.

C. Divesting Responsibility for VHPs

As noted in Part II.C, statutory and other legal mechanisms do not begin to exculpate hospitals from various types of liability related to the use of VHPs during emergencies. However, hospitals can divest some of their responsibility for the actions of VHPs through binding memoranda, informed consent documents, or other contracts. Memoranda of understanding between regional hospitals regarding the sharing of resources during emergencies are an effective contractual tool. Many hospitals enter into these agreements to authorize the sharing of medical staff, supplies, and equipment during emergencies when each of these resources may be limited in supply. Prioritization for the use of these resources typically lies with the hospital at risk. MOUs not only involve the exchange of essential resources, but also frequently address the allocation of liability regarding the use of resources. They may, for example, indicate that hospitals hosting VHPs will not assume liability for their negligence. Though such agreements may be challenged in court by aggrieved patients, their attempt to spell out the nature of a hospital's responsibility for the actions of VHPs in advance may help to reduce the potential for the hospital's corporate negligence or vicarious liability in the administration of volunteer programs. Conversely, these agreements may adversely affect the willingness of VHPs to serve at the hospital's request.

Additional contractual tools may be used to notify patients and VHPs of the nature of their own risks during emergencies, which can diminish their expectation of the hospital's potential liability. The *Center for Law and the Public's Health* has prepared a draft model "ESAR-VHP Volunteer Agreement"¹⁴⁵ that VHPs might

144. See, JCAHO OFFICIAL HANDBOOK, *supra* note 43.

145. THE CTR. FOR LAW & THE PUB. HEALTH, HRSA EMERGENCY SYSTEM FOR ADVANCE REGISTRATION OF VOLUNTEER HEALTH PROFESSIONALS (ESAR-VHP)—LEGAL AND REGULATORY ISSUES, ESAR-VHP VOLUNTEER AGREEMENT, *available at* <http://www.publichealthlaw.net/>

be asked to execute prior to their participation as a volunteer in a hospital or other setting. Among its provisions, VHPs assert that they will:

- Perform volunteer services and activities under the terms, conditions, and general direction of the sponsoring health care organization;
- Waive any claims for compensation from the sponsoring organization for any services performed related to volunteer services;
- Be subject to state regulations concerning Standards of Conduct and Conflicts of Interest;
- Be eligible for coverage under any identified applicable immunity statutes for any damages or injuries that may arise from their volunteer services;
- Maintain current health professional licensure, certification or registration; and
- Be responsible for any actions that are not directly related to the performance of volunteer services.

Collectively, these contractual promises between the hospital and VHPs set reasonable expectations as to the nature of the volunteer's own liability as well as his or her expected duties to help limit the hospital's liability (e.g., maintaining current licensure and assuming responsibility for his or her own actions).¹⁴⁶

Hospitals may also prepare for an emergency by drafting specific informed consent forms for incoming patients. In addition to standard informed consent documents that spell out the terms and risks of admission and treatment at the hospital, these forms could explain some of the additional risks of treatment during emergencies (to the extent these can be assessed). Emergency informed consent documents might, for example, include simple, plain language provisions addressing (1) altered standards of care during times of triage; (2) resulting diminutions in quality of care as compared with non-emergency scenarios; (3) differences in hospital treatment practices and procedures during emergencies; (4) agreements to seek arbitration to resolve any claims prior to filing actions in court; and, importantly, (5) the possibility that patients may be treated by VHPs that may not be licensed or credentialed in the state, or have regular privileges at the hospital. The effect of this latter clause in an emergency informed consent form is to seek the patient's agreement in advance of accepting treatment from VHPs.

Patient execution of specific informed consent forms that include these provisions may not fully insulate the hospital from all liability regarding the use of

Research/PDF/ESAR%20VHP%20Agreement.pdf (last accessed Nov. 18, 2005).

146. See, *supra* note 103 (discussing the finding in *Darling*, 211 N.E.2d 253, that the hospital's contract denying that a physician was to be considered an "employee," precluded liability for the physician's action on the basis of vicarious liability, although the hospital was ultimately found liable via the doctrine of corporate negligence).

VHPs. However, they serve, at the least, to notify patients that it may not be possible to provide standard treatment regimens during emergencies. In many cases, this may be immediately obvious to patients based on the nature of the emergency. Yet it may help to specifically inform patients of their own increased risks through more formal means. Of course, execution of specific informed consent forms for all presenting patients may not be possible during emergencies. By no means would the failure of a patient to execute this kind of agreement be acceptable grounds for denying emergency treatment. Ideally, the forms would allow most patients to assess and understand their risks and to decide whether to accept treatment under altered standards of care.

IV. CONCLUSION

Maintaining an adequate standard of care during emergencies is an enormous challenge for hospitals. The impact of Hurricanes Katrina, Rita, and Wilma on the Gulf Coast states demonstrated the potential for short- and long-term consequences for hospitals, especially in flood-ravaged New Orleans. Hospitals across the region experienced immediate increases in the numbers of patients coupled, in some locations, with the flight of some existing medical personnel seeking to avoid the disaster itself. As a result, many hospitals scrambled to fill gaps in essential medical personnel through the use of VHPs. Though risks to patients posed by the hospital's use of volunteers can be minimized, the specter of liability for hospitals still looms. Theories of corporate negligence and vicarious liability may apply to hospitals in times of emergency just as in non-emergencies. Statutory or other legal protections from liability claims against hospitals are not comprehensive. Hospitals may thus be uniquely exposed to potential claims of injured patients for damages if VHPs are negligent in the provision of care. Accordingly, hospitals should consider implementing policies and procedures designed to manage risks before and during emergencies. These proactive measures may not only reduce potential liability arising out of the use of VHPs during emergencies, but they can also improve patient care by facilitating the deployment of essential medical personnel when and where they are most needed.