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## The Legal Framework for Meeting Surge Capacity Through the Use of Volunteer Health Professionals During Public Health Emergencies and Other Disasters

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# THE LEGAL FRAMEWORK FOR MEETING SURGE CAPACITY THROUGH THE USE OF VOLUNTEER HEALTH PROFESSIONALS DURING PUBLIC HEALTH EMERGENCIES AND OTHER DISASTERS

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## I. INTRODUCTION

Recent terrorist bombings in London in July, 2005 and the disastrous aftermath of Hurricane Katrina in late August-September, 2005 demonstrated the need for advance emergency preparedness measures. Hundreds of people who sought care from London hospitals in the hours and days after the bombings relied on the city's medical infrastructure to provide timely medical services. London's health facilities appeared able to meet these demands.<sup>4</sup> Hospitals in the Gulf Coast region faced a very different set of issues in Katrina's aftermath. In addition to providing care to thousands of individuals injured during the hurricane, many were required to close their doors and evacuate patients after the storm because of structural damages, lack of electricity, and flood waters.<sup>5</sup> Those that were able to remain open were forced to function for days with limited medical resources, no electricity, and little food and water.<sup>6</sup> Throughout the response to Hurricane Katrina, volunteer health professionals (VHP) have been essential to meeting surge capacity in existing health care entities and newly-opened mobile and satellite medical units trying to care for thousands of people.<sup>7</sup>

These events underscore the importance of having public health and medical systems that are prepared to increase surge capacity in a variety of emergency scenarios. 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."<sup>8</sup> A core component to increasing surge

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4. *Blast Victims Remain in Hospital*, BBC NEWS, July 8, 2005, <http://news.bbc.co.uk/1/hi/health/4659641.stm>.

5. *Evacuations Resume at Flooded Hospital*, CNN, Sept. 2, 2005, <http://www.cnn.com/2005/HEALTH/09/02/katrina.hospitals/index.html>.

6. Susanna Schrobsdorff, *'A Horrible Dream': The inside story of how the staff of one New Orleans-area hospital heroically saved their patients and themselves*, NEWSWEEK, Sept. 7, 2005, <http://msnbc.msn.com/id/9179702/site/newsweek/>; *Luck, planning helps New Orleans clinic survive*, REUTERS, Sept. 6, 2005, <http://www.msnbc.msn.com/id/9227585/>; Susanna Schrobsdorff, *Working Through the Storm*, NEWSWEEK, Sept. 6, 2005, <http://www.msnbc.msn.com/id/9229349/site/newsweek/>; Matthew Herper, *One Hospital's Fight Against Katrina's Wrath*, MSNBC, Sept. 2, 2005, <http://www.msnbc.msn.com/id/9176916/>.

7. See, e.g., OFFICE OF THE SURGEON GENERAL, MEDICAL RESERVE CORPS, MRC VOLUNTEER ACTIVATION THROUGH THE AMERICAN RED CROSS, <http://www.medicalreservecorps.gov/page.cfm?pageID=343> (last visited Sept. 28, 2005); *Chaos Hinders Efforts to Treat Katrina Survivors*, ASSOCIATED PRESS, Sept 5, 2005, <http://www.msnbc.msn.com/id/9207678/>; *On an Old Baseball Field, Makeshift Medicine*, ASSOCIATED PRESS, Sept. 3, 2005 <http://www.msnbc.msn.com/id/9189282/>.

8. Asher Hirshberg, et al. *Does Casualty Load Affect Trauma Care in Urban Bombing Incidents? A Quantitative Analysis*, 58 J. TRAUMA 686, 691 (2005).

capacity is the availability of skilled health professionals to supplement the existing health workforce. During small-scale, localized emergencies, response planners and coordinators may be able to maintain a satisfactory level of surge capacity by adding paid temporary staff to bolster their workforce. Larger scale emergencies, however, demand participation of significant numbers of capable VHPs to provide health care and services to potentially thousands of victims. Mass casualty incidents, natural disasters, and other emergencies that threaten the health and safety of the population consistently feature the assistance and support of VHPs.<sup>9</sup> Federal, state, and local emergency preparedness plans broadly recognize the deployment and use of VHPs as essential to effective emergency responses.<sup>10</sup> Volunteer responders represent a range of health professions, such as physicians, nurses, pharmacists, public health workers, lab technicians, emergency medical technicians, and psychologists.<sup>11</sup>

Many volunteers are organized, trained, and directed to respond through public sector programs at the national, regional, state, and local levels, including over seventy Disaster Medical Assistance (DMAT) teams<sup>12</sup> and 306 Medical Reserve Corps (MRC) units<sup>13</sup> nationwide. Private sector organizations, such as the American Red Cross<sup>14</sup> and Orthopedic Trauma

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9. See BRIAN JACKSON, ET AL., PROTECTING EMERGENCY RESPONDERS: LESSONS LEARNED FROM TERRORIST ATTACKS 18 (2002), <http://www.rand.org/publications/CF/CF176/>; David C. Cone, et al., *Convergent Volunteerism*, 41 ANN. EMERG. MED. 457 (2003); M. Romano, *Medical Personnel espond: Physicians Across the Nation Eager to Volunteer*, MOD. HEALTH., Sept. 17, 2001, at 24; David E. Hogan, et al., *Emergency Department Impact of the Oklahoma City Terrorist Bombing*, 34 ANN. EMERG. MED. 160, 164 (1999).

10. DEP'T OF HEALTH AND HUMAN RES., HEALTH RESOURCES AND SERVICES ADMINISTRATION, EMERGENCY SYSTEM FOR ADVANCE REGISTRATION OF VOLUNTEER HEALTH PROFESSIONALS (ESAR-VHP) – LEGAL AND REGULATORY ISSUES 10 (2005), available at <http://www.hrsa.gov/bioterrorism/esarvhp/legalissues.htm>. [hereinafter LEGAL AND REGULATORY ISSUES REPORT].

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

12. NAT'L ASS'N OF DISASTER RESPONSE TEAMS, MISSION STATEMENT, <http://medicom.org/public/NADMAT/default.htm> (last visited Sept. 28, 2005).

13. Robert Tosatto, Commander, Medical Reserve Corps, Address before the Emergency System for Advance Registration of Volunteer Health Professionals Focus Group Meeting; Medical Reserve Corps and Volunteer Recruitment (Aug. 12, 2005).

14. See DEP'T OF HOMELAND SECURITY, NATIONAL RESPONSE PLAN 6, (2004) [http://www.dhs.gov/interweb/assetlibrary/NRP\\_FullText.pdf](http://www.dhs.gov/interweb/assetlibrary/NRP_FullText.pdf) [hereinafter NAT'L RESPONSE PLAN].

Association Mass Casualty Teams,<sup>15</sup> also coordinate, prepare, and provide health volunteers for emergency responses. Other volunteers, however, simply show up at hospitals, health care entities, or at the site of a disaster or emergency. Thousands of volunteers streamed into the Gulf Coast region to provide essential medical care.<sup>16</sup> Many of these volunteers had spontaneously responded to requests for assistance from the American Red Cross, the American Medical Association, and other volunteer organizations.<sup>17</sup> Others have volunteered their services in response to requests for assistance from the U.S. Department of Health and Human Services (DHHS),<sup>18</sup> MRC units,<sup>19</sup> and state emergency response teams.<sup>20</sup> Similarly, during the terrorist attacks in New York City on September 11, 2001, New York State received 75,000 responses from volunteers to its call for emergency assistance, at least 8,000 of which were from medical providers within the first few hours of the attack.<sup>21</sup> These spontaneous volunteers are willing to help, but lack organization, identification, credentials, and, ultimately, utility. Rather than assisting in emergency efforts, their presence may actually impede effective emergency responses.<sup>22</sup>

The experience of New York City hospitals during the September 11 tragedy revealed the complications that may result from a proliferation of spontaneous medical volunteers. Some hospital administrators in Lower Manhattan reported that they were unable to use health professionals because they could not verify their medical or other credentials. Administrators were unable to confirm the identities of volunteer physicians or their basic licensing or credentialing information, including training, skills, competencies, and employment. Disruptions to standard

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15. See generally, Christopher T. Born & William G. DeLong, *Organizing the Orthopaedic Trauma Association Casualty Response Team*. CLIN. ORTHOP. RELAT. RES., May 2004, at 114.

16. See *Chaos Hinders Efforts to Treat Katrina Survivors*, *supra* note 7.

17. See *id.*; Associated Press, *Citizen Volunteers Training for Response Teams*, MSNBC, Sept. 3, 2005, <http://www.msnbc.msn.com/id/9185163/>.

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

19. OFFICE OF THE SURGEON GENERAL, MEDICAL RESERVE CORPS, *supra* note 7.

20. Press Release, Emergency Mgmt. Assistance Compact, Deploying Help Across Disciplines (Sept. 12, 2005), <http://www.astho.org/pubs/EMACHurricaneKatrinaReleaseSept9-05.pdf>.

21. See Judith Faust, Address before the Emergency System for Advance Registration of Volunteer Health Professionals Focus Group Meeting: Volunteer Surge during 9/11 in New York, (Aug. 11, 2005); Romano, *supra* note 9, at 24.

22. See *Chaos Hinders Efforts to Treat Katrina Survivors*, *supra* note 7; Cone, *supra* note 9, at 459.

telecommunications prevented hospitals from contacting other sources that could have provided verification.<sup>23</sup> These complications led Congress to authorize DHHS to fund, and assist states and territories to develop, emergency systems for the advance registration of volunteer health professionals (ESAR-VHP).<sup>24</sup> Through advance registration at the state level, VHPs can be vetted, counseled, trained, and mobilized when needed for the benefit of individual and community health. Led by the Health Resources and Services Administration (HRSA), a division of DHHS, states and territories are beginning to assess and register thousands of skilled medical professionals willing to volunteer their services during interstate and intrastate emergencies.

However, the use of VHPs during emergencies raises significant legal questions that impact volunteers, the public and private entities that host them, and by implication, the entire emergency response system. What constitutes an “emergency” sufficient to authorize the initiation of volunteer efforts? How is such an emergency declared? What are the legal and practical ramifications of such declarations? Under what circumstances could volunteers or their hosts face civil liability for their actions in response to public health emergencies? What legal protections are in place to insulate volunteers, their hosts, or emergency response coordinators from liability? When may hospitals or other providers use out-of-state volunteers who are not licensed or credentialed in the host state? Will volunteers be compensated for the injuries or other harms they incur while responding to emergencies? Do privacy laws limit the collection of volunteers’ identifiable information in information systems or allow volunteers to access confidential patient information during an emergency? Are public and private entities hosting volunteers required to comply with legal requirements to provide emergency care? Answers to these and other legal questions define the legal environment that governs the use and roles of

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23. Marna L. Hoard & Robert J. Tosatto, *Medical Reserve Corps: Strengthening Public Health and Improving Preparedness*, 3 DISASTER MGMT. & RESPONSE 48, 49 (2005).

24. Public Health Security and Bioterrorism Preparedness and Response Act of 2002, Pub. L. No. 107-188, 116 Stat. 595 (codified as amended at 42 U.S.C. § 247d-7b). This act was one of many pieces of legislation at the federal and state level enacted in the aftermath of the September 11, 2001 attacks. These legislative efforts responded to, among other things, concerns in the public health community regarding the adequacy of the legal authorization for many of the public health powers needed to prepare for and counteract public health emergencies. See, e.g., Lawrence O. Gostin et al., *The Model State Emergency Health Powers Act: Planning for and Response to Bioterrorism and Naturally Occurring Infectious Diseases*, 288 J. AM. MED. ASS’N 622 (2002); Lawrence O. Gostin, *Public Health Law in an Age of Terrorism: Rethinking Individual Rights and Common Goods*, 21 HEALTH AFF. 79 (2002).

VHPs in emergencies and demonstrate how the law is an essential tool to facilitate volunteer participation in emergency response efforts.

Part II begins to address these questions by describing how VHPs may be utilized to meet surge capacity during emergencies. When existing staffing resources are being used at full capacity, hospitals and other institutional health care providers need additional health professionals from outside their normal staffing rosters. Public health departments may similarly need supplementary volunteer support. Under the current emergency response framework, VHPs may be deployed for emergency response purposes at the federal, state, and local levels. The ongoing efforts to build ESAR-VHP programs at the state and territorial levels throughout the United States will significantly improve the recruitment of VHPs as well as the coordination and organizational efforts necessary for their successful deployment during emergencies.

Part III frames the legal environment for VHPs through an examination of six core legal issues: emergency declarations, liability, license portability, compensable injuries and reemployment, privacy, and the duty to provide care. Emergency declarations alter the legal landscape, providing for additional legal powers and protections during public health emergencies or other disasters. Laws governing the declaration of an emergency may simultaneously authorize the use of volunteers, regulate the administration of volunteer registries, circumscribe the permissible roles that VHPs may fill in response efforts, and provide legal protections to volunteers. The current legal framework for emergency declarations at the federal and state levels is discussed in Part III.A, including the declaration procedures of the Model State Emergency Health Powers Act (MSEHPA), which many states have used to establish definitional and declaratory criteria applicable to public health emergencies.

Patients and others will inevitably be harmed during emergency responses. Potential civil liability for these harms raises significant concerns among volunteers and entities that provide or utilize them. Prospective VHPs are often anxious about liability because of the potential that their actions during emergencies will not be covered by their medical malpractice insurance or other resources. Host entities and entities administering volunteer registries may be exposed to liability for harms resulting from their own negligent actions or the actions of their volunteers. Despite multiple risks of liability, volunteers and host entities may be protected under a variety of statutory and regulatory provisions that provide immunity or indemnification. The legal theories of liability and protections from liability are discussed fully in Part III.B.

State professional regulation requirements such as licensing, credentialing, and privileging, and related concerns over the portability of professional practice, affect the ability of states to mount multi-jurisdictional responses to emergencies. Many states that have implemented exceptions to



professional regulation requirements during emergencies or otherwise have altered or expedited these processes to enhance the capacity for rapid response.<sup>25</sup> In states without such exceptions, the normal professional regulation requirements may impede the recruitment of VHPs and consequently limit the ability of hospitals and public health agencies to meet necessary surge capacity levels during an emergency. Furthermore, uncertainty about these requirements contributes to reluctance among hospital administrators to utilize out-of-state VHPs, even if the VHPs have verifiable credentials. Part III.C defines the concepts of licensure, credentialing, and privileging, examines their applicability during emergencies, and discusses their implications for the participation of VHPs in emergencies and the administration of registry systems like ESAR-VHP.

Many VHPs express a fundamental concern that they may not have sufficient legal protection from harm and guaranteed compensation for injuries or deaths they incur during an emergency response. Federal, state, and private workers' compensation programs cover any injuries or deaths of employees at the workplace. However, workers' compensation laws do not automatically protect VHPs because unpaid volunteers are not typically defined as employees of their host entities. Though some states explicitly apply workers' compensation protections to volunteers assisting in emergency response efforts, some VHPs may be left without direct recourse for sustained injuries or harms during emergencies. Part III.D addresses these issues in detail.

Privacy laws and regulations impact the response efforts of the health workforce and the administration of volunteer registries, as noted in Part III.E. These laws may define how identifiable information about volunteers, which is an inherent component of a registry, will be protected within the administrative structure of a volunteer registry. These laws may also impact access to patients' identifiable health information by VHPs and dictate how this information may be used or shared in an emergency setting. Part III.F discusses the role of the Emergency Medical Treatment and Active Labor Act (EMTALA).<sup>26</sup> EMTALA requires that hospitals screen and stabilize all patients who arrive at a hospital seeking emergency medical treatment, provided that the hospital has the available resources to do so.<sup>27</sup> With the availability of VHPs through ESAR-VHP, EMTALA may impose a significant burden on hospitals to recruit volunteers to increase surge capacity to treat all patients that present themselves for care in an emergency.

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25. From a practical perspective, the ESAR-VHP program is explicitly designed to establish a mechanism for rapid assessment, evaluation, and verification of VHP during an emergency. *See* LEGAL AND REGULATORY ISSUES REPORT, *supra* note 10, at 36.

26. 42 U.S.C. § 1395dd (West 2005).

27. *Id.*

This assessment of the legal framework for the organization, deployment, and use of VHPs during emergencies suggests a patchwork of legal protections that could be improved through the adoption of several substantive recommendations. The recommendations, offered in Part IV, encourage the proactive development and implementation of laws and policies to enhance the participation and utilization of VHPs during emergencies. First, states should incorporate advance registration systems and protections for volunteers into laws that authorize emergency preparedness and response efforts. These laws should explicitly define the powers of state government during emergencies and clarify the legal provisions applicable to VHPs and the entities or organizations that may rely on them. Second, a floor of legal protections for volunteers is essential to achieve a minimum level of uniformity among the states and facilitate multi-jurisdictional cooperation in emergency response. Third, the scope and breadth of state-based volunteer registries must be expanded to ensure comprehensive and coordinated emergency response efforts among states. Fourth, laws must ensure balanced civil liability protections for VHPs and their host entities by creating responsible immunity protections and alternative mechanisms to compensate injured patients. Fifth, states are encouraged to enact laws and regulations providing for license portability during emergencies. Sixth, VHPs should be vested with workers' compensation protections for injuries, disabilities, or deaths experienced while carrying out their duties. Finally, state and federal laws should confer robust privacy protections on volunteer registries, implement fair information practices to allow VHPs and patients to access and verify registry data, and simultaneously ensure responsible access to and use of registry information to mount an effective response.

## II. VOLUNTEER HEALTH PROFESSIONALS IN PUBLIC HEALTH EMERGENCIES AND OTHER DISASTERS

In the aftermath of a significant public health emergency or other disaster, a surge of patients may require medical assistance and consequently overwhelm the capacity of local medical facilities and public health services.<sup>28</sup> An essential element of large-scale emergency preparedness is the ability to increase the number of qualified personnel available to meet surge capacity.<sup>29</sup> VHPs may be used in several different capacities during a public health emergency or mass casualty incident, depending on the nature

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28. DEP'T OF HOMELAND SECURITY, FEDERAL RESPONSE PLAN: EMERGENCY SUPPORT FUNCTION #8: HEALTH AND MEDICAL SERVICES ANNEX ESF 8-4 (2003), available at <http://www.au.af.mil/au/awcgate/frp/frpesf8.htm> [hereinafter "ESF #8"].

29. Hirshberg et al., *supra* note 8, at 691.

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 traumatic injuries as well as those related to dehydration, malnutrition, and 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. VHPs may also be needed by hospitals and local emergency medical systems to triage patients, coordinate medical responses, or provide administrative assistance.

Volunteer assistance may be integral to augment public health efforts as well. For example, in the case of a bioterrorist incident or infectious disease outbreak, qualified medical professionals will be needed to vaccinate individuals, screen patients for symptoms, conduct laboratory testing, deliver pharmaceuticals and other medications, or implement quarantine and isolation procedures to prevent further spread of the disease. During emergencies caused by other conditions, such as a toxic chemical spill, VHPs could bolster the public health response by administering prophylactic therapy, educating the public about symptoms of exposure, or decontaminating persons exposed to chemical, biological, or radiological agents. Thus, the nature of the incident and the corresponding need for certain types of medical services and public health support could determine the roles for VHPs.<sup>30</sup>

#### *A. Traditional Modes of Volunteer Deployment in Public and Private Sectors.*

There are three primary sources of volunteer response during public health emergencies: government deployments, private sector responses, and spontaneous volunteers.

##### *1. Government Deployment of VHPs*

Government deployments of volunteers typically involve activating teams of volunteers, like Disaster Medical Assistance Teams (DMAT),<sup>31</sup> Medical

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30. See generally Neil Osterweil, *All Physicians Urged to Specialize in Disaster Preparedness*, MEDPAGE TODAY, July 7, 2005, <http://medpagetoday.com/PublicHealth/Policy/PublicHealth/tb/1328>.

31. 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

Reserve Corps (MRC) units,<sup>32</sup> or search and rescue teams, who are pre-registered with a government entity and designated as emergency responders. These teams are sent to the disaster site or other affected locations to provide medical care or other needed assistance. Government deployment of volunteers can occur at the federal, regional, state, and local levels.

The National Response Plan (NRP) governs federal deployment during an emergency declared by the President.<sup>33</sup> Within the NRP, Emergency Support Function #8 (ESF-8) outlines the role of the federal government in the deployment of health and medical responders.<sup>34</sup> The President's declaration of an emergency activates the NRP. The Department of Health and Human Services (DHHS) then coordinates the health and medical components of the emergency response based on the need for assistance identified at the state or local levels.<sup>35</sup> The National Disaster Medical System (NDMS) comprises a key component of the national response.<sup>36</sup> NDMS coordinates 7,000-8,000 VHPs, organized into several different response groups,<sup>37</sup> including DMAT,<sup>38</sup> Burn Teams, Pediatric Teams, Crush Medicine Teams, and Mental Health Teams.<sup>39</sup> Although part of a national system, such teams are "locally organized and sponsored."<sup>40</sup> They are available for deployment by the federal government, state governments, or at the request of a locality.<sup>41</sup> Volunteers organized through NDMS "are [typically] considered intermittent disaster response personnel" under federal law, entitling them to

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evacuated to health care facilities. See Robert F. Knouss, *National Disaster Medical System*, 116 PUB. HEALTH REP. 49, 50 (2001).

32. 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 Hoard & Tosatto, *supra* note 23, at 49. MRC units function as a specialized component of Citizen Corps, a national network of volunteers dedicated to making sure their families, homes, and communities are safe from terrorism, crime, and disasters. *Id.*

33. The NRP was developed by the Department of Homeland Security to establish "an all-hazards plan that provides the structure and mechanisms for national level policy and operational coordination for domestic incident management." NAT'L RESPONSE PLAN, *supra* note 14, at 1.

34. See generally ESF #8, *supra* note 28.

35. *Id.* at 8-2.

36. NDMS is a "nationwide medical mutual-aid network between Federal and non-Federal sectors that includes medical response, patient evacuation, and definitive medical care." *Id.*

37. See Knouss, *supra* note 31, at 50.

38. DMATs are a key component of NDMS. *Id.*

39. See *id.* at 50.

40. *Id.*

41. *Id.*

a broad spectrum of legal protections, including liability protection and workers' compensation coverage.<sup>42</sup>

Individual federal agencies may also deploy health care volunteers as part of an emergency response.<sup>43</sup> For example, during the response to Hurricane Katrina, DHHS requested additional medical volunteers, and over thirty-three thousand persons responded to this request.<sup>44</sup> Medical personnel may be deployed by MRC units to assist in the establishment of mobile health care facilities and to provide care in existing facilities.<sup>45</sup> These volunteers are classified as temporary volunteers with the Public Health Service (PHS).<sup>46</sup> Although the PHS is entitled to employ volunteers to assist in emergency response efforts, legal protections available for those volunteers may be limited and subject to the orders of DHHS' Secretary.<sup>47</sup>

State emergency preparedness laws and response plans also authorize emergency response activities. A state emergency preparedness plan may include the recruitment of volunteers by public or private entities to become members of state emergency response teams and the subsequent mobilization and deployment of these teams.<sup>48</sup> DMATs and MRC units can

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42. See JAMES G. HODGE & LANCE A. GABLE, HURRICANE KATRINA RESPONSE: LEGAL PROTECTIONS FOR INTERMITTENT DISASTER RESPONSE PERSONNEL UNDER A FEDERAL DECLARATION OF PUBLIC HEALTH EMERGENCY 2 (2005), available at <http://www.publichealthlaw.net/Research/PDF/Katrina%20%20Federal%20PH%20Dec%20and%20IDRP.pdf>; see also 42 U.S.C. §§ 300hh-11(d), (e) (West 2003).

43. JAMES G. HODGE & LANCE A. GABLE, HURRICANE KATRINA RESPONSE: LEGAL PROTECTIONS FOR TEMPORARY VOLUNTEERS UNDER A FEDERAL DECLARATION OF PUBLIC HEALTH EMERGENCY 1 (2005), available at <http://www.publichealthlaw.net/Research/PDF/Katrina%20%20Federal%20Temp%20Volunt.pdf>.

44. See HEALTH CARE PROFESSIONALS AND RELIEF PERSONNEL WORKER PAGE, *supra* note 18, at 1.

45. For example, MRC units were deployed by the federal government as part of the medical response to 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 care following the hurricane. See OFFICE OF THE SURGEON GENERAL, MEDICAL RESERVE CORPS, MRC RESPONSE TO HURRICANES KATRINA AND RITA – INTERIM REPORT, Oct. 11, 2005, <http://www.medicalreservecorps.gov/page.cfm?pageID=1047>.

46. See 42 U.S.C. § 217b (West 2003); HODGE & GABLE, LEGAL PROTECTIONS FOR TEMPORARY VOLUNTEERS, *supra* note 43, at 1.

47. See HODGE & GABLE, LEGAL PROTECTIONS FOR TEMPORARY VOLUNTEERS, *supra* note 43, at 1.

48. See e.g., CALIFORNIA EMERGENCY MEDICAL SERVICES AUTHORITY, GENERALIZED DESCRIPTION OF STATE MEDICAL AND HEALTH DISASTER RESPONSE SYSTEM, <http://www.emsa.ca.gov/dms2/dmsrspns.asp> (2003).

also be deployed as a part of the state's emergency response efforts.<sup>49</sup> In some cases, these teams will be deployed to other states pursuant to memoranda of understanding between states or interstate compacts governing emergency response efforts.<sup>50</sup> 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.<sup>51</sup> The decentralized, flexible organization of MRC units and their local roots allows for great variation in their roles within government emergency response plans. Some states incorporate MRC units directly into their emergency response plans, while others utilize them in a less formal capacity.<sup>52</sup>

Local health departments also may have a crucial role in recruiting, mobilizing, and deploying volunteers because they are proximately nearer to the emergency and often maintain a cadre of first responders.<sup>53</sup> Local emergency response resources may include volunteer fire department and EMS teams that can provide some types of emergency medical care as well as personnel from local MRC units.<sup>54</sup>

## *2. Private Sector Deployment of VHPs*

Private sector entities likewise play an important role in deploying volunteers during public health emergencies and other disasters. Large,

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49. See e.g., TEXAS DEPARTMENT OF PUBLIC SAFETY, GOVERNOR'S DIVISION OF EMERGENCY MANAGEMENT, TEXAS HOMELAND SECURITY STRATEGIC PLAN, PART III, STATE OF TEXAS EMERGENCY MANAGEMENT PLAN, ANNEX H: HEALTH AND MEDICAL SERVICES H-1 – H-2, [ftp://ftp.txdps.state.tx.us/dem/plan\\_state/state\\_annex\\_h.pdf](ftp://ftp.txdps.state.tx.us/dem/plan_state/state_annex_h.pdf) (2005). See generally, Office of the Surgeon General, Medical Reserve Corps, Getting Started: A Guide for Local Leaders 4, <http://www.medicalreservecorps.gov/pdf/MRCTASeries00.pdf> [hereinafter GETTING STARTED].

50. See generally INTERNATIONAL EMERGENCY MANAGEMENT ASSISTANCE MEMORANDUM OF UNDERSTANDING (July 18, 2000), available at [http://www.scics.gc.ca/cinfo00/85007918\\_e.html](http://www.scics.gc.ca/cinfo00/85007918_e.html) [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).

51. See Hoard & Tosatto, *supra* note 23, at 49-50.

52. April Kidd, *Medical Reserve Corps Volunteers Strengthen Local Public Health and Response Efforts*, 11 AM. PUB. HEALTH ASS'N, INJURY CONTROL & EMERGENCY HEALTH SERV. SEC. n. 5 (2004), available at <http://www.icehs.org/enews/e-news0504.pdf>.

53. See NAT'L RESPONSE PLAN, *supra* note 14, at 8.

54. See GETTING STARTED, *supra* note 49, 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 J. PUBLIC HEALTH MGMT. & PRACTICE 291, 292 no. 4 (2005).

national volunteer organizations and consortia, such as the American Red Cross<sup>55</sup> and the National Voluntary Organizations Active in Disaster (NVOAD),<sup>56</sup> contribute manpower and expertise to emergency response efforts. Many smaller volunteer organizations, such as Catholic Charities USA and the Salvation Army, also provide significant support.<sup>57</sup> Additionally, medical associations have organized their own disaster response teams. 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.<sup>58</sup> Individual medical institutions may also assemble disaster response teams to provide assistance to state governments as a part of emergency response efforts.<sup>59</sup> Government emergency management plans often incorporate the resources of these private organizations.<sup>60</sup>

Private sector health facilities are often responsible for providing medical care to victims. While patients may receive initial triage and treatment at the site of a disaster, many will later be moved to private medical facilities for additional care.<sup>61</sup> 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

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55. Under the NRP, the American Red Cross is responsible for “coordinating... mass care resources.” See NAT’L RESPONSE PLAN, *supra* note 14, at 3.

56. *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](http://www.nvoad.org/articles/Annual_rep02.pdf).

57. See CATHOLIC CHARITIES USA, DISASTER RESPONSE, <http://www.catholiccharitiesusa.org/response/index.cfm?cfid=4603538&cfToken=69474944>; THE SALVATION ARMY, OUR ROLE IN DISASTER SERVICES, [http://www.salvationarmyusa.org/usn/www\\_usn.nsf/vw-dynamic-arrays/8214F21A914E09CE80256FE80071ECF1?openDocument](http://www.salvationarmyusa.org/usn/www_usn.nsf/vw-dynamic-arrays/8214F21A914E09CE80256FE80071ECF1?openDocument).

58. See Born & DeLong, *supra* note 15, at 115.

59. One such 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 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).

60. NAT’L RESPONSE PLAN, *supra* note 14, at 11.

61. See ESF #8, *supra* note 28, at 8-9, 8-10, and 8-14.

reciprocal privileges to facilitate a coordinated medical response to a disaster.<sup>62</sup>

### 3. *Spontaneous volunteers*

During emergencies, a number of spontaneous volunteers will inevitably arrive at the emergency site and at nearby health treatment facilities to offer assistance without any prompting from incident command systems. The appearance of spontaneous volunteers without an established system to organize them and provide for their advance credentialing may contribute to the confusion associated with the triage of large numbers of patients, all of whom need medical care. Although volunteers may possess useful skills and qualifications to assist in response efforts, the inability to confirm their professional qualifications, such as licensure or credentials, may diminish their utility to emergency response coordinators. Some state emergency preparedness plans call for the participation of the American Red Cross or local organizations to coordinate spontaneous volunteers in order to increase their utility.<sup>63</sup> This may involve setting up volunteer reception areas at the disaster site to receive medical and civilian volunteers, determine their credentials, and assign them to places where their skills are needed. Although useful, delays inherent in these systems may limit the effectiveness of spontaneous volunteers, especially when VHPs are needed immediately to treat patients.

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62. 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 69 percent of urban hospitals have agreements with other hospitals to share resources in the event of bioterrorism. U.S. GOV'T ACCT. OFF., 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. HOSPITAL ASS'N, MUTUAL AID MEMORANDUM OF UNDERSTANDING 6-10 (Sept 27, 2001), available at <http://www.dcha.org/EP/dchamou.pdf>.

63. See ESF #8, *supra* note 28, at 8-19. When implemented, the ESAR-VHP system will provide emergency response coordinators with a mechanism to assess the qualifications of VHPs in the system.



The proliferation of thousands of spontaneous volunteers after Hurricane Katrina provides a prime example of the need for advance registration systems to coordinate spontaneous volunteers and provide advance credentialing. Following the hurricane, health care 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.<sup>64</sup> The inability to perform appropriate credentialing meant that many of these volunteers were put to work based only on personal representations of their licensure and capabilities to provide care. Emergency response coordinators were forced to develop ad hoc systems to immediately register and screen potential medical volunteers.<sup>65</sup> This led to delays in the ability of government entities to organize and deploy essential VHPs to participate in the medical component of the response efforts.

### *B. Limitations of Existing Deployments of VHPs*

Though varied, the existing modes of deployment of VHPs in emergencies are limited in three predominant ways: (1) recruitment of qualified VHPs; (2) effective utilization of VHPs during emergencies; and (3) verification of the identity and qualifications of VHPs by those seeking their assistance. Recruitment of properly licensed and credentialed VHPs presents significant challenges for public and private health entities.<sup>66</sup> The potential to sustain uncompensated injuries or personal liability can greatly deter VHP participation. Often circumstances will necessitate the assistance VHPs from across state lines, resulting in a need for cross-border recognition of medical licenses and practitioner certification. Although license reciprocity provisions exist under the current emergency response system through state mutual aid agreements<sup>67</sup> and state laws,<sup>68</sup> there are no uniform legal mechanisms that apply to all VHPs in emergencies. Consequently, emergency planners may have difficulty recruiting VHPs

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64. See *Chaos Hinders Efforts to Treat Katrina Survivors*, *supra* note 7.

65. *Id.*; HEALTH CARE PROFESSIONALS AND RELIEF PERSONNEL WORKER PAGE, *supra* note 18.

66. See Hodge, et al., *supra* note 11, at 218.

67. See, e.g. IEMAC, *supra* note 50; EMAC, *supra* note 50. See also Fox, *supra* note 50, at 77.

68. 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).

from other states to mount a comprehensive and coordinated medical response.

Entities seeking the assistance of VHPs are challenged by their need to coordinate effective responses during the exigencies of an emergency situation. As a result, 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 medical liability. The problem is compounded by the lack of a common system to coordinate volunteer response at the state and local levels. A coordinated system may help prevent duplication of efforts, waste of resources, and delays in emergency responses. Even where volunteer databases have been implemented, their utility in a multi-jurisdictional emergency may be limited by a lack of interoperability with similar systems in adjacent jurisdictions.

Finally, entities seeking the assistance of VHPs during an emergency must confirm the qualifications of VHPs, including licensure, credentialing, and accreditation, in an expedited manner. Legal and accreditation requirements demand that volunteers meet certain quality standards even during emergencies. Unfortunately, there may be little time to fully and accurately check the licensure and credentialing of VHPs during emergencies. Entities that fail to verify the identity and qualifications of VHPs may face civil liability.

### *C. ESAR-VHP: Addressing the Limitations*

In partial response to these and other limitations (among other objectives), Congress addressed the effective use of volunteer health personnel during public health emergencies by enacting the Public Health Security and Bioterrorism Preparedness and Response Act of 2002.<sup>69</sup> Section 107 of the Act directs DHHS' Secretary to "establish and maintain a system for the advance registration of health professionals, for the purpose of verifying the credentials, licenses, accreditations, and hospital privileges of such professionals when, during public health emergencies, the professionals volunteer to provide health services."<sup>70</sup> Pursuant to this mandate, HRSA created the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) Program.<sup>71</sup> The intent of the ESAR-VHP Program is to fund and encourage states and territories to develop and implement volunteer registry systems containing readily available, verifiable, and up-to-date information regarding the volunteer's

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69. Public Health Security Bioterrorism Preparedness and Response Act of 2002, Pub. L. No. 107-188, 116 Stat. 594 (codified as amended 42 U.S.C. § 201 (2002)).

70. *Id.* at § 107.

71. LEGAL AND REGULATORY ISSUES REPORT, *supra* note 10, at 14.

identification and qualifications.<sup>72</sup> ESAR-VHP databases include licensing, credentialing, accreditation, and hospital privileging information that can be utilized by medical facilities or other entities that might need VHPs during an emergency.<sup>73</sup> Ideally, these standardized systems allow states and territories to quickly identify and better utilize volunteer health professionals in emergencies and disasters. Ultimately, they may enable the development of an interoperable system that will allow aggregation of state registration systems for use at the regional or national level.<sup>74</sup>

### III. ASSESSING THE MODERN LEGAL FRAMEWORK FOR VHPs

Deployment of VHPs during emergencies is essential to meet surge capacity and to protect individual and communal health. Given limitations in existing volunteer structures and modes of deployment, new systems like ESAR-VHP are needed to better organize, vet, and prepare VHPs for emergency call-up and service. Yet their organization and participation during an emergency presupposes a favorable legal environment. Legal challenges confront many jurisdictions seeking to maximize the deployment and use of volunteers during intra- and inter-state emergencies. VHPs and the entities that host them face different legal issues than their “non-volunteer” (or even non-medical) counterparts. VHPs serve in a limited capacity, for a limited period of time, and in positions that may not be entirely familiar to them. They may lack formal, employment-based relationships with the entities they assist. Still, they are called and relied upon to provide high levels of medical and public health care to patients and populations. Inevitable legal tensions and trade-offs arise. The following sections frame the legal and regulatory environment for VHPs in six key areas: emergency declarations, liability, license portability, compensable injuries and reemployment, privacy, and the duty to provide care.

#### *A. Emergency Powers and Protections*

An essential element of a strong emergency response infrastructure is a comprehensive set of laws and regulations to govern, authorize, and coordinate the implementation of the response measures. Emergency declaration provisions reshape the legal landscape and can have a severe impact on the use of VHPs. An emergency declaration may authorize enhanced legal powers for government officials and substantial legal protections for VHPs that would not exist otherwise.

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72. *Id.*

73. *Id.*

74. *See id.* at 10.

The current legal framework for emergency powers and declarations, which exists predominantly at the state level, presents differing standards for the declaration of an emergency and vests various powers in state or local governments. Some states have chosen to adopt provisions of the Model State Emergency Health Powers Act (MSEHPA), which provides a comprehensive set of government powers that arise from the declaration of a public health emergency.<sup>75</sup> MSEHPA provisions present high-threshold criteria for what constitutes a public health emergency and focus resulting legal powers and protections on affecting a public health response. Other states predicate their emergency powers on the declaration of a general emergency or disaster, which may include any event that threatens the public's health or safety.<sup>76</sup> Some states allow for the dual declaration of public health emergencies and general emergencies.<sup>77</sup> These states face the potential for legislative confusion and duplication of efforts, which may detract from the implementation of efficient emergency management functions. The federal government also has emergency declaration powers, which may operate independently or in conjunction with state and local emergency response efforts.<sup>78</sup>

### *1. Public Health Emergencies*

Before the adoption of MSEHPA's model provisions by states, "most states did not statutorily define 'public health emergency,' nor provide for specific declarations of a state of public health emergency."<sup>79</sup> No clear legislative mechanism existed regarding emergency planning and response actions taken specifically in the interest of the public's health. Rather, states typically employed a declaration of general emergency or disaster to "grant additional powers and duties to the governor and to emergency management

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75. See THE CENTER FOR LAW AND THE PUBLIC'S HEALTH AT GEORGETOWN AND JOHNS HOPKINS UNIVERSITIES, THE MODEL STATE EMERGENCY HEALTH POWERS ACT: A DRAFT FOR DISCUSSION (2001), available at <http://www.publichealthlaw.net/MSEHPA/MSEHPA2.pdf>. [hereinafter "MSEHPA"]. For example, the District of Columbia, Illinois, Minnesota, Wisconsin, Florida, Georgia, and Oklahoma, which have all adopted definitions of public health emergency that resemble MSEHPA. See LEGAL AND REGULATORY ISSUES REPORT, *supra* note 10, at 21, tbl. 2; Fla. Stat. Ann. § 381.00315 (West 2002); Ga. Code. Ann. § 38-3-3 (2005); Okla. Stat. Ann. tit. 63 § 6104 (West 2004) (defining "catastrophic health emergency").

76. LEGAL AND REGULATORY ISSUES REPORT, *supra* note 10, at 24.

77. *Id.* at 26.

78. See 42 U.S.C. §§ 5121 - 5206, 247d (2005).

79. LEGAL AND REGULATORY ISSUES REPORT, *supra* note 10, at 18.

or public safety authorities,” which coordinate efforts among many governmental agencies, including public health authorities.<sup>80</sup>

MSEHPA presents state and local governments with a template for reviewing existing emergency declaration laws and assists states in developing legislative or other regulatory reforms necessary to facilitate an effective public health response.<sup>81</sup> Many state legislatures have introduced or adopted some or all of MSEHPA’s provisions to enhance existing emergency response laws.<sup>82</sup> MSEHPA authorizes a host of public health functions related to public health emergencies, including preparedness, surveillance, management of property, protection of persons, and communication.<sup>83</sup> MSEHPA defines a “public health emergency” as:

an occurrence or imminent threat of an illness or health condition that:

(1) is believed to be caused by any of the following: (i) bioterrorism; (ii) the appearance of a novel or previously controlled or eradicated infectious agent or biological toxin; (iii) [a natural disaster]; (iv) [a chemical attack or accidental release]; or (v) [a nuclear attack or accident];; and (2) poses a high probability of any of the following harms: (i) a large number of deaths in the affected population; (ii) a large number of serious or long-term disabilities in the affected population; or (iii)

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80. See *infra* section III.A.2.

81. The Model law presents a modern synthesis of public health laws for controlling a host of conditions during emergencies that balances public health needs with the rights and dignity of individuals. This framework allows the statutory incorporation of specific public health powers and duties that may not be applicable to general emergencies or disasters, and requires input from public health authorities regarding the nature of the emergency and an appropriate response. In the Fall of 2001, the Center for Law and the Public’s Health drafted a model law, the MSEHPA, in collaboration with the Centers for Disease Control and Prevention and multiple national partners, including the National Governors Association, National Conference of State Legislatures, Association of State and Territorial Health Officials, National Association of County and City Health Officers, and the National Association of Attorneys General. See generally Lawrence O. Gostin, et al., *The Model State Emergency Health Powers Act: Planning for and Response to Bioterrorism and Naturally Occurring Infectious Diseases*, *supra* note 24.

82. See CENTER FOR LAW AND THE PUBLIC’S HEALTH AT GEORGETOWN AND JOHNS HOPKINS UNIVERSITIES, MODEL STATE EMERGENCY HEALTH POWERS ACT: LEGISLATIVE SURVEILLANCE TABLE I (2004), available at <http://www.publichealthlaw.net/MSEHPA/MSEHPA%20Surveillance.pdf> (last visited June 20, 2005) [hereinafter Legislative Surveillance Table].

83. See generally Lawrence O. Gostin, et al., *The Model State Emergency Health Powers Act: Planning for and Response to Bioterrorism and Naturally Occurring Infectious Diseases*, *supra* note 24.

widespread exposure to an infectious or toxic agent that poses a significant risk of substantial future harm to a large number of people in the affected population.<sup>84</sup>

This definition sets a “high threshold for what may constitute a public health emergency.”<sup>85</sup> Once a state of public health emergency has been declared, MSEHPA grants the governor specific emergency powers, including the suspension of ordinary state rules and regulations and the utilization of available resources within the state government, to facilitate emergency response efforts.<sup>86</sup> Importantly, MSEHPA grants state and local public health agencies a number of extraordinary public health powers, including the waiver of state professional licensing and certification requirements for health professionals from other jurisdictions participating in emergency response efforts.<sup>87</sup>

These waiver provisions have the potential to impact the administration of volunteer health registries on several levels. First, the invocation of a licensure waiver expands the population of eligible VHPs to include qualified providers from other jurisdictions or states. Additionally, the waiver of health professional licensing or credentialing requirements may facilitate the process through which volunteers are identified, contacted, deployed, and utilized, especially when health care providers from many different jurisdictions with differing licensing requirements are called upon to assist in responding to an emergency.<sup>88</sup>

Many states and territories have utilized the framework in the MSEHPA as a basis for adopting a statutory definition of “public health emergency” and for developing their own processes for declaring public health emergencies.<sup>89</sup> Other states have developed different processes through

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84. MSEHPA, *supra* note 75, at § 104(m). Italicized language indicates optional language for consideration by states.

85. LEGAL AND REGULATORY ISSUES REPORT, *supra* note 10, at 20.

86. *Id.* at 21; *see also* MSEHPA, *supra* note 75, at § 403(a)(1).

87. *Id.* at 22; *see also* MSEHPA, *supra* note 75, at § 608(b).

88. Illinois, for example, has legal provisions that “allow for the waiver of licensure requirements for health professionals during a declared public health emergency.” LEGAL AND REGULATORY ISSUES REPORT, *supra* note 10, at 24. (“The Illinois statute provides for the suspension of temporary or permanent licensure requirements and the modification of the scope of practice restrictions for health professionals licensed in another state who are working under the supervision of the Illinois Emergency Management Agency and the Illinois Department of Public Health pursuant to the declared emergency.” *Id.*; *see also* 20 ILL. COMP. STAT. 2105/2105-400 (2005)).

89. As of June 30, 2005, MSEHPA’s provisions have been introduced in whole or part through legislative bills or resolutions in 44 states, the District of Columbia, and the Northern Mariana Islands, and passed in 37 states and the District of Columbia. *See*

which public health needs can be addressed in emergency situations without declaring a public health emergency. Wisconsin, for example, allows its governor to proclaim a state of emergency, and, under certain conditions, to declare a state of emergency related to public health.<sup>90</sup> The governor may designate the Department of Health and Family Services as the lead state agency in coordinating a public health response<sup>91</sup> and may suspend any administrative provisions that would impede emergency response efforts and increase the threat to public safety.<sup>92</sup> However, compared to MSEHPA, “Wisconsin law does not delineate a specific procedure for the declaration of a public health emergency, and does not require that the governor seek input from public health authorities in making a declaration.”<sup>93</sup>

## 2. General Emergencies

Although many states do not attempt to define the parameters of a “public health emergency,”<sup>94</sup> “nearly every state has developed a legal structure for declaring a ‘general emergency’ or ‘disaster’ and related emergency management functions.”<sup>95</sup> Typically, a general emergency is defined under a broader standard including any event or occurrence that immediately threatens the public’s health or safety. The definition of a disaster, by contrast, focuses primarily on the nature of the incident giving rise to the emergency (e.g., a natural disaster, fire, civil disorder). For example, Missouri defines an emergency as “. . . the actual occurrence of a natural or man-made disaster of major proportions within [the] state when the safety

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CENTER FOR LAW AND THE PUBLIC’S HEALTH AT GEORGETOWN AND JOHNS HOPKINS UNIVERSITIES, MODEL STATE PUBLIC HEALTH LAWS, <http://www.publichealthlaw.net/Resources/Modellaws.htm>; CENTER FOR LAW AND THE PUBLIC’S HEALTH AT GEORGETOWN AND JOHNS HOPKINS UNIVERSITIES, THE MODEL STATE EMERGENCY HEALTH POWERS ACT, LEGISLATIVE SURVEILLANCE TABLE 1 (2005), available at <http://www.publichealthlaw.net/MSEHPA/MSEHPA%20Surveillance.pdf>. Since the MSEHPA’s drafting in 2001, at least twenty-three states have a statutory definition of “public health emergency” or a like term and eighteen states have developed public health emergency management plans. *See id.* at 2.

90. WIS. STAT. § 166.03(1)(b)(1) (West Supp. 2004).

91. *Id.*

92. WIS. STAT. § 166.03(1)(b)(8) (West Supp. 2004). The Division of Emergency Management of the Wisconsin Department of Military Affairs is the lead state agency for all other declared emergencies. WIS. STAT. § 166.03(1)(a)(3) (West. Supp. 2004).

93. LEGAL AND REGULATORY ISSUES REPORT, *supra* note 10, at 24.

94. For example, Massachusetts, Missouri, Ohio, Texas, and West Virginia have not yet statutorily defined “public health emergency” or other similar terms. *Id.* at 20.

95. *Id.* at 24.

and welfare of the inhabitants of [the] state are jeopardized.”<sup>96</sup> It defines a disaster as an event that results from “. . . terrorism, including bioterrorism, or from fire, wind, flood, earthquake, or other natural or man-made causes.”<sup>97</sup>

The processes in many states for declaring a general emergency resemble the processes for declaring a public health emergency through MSEHPA, “and may invoke comparable powers and duties that aim to protect the public’s health and safety.”<sup>98</sup> While Massachusetts does not define public health emergency in its statutes, “its laws allow the governor to declare an emergency and specify its potential to be detrimental to the public’s health.”<sup>99</sup> Oregon has one of the most comprehensive sets of emergency declaration laws. Oregon law empowers the governor to declare an emergency when a man-made or natural event threatens or causes loss of life, injury or human suffering resulting from various circumstances, including the spread of disease.<sup>100</sup> During a declared emergency, Oregon law delegates broad powers to the governor, including the ability to suspend the provisions of state regulations if compliance with those regulations would hinder the emergency response.<sup>101</sup> The governor can also direct state agencies to utilize or employ emergency service workers to provide supplemental health services for the health and safety of the people in the effected area.<sup>102</sup> Emergency service workers include volunteers registered with the state under the emergency health care provider registry<sup>103</sup> who are providing emergency services under the direction of an emergency service or management agency.<sup>104</sup> Additionally, the Oregon Department of Human

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96. MO. REV. STAT. § 44.010(6) (1998).

97. MO. REV. STAT. § 44.010(4) (1998).

98. LEGAL AND REGULATORY ISSUES REPORT, *supra* note 10, at 26.

99. *Id.* (examining MASS. ANN. LAWS ch. 17, § 2A (Law. Co-op. 1965)).

100. OR. REV. STAT. § 401.025(4) (2003). Oregon law also permits the governor to declare a “state of impending public health crisis” when there is “a threat to the public health is imminent and likely to be widespread, life-threatening and of a scope that requires immediate medical action .” OR. REV. STAT. § 433.441(1) (Supp. 2004). In addition, “[a] public health crisis can result from bioterrorism, chemical or radiological contamination, pandemic influenza or any other unusual or extraordinary incidence of a communicable or reportable disease.” OR. REV. STAT. § 433.441(2) (Supp. 2004).

101. OR. REV. STAT. § 401.065(2) (2003).

102. *Id.*

103. The registry includes information regarding the health care provider’s identity, licensure, certifications, and usual area of practice. OR. REV. STAT. § 401.654 (2003). This registry, which states could emulate as a model for ESAR-VHP implementation, may act as an important source of information to credential volunteers who are registered and spontaneously respond to assist in an emergency.

104. OR. REV. STAT. § 401.025(9) (2003).



Services may designate a health care facility as an emergency health care center during a declared emergency<sup>105</sup> Both designated emergency service workers and emergency health care centers receive legal liability protections under the law.<sup>106</sup>

### 3. Dual Declarations

In states like Delaware and Louisiana that have defined “general emergency” and “public health emergency,” there is potential for legislative confusion and duplication because these definitions typically share common components.<sup>107</sup> The broader concept of a general emergency or disaster may include factors that many would consider public health emergencies.<sup>108</sup> Furthermore, “dual definitions present different thresholds for the declaration of a state of emergency. The threshold of what constitutes a public health emergency is typically more precise than what may amount to a general emergency.”<sup>109</sup> This may create an incentive for a governor to initially declare a general state of emergency, potentially bypassing the need to declare a public health emergency. Any subsequent declaration of a public health emergency would overlap the existing general declaration.

The dilemma concerning dual, overlapping declarations exceeds mere semantics: depending on the declaration, differing state or local agencies may be legislatively responsible for coordinating responses. In many states,

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105. OR. REV. STAT. § 401.657 (2003).

106. OR. REV. STAT. § 401.667 (2003).

107. See DEL. CODE ANN. tit. 20, §§ 3102(2), 3132(11) (2005); LA. REV. STAT. ANN. § 29:762 (2005).

108. “As a consequence, the governor and state agencies could be required to decide whether an emergency that may impact the public’s health is a general emergency or a public health emergency. This choice may be further confused by the use of similar terminology in both conceptions of emergencies.” LEGAL AND REGULATORY ISSUES REPORT, *supra* note 10, at 26. In the District of Columbia, for example, a public (general) emergency may be declared for an “[o]utbreak of a communicable disease that threatens or causes damage to life, health, or property.” D.C. CODE ANN. § 7-2301(3)(I) (2002). A public health emergency could similarly be declared for “widespread exposure to an infectious or toxic agent that poses a significant risk of substantial future harm to a large number of people.” D.C. CODE ANN. § 7-2304.01(a)(3)(2002). The definitional criteria for either emergency clearly overlap. To avoid some confusion, D.C. law requires that a public emergency must be declared before a public health emergency declaration. D.C. CODE ANN. § 7-2304.01(a)(2002)

109. LEGAL AND REGULATORY ISSUES REPORT, *supra* note 10, at 27. So doing “may provide an incentive for the governor to choose to declare a general state of emergency under a lower threshold even when circumstances suggest the need for a public health emergency response.” *Id.*

public health authorities are responsible for managing a public health emergency, while public safety or emergency management authorities are responsible for responding to general emergencies. Dual emergency declarations could trigger the responses of multiple state agencies, potentially resulting in conflicting powers and duties. Of course, advance emergency planning at state and local levels may soften these potential conflicts. Many states have engaged effective planning, communication, and relationship building to adequately prepare for all types of emergencies.<sup>110</sup>

Even with adequate planning, legislative or administrative designations of an emergency as “general” or “public health” impact VHPs participating in emergency response efforts. The provisions suggested by MSEHPA, for instance, “waive certain licensing and certification requirements in the event of a public health emergency; a similar waiver might not be statutorily permitted during a general emergency.”<sup>111</sup> General emergency declarations may authorize the use of a variety of volunteers during an emergency response, and state statutory definitions of the term “volunteer” within an emergency management context may or may not include health care professionals.<sup>112</sup> The declaration of a public health emergency, however, would sustain assistance from a more specific class of volunteers within the health care system. VHPs may need these more specific protections that are not statutorily provided through general emergency management provisions.

#### 4. Federal Declarations

The federal government also has the power to declare an emergency or disaster. The Robert T. Stafford Disaster Relief and Emergency Assistance Act (Stafford Act)<sup>113</sup> and the Public Health Security and Bioterrorism

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110. See, e.g., Or. Rev. Stat. §§ 401.015-.050 (2003); Health Resources Services Administration, National Hospital Bioterrorism Preparedness Program Awardees Descriptive Analysis Regarding ESAR-VHP Activities, ESAR-VHP Awardee: Illinois 1-2 (May 23, 2005) (on file with authors); Health Resources Services Administration, National Hospital Bioterrorism Preparedness Program Awardees Descriptive Analysis Regarding ESAR-VHP Activities, ESAR-VHP Awardee: Texas 1-2 (May 23, 2005) (on file with authors).

111. LEGAL AND REGULATORY ISSUES REPORT, *supra* note 10, at 27.

112. *Id.*

113. The purpose of the federal emergency powers is to supplement state and local government’s emergency response efforts by providing expediting the rendering emergency medical, rehabilitation and reconstruction aid. 42 U.S.C. §§ 5120-5206 (2002).

Preparedness and Response Act of 2002<sup>114</sup> vest the President with various powers to coordinate and implement disaster response assistance measures, including the National Response Plan.<sup>115</sup> Under the Stafford Act, depending on whether the event is an emergency or a major disaster, the federal government has differing powers to provide assistance in the response efforts.<sup>116</sup> The President may authorize emergency assistance “to save lives and to protect property and public health and safety, or to lessen or avert the threat of a catastrophe in any part of the United States” at the request of a state governor or when the emergency is primarily a federal responsibility.<sup>117</sup> The definition of a major disaster is more specific, with a greater emphasis on the specific nature of the incident. Federal disaster assistance is only available upon the request of the state Governor for major disasters, including natural catastrophes, fires, floods, or explosions, “of such severity and magnitude that effective response is beyond the capabilities of the State and the affected local governments and that Federal assistance is necessary.”<sup>118</sup> Additionally, DHHS’ Secretary has the authority to declare a public health emergency<sup>119</sup> to engage in actions necessary to respond to the emergency, including the hiring of intermittent disaster response personnel or the acceptance of volunteer services.<sup>120</sup>

Volunteers could be recruited to assist at the federal level during the implementation of the National Response Plan or an individual federal agency’s emergency assistance plan. Yet federal emergency declaration laws do not directly provide volunteers with comprehensive legal protections. During a federally-declared emergency, federal agencies and employees are immune from civil liability for any discretionary actions

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114. Public Health Security and Bioterrorism Preparedness and Response Act of 2002, Pub. L. No. 107-188; 116 Stat. 594.

115. The federal government may also provide assistance in response to incidents under its jurisdiction and that do not rise to the level of national significance. In these cases, the federal agency or department that has primary responsibility for the response may request assistance from other federal agencies. See NAT’L RESPONSE PLAN, *supra* note 14, at 94.

116. See 42 U.S.C. § 5120-5206 (2001).

117. See 42 U.S.C. §§ 5122(1), 5191(2001).

118. Prior to requesting federal assistance from the President, the state governor must utilize state resources to respond to the emergency, including the activation of the state emergency management plan. 42 U.S.C. §§ 5170, 5191 (2001). See also 42 U.S.C. § 5122(2) (2001) (defining “major disaster”).

119. 42 U.S.C. 247d (2001). See also HODGE & GABLE, LEGAL PROTECTIONS FOR INTERMITTENT DISASTER RESPONSE, *supra* note 42, at 1.

120. 42 U.S.C. 247d; HODGE & GABLE, LEGAL PROTECTIONS FOR INTERMITTENT DISASTER RESPONSE, *supra* note 42, at 2; HODGE & GABLE, LEGAL PROTECTIONS FOR TEMPORARY VOLUNTEERS, *supra* note 43, at 1.

undertaken in the course of providing emergency assistance,<sup>121</sup> but these protections do not specifically extend to volunteers.<sup>122</sup> Intermittent volunteers providing assistance through NDMS are considered employees of the Public Health Service during the course of the performance of their volunteer duties.<sup>123</sup> Thus, they are entitled to governmental immunity.<sup>124</sup> While federal laws do not address licensure reciprocity for VHPs (because licensure requirements are state-based), many state licensure laws permit individuals providing medical assistance on behalf of the federal government to engage in professional practice.<sup>125</sup> Intermittent disaster response personnel may also receive workers' compensation coverage and reemployment protection under federal laws.<sup>126</sup> The availability of legal protections for temporary volunteers is less certain. For these individuals to be entitled to liability protection, workers' compensation coverage, or reemployment protection, DHHS' Secretary must explicitly extend these protections to temporary volunteers.<sup>127</sup>

### *B. Volunteer and Host Civil Liability for Harm to Patients*

The risk of civil liability for harm to patients is one of the most contentious legal issues related to the use of VHPs for emergency medical response efforts. Health professionals who volunteer may face civil liability for negligence or intentional torts committed while performing their duties. Similarly, health care entities that provide or accept VHPs may face vicarious or corporate liability related to their own actions and the actions of the VHPs. A variety of statutory provisions, including volunteer protection

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121. 42 U.S.C. § 5148 (2001).

122. Federal volunteers are, however, protected under the Volunteer Protection Act of 1997, Pub.L. 105-19, 111 Stat. 218 (codified as amended at 42 U.S.C. §§ 14501-14505 2000)). For further discussion of the Federal Volunteer Protection Act, see Section III.B.1 of this article, *infra*.

123. Intermittent disaster response personnel covered by these provisions include medical practitioners appointed by the Secretary for Public Health Emergency Preparedness to provide medical assistance through the NDMS in the case of an emergency or disaster. See 42 U.S.C. § 300hh-11(d)(2) (2002).

124. See *id*.

125. See, e.g., CONN. GEN. STAT. §20-9(b) (1999). Intermittent disaster response personnel are considered federal employees and thus are entitled to these waiver of licensure requirements in order to provide medical assistance as a part of NDMS emergency response measures. See 42 U.S.C.A. 5159(b). See also Hodge & Gable, LEGAL PROTECTIONS FOR INTERMITTENT DISASTER RESPONSE, *supra* note 42.

126. See 42 U.S.C. § 300hh-11(e) (2003).

127. See 45 C.F.R. § 57.5; Hodge & Gable, LEGAL PROTECTIONS FOR TEMPORARY VOLUNTEERS, *supra* note 43, at 2.

laws and Good Samaritan laws, may grant immunity to volunteers. Such provisions are designed to encourage VHPs to assist in emergency response efforts by protecting them from liability for acts occurring during the gratuitous provision of health care and services. Although some legal protections are also available for host entities, these entities generally do not enjoy the same level of protection as VHPs.

### *1. Volunteer Liability, Immunity, and Indemnification*

When providing health care services in response to an emergency or disaster, volunteer health professionals (VHPs) are confronted with the risk of civil liability for negligent actions.<sup>128</sup> Since tort liability for professional negligence is generally governed by state law, the acts of the VHP will be assessed under the laws of the jurisdiction where the act took place.<sup>129</sup> The

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128. LEGAL AND REGULATORY ISSUES REPORT, *supra* note 10, at 43. Negligence theories, rooted in the failure of the VHP to adhere to a particular standard of care when providing health care services, are most commonly the basis for civil liability claims. In addition to the direct liability of VHPs for their own actions, their employers may be held vicariously liable for their actions. *Id.* at 41. *See generally* DAN B. DOBBS, *THE LAW OF TORTS* 269-73 (2000). In addition to negligence, VHPs could be subject to civil liability for several other types of torts:

[T]he performance of an invasive bodily procedure without informed consent could be considered a battery and subject the VHP to civil liability (although exceptions to informed consent apply during some emergency situations).” Similarly, if a health professional intentionally misrepresents relevant information about a procedure to a patient, he or she may face charges of negligent misrepresentation in some jurisdictions. A practitioner may also be found civilly liable in some jurisdictions for negligent infliction of emotional distress if the actions taken caused the patient or a bystander substantial emotional suffering with concordant physical injuries and the reaction was foreseeable.

LEGAL AND REGULATORY ISSUES REPORT, *supra* note 10, at 62; *see also* BARRY FURROW, *HEALTH LAW* 282-85 (2000). We do not provide an extensive discussion of alternative avenues of tort liability in this article because we have chosen to focus on the risk of liability related to negligent torts. Volunteers may also be exposed to criminal liability for their actions. “Criminal responsibility of an individual volunteer will be determined by the elements of the crime that he or she is alleged to have committed. As with civil liability, some state or federal laws may potentially insulate an individual from criminal responsibility.” LEGAL AND REGULATORY ISSUES REPORT, *supra* note 10, at 62. However, the scope and applicability of immunity from criminal liability is more restricted than civil liability.

129. The interpretation of negligence standards differ between states, are highly dependent on the circumstances of the particular situation. *See* LEGAL AND REGULATORY ISSUES REPORT, *supra* note 10, at 43.

elements of a negligence claim require the VHP to (1) owe a duty to the injured party; (2) breach the duty by failing to adhere to the requisite standard of care; and (3) cause actual harm to the injured party as a consequence of the breach.<sup>130</sup> In the context of medical care, the “duty” element is met once the provider establishes a relationship with the patient and begins to provide them with health care or evaluation.<sup>131</sup> The provider-patient relationship may be implied by the actions of the parties, and need not be explicitly discussed or agreed upon by the parties.<sup>132</sup>

A breach of duty occurs when the VHP fails to adhere to the appropriate standard of care required for someone of their profession and training under the circumstances.<sup>133</sup> As with any malpractice case, facts must be evaluated on an individual basis to determine whether the physician or hospital acted within the standard of care.<sup>134</sup> The circumstances of the emergency as a whole play a role in establishing the standard of care for the VHPs and other health practitioners rendering care.<sup>135</sup> Additionally, the VHP’s actions must have proximately caused the patient’s injury in order to give rise to liability. A determination of proximate cause usually requires a demonstration that

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130. *Id.*

131. *Id.*

132. *Id.*

133. *Id.* at 41. A related issue with implications for the use of volunteers in emergencies is whether the standard of care is reduced during an emergency situation in which hospitals may be overwhelmed and staffed with numerous volunteers. To date, case law has not specifically addressed this issue. However, generally, “[a] hospital rendering emergency treatment is obligated to do that which is immediately and reasonably necessary for the preservation of the life, limb or health of the patient.” *New Biloxi Hospital, Inc. v. Frazier*, 146 So. 2d 882 (Miss. 1962). Under this standard, an emergency room physician would likely be subject to the standard of care for a specialist in the field. *See e.g. Wright v. HCA Health Services of Louisiana*, 877 So. 2d 211, 215 (La. App. 2 Cir. 2004). Likewise, the hospital would be subject to the general negligence standard of care and statutory duty to provide emergency care to patients who need such care applicable to the jurisdiction. For example, hospitals are subject to a duty to screen and stabilize patients presenting to the emergency department for medical care under the Emergency Medical Treatment and Labor Act (“EMTALA”), 42 U.S.C. § 1395dd. For a detailed discussion of EMTALA, *see infra* section III.F.

134. LEGAL AND REGULATORY ISSUES REPORT, *supra* note 10, at 41.

135. *Id.* Although courts have yet to address the standard of care under EMTALA, the Department of Health and Human Services has suggested that altered standards of care apply during mass casualty events. *See* HEALTH SYSTEMS RESEARCH, INC., AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, ALTERED STANDARDS OF CARE IN MASS CASUALTY EVENTS 2 (2005) (suggesting that in order to maximize the number of lives saved, it may be necessary to ration scarce medical resources rather than “doing everything possible to save every human life.” *Id.* at 2.

the actions of the practitioner were the predominant and direct cause of the resulting injury.<sup>136</sup> If there were subsequent intervening circumstances or multiple factors contributing to the ultimate injury, civil liability may be reduced or avoided.<sup>137</sup> Finally, in most jurisdictions the patient must have suffered an actual harm or damages (e.g., an injury, detrimental impact on health, or a quantifiable economic loss).<sup>138</sup>

All jurisdictions offer VHPs some degree of immunity from civil liability, depending on the circumstances. For volunteers that are government employees, uncompensated for their work, or helping during a declared emergency, immunity from civil liability is often broadly available. Several sources of law offer potential immunity from civil liability to VHPs. Statutory and constitutional limits on civil liability for normal volunteer practices may derive from (1) governmental immunity provisions (if the volunteer is a government employee or agent) and (2) volunteer protection statutes. During emergency situations, additional legal sources of immunity may be available, including (3) Good Samaritan statutes; (4) emergency statutes; and (5) mutual aid compacts. Immunity provisions provide an affirmative defense that prevents a civil liability claim from going forward. Alternatively, VHPs may receive protection from indemnification provisions, which provide for the payment of damages (reimbursed by the state or another source) if a civil liability claim is successful.<sup>139</sup>

Employees or agents of state governments “will typically receive protection from civil liability pursuant to the governmental immunity, also known as “sovereign immunity,” held by federal or state governments as sovereign entities.<sup>140</sup> For a volunteer to receive sovereign immunity, he or she must be considered an employee or agent of the government.<sup>141</sup>

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136. The proximate cause element requires that the defendant’s negligence was the cause in fact of the plaintiff’s injury and that the injury was a foreseeable consequence of the defendant’s negligence. *See Pratho v. Zapata*, 157 S.W.3d 832, 836 (Tex.App.-Fort Worth, 2005).

137. W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS 301-19 (5th ed. 1984).

138. *See FURROW, supra* note 128, at 259-78.

139. *See DOBBS, supra* note 128, at 732-33.

140. LEGAL AND REGULATORY ISSUES REPORT, *supra* note 10, at 45. (“State governmental immunity is grounded in tradition and reflected in the Eleventh Amendment to the U.S. Constitution, which prohibits individuals from bringing private claims against the state. Although sovereign immunity is traditionally absolute in common law, federal and state legislatures have gradually eroded its breadth through the passage of tort claims acts (TCAs)” *Id.* at 45-46).

141. Volunteers may be considered government employees if 1) they are statutorily granted employee status or 2) they are working as an agent of the state and the state law allows sovereign immunity to extend to government contractors. *Id.* at 46.

Sovereign immunity does not provide absolute protection from civil liability. Under federal<sup>142</sup> and state tort claims acts (TCAs), claims may be brought against federal or state governments and its agents acting within their official duties.<sup>143</sup> In general, TCAs provide the exclusive remedy for individuals harmed by the negligence of government employees.<sup>144</sup> In most jurisdictions, governmental immunity only applies to employees, officers, or agents of the government if the relevant acts were performed within the scope of their employment. Some jurisdictions, by contrast, allow employees to be held liable for their actions within the scope of their employment, though the state is required to defend the employee from liability claims or indemnify the employee for any damages resulting from a finding of liability<sup>145</sup>

Statutory volunteer protection acts (VPAs) at the federal and state levels also limit the civil liability of volunteers if certain criteria are met.<sup>146</sup> These statutes provide volunteers with immunity from liability for acts performed within the scope of their volunteer duties, and which do not amount to gross

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142. The Federal Tort Claims Act ("FTCA"), 28 U.S.C. §§ 1346(b), 2401(b), 2671-80 (West 2005), represents a limited waiver of federal sovereign immunity under which, with certain exceptions, the United States may be liable for the tortious conduct of its employees to the same extent as a private party. *See* *United States v. Nordic Village, Inc.*, 503 U.S. 30, 33-34 (1992).

143. The structure and scope of TCAs vary. Some state laws generally abolish sovereign immunity, reserving immunity for specific circumstances only. *See, e.g.*, ALASKA STAT. § 09.50.250 (2004); GA. CODE ANN. § 50-21-23 (2002). Other states retain sovereign immunity in most cases, but list exceptions where civil liability may arise. *See, e.g.*, COLO. REV. STATS. § 24-10-106 (2004); TEX. CIV. PRAC. & REM. CODE § 101.021 (2005). Washington state has abolished sovereign immunity altogether. WASH. REV. CODE ANN. § 4.92.090 (West 2005).

144. Suits under the FTCA are limited to those that involve claims arising from "the negligent or wrongful act or omission of any employee of the Government . . . acting within the scope of his office or employment." 28 U.S.C. § 1346(b) (West 2005).

145. DOBBS, *supra* note 128, at 732-33.

146. VPAs are found in all fifty states and the District of Columbia, and offer a variety of civil liability protections to volunteers. The federal VPA, passed in 1997, asserts that volunteers for nonprofit organizations or governmental entities shall not be liable for harm caused by their acts or omissions on behalf of the organization or entity. Federal Volunteer Protection Act of 1997, Pub. L. No. 105-19, § 4, 111 Stat. 218, 219 (codified as amended 42 U.S.C. §§ 14501-14505 2000)). Inconsistent state laws are overridden by the federal VPA although more protective state laws remain in effect. 42 U.S.C. § 14502. Examples of state VPAs include Alabama and Mississippi, which provide volunteers with immunity for injuries resulting from good faith acts associated with the performance of their volunteer duties. *See* ALA. CODE. § 6-5-336 (2005); MISS. CODE ANN. § 95-9-1 (West 1999). These acts, however, contain exceptions to immunity for actions that amount to willful or wanton misconduct.



negligence or reckless misconduct.<sup>147</sup> The liability protection provided under the VPAs only applies to VHPs who are uncompensated and volunteering for a government or non-profit entity. Organizations employing or supervising VHPs, VHPs volunteering for a for-profit entity, or VHPs receiving compensation for their services will not qualify for liability protection under these provisions.<sup>148</sup>

Good Samaritan statutes generally diminish the potential civil liability by reducing the required duty of care for the actions of VHPs providing assistance in response to an immediate emergency outside the practitioner's normal practice. In most states, health professionals volunteering in good faith and without compensation at the scene of an emergency are protected from civil liability for ordinary negligence.<sup>149</sup> Good Samaritan protections may apply to volunteer emergency services provided in hospital settings if the practitioner is not on duty and does not charge a fee.<sup>150</sup> Good Samaritan

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147. To receive this civil liability protection, a volunteer must:

(1) be acting within the scope of the volunteer's responsibilities; (2) be properly licensed, certified, or authorized by the appropriate authorities as required by law in the state in which the harm occurred; (3) have not engaged in willful or criminal misconduct, gross negligence, reckless misconduct, or a conscious, flagrant indifference to the rights or safety of the individual(s) harmed by the volunteer; and (4) not have caused the harm by operating a motor vehicle, vessel, aircraft, or other vehicle for which the state requires its operator to possess an operator's license or maintain insurance.

42 U.S.C. § 14503(a) (2000).

148. Federal VPA immunity applies to uncompensated, individual volunteers, but not organizations employing or supervising volunteers. *See* 42 U.S.C. § 14505 (2000).

149. Good Samaritan statutes may apply different levels of legal protections to VHPs with different professional qualifications. For example, Massachusetts law provides physicians and nurses with protection for emergency care provided in good faith and without a fee and for giving advice by remote communication to EMS personnel. MASS. GEN. LAWS ANN. ch. 112, § 12B, ch. 111C, § 20 (2003). However, people trained in CPR, AEDs, or basic cardiac life support only receive protection for uncompensated emergency CPR or defibrillation other than in the course of regular business activity. MASS. GEN. LAWS ANN. ch. 112, § 12V (2003). The protections of Illinois' and Connecticut's Good Samaritan Statutes only apply to licensed health care professionals. *See* 745 ILL. COMP. STAT. ANN. 49/1-120 (West 2005) (limiting liability protection to emergency care provided at the scene of an accident); CONN. GEN. STAT. § 52-557b (Supp. 2005). Still other states provide broad protection to any person that gratuitously provides emergency care outside of a hospital. *See e.g.*, D.C. CODE § 7-401 (2005); MINN. STAT. ANN. § 604A.01 (West Supp. 2004); OHIO REV. CODE ANN. § 2305.23 (LexisNexis 2005).

150. *See, e.g.*, Villamil v. Benages, 628 N.E.2d 568 (Ill.App. 1993); Gordin v. William Beaumont Hosp., 447 N.W.2d 793 (Mich. Ct. App. 1989); *see generally*, FURROW, *supra* note 128, at 292-94. Some Good Samaritan statutes do not apply to

statutes preserve avenues of civil liability against health professionals with a pre-existing duty to provide aid by excepting them from liability protection.<sup>151</sup> While Good Samaritan provisions provide some level of immunity from civil liability, the applicable conditions and standards of negligence vary widely.<sup>152</sup> Nevertheless, VHPs in many states may benefit from a reduced standard of care under these laws provided that they are truly volunteers and do not expect payment for their services.

Several states have enacted emergency statutes and regulations that provide civil liability protection for VHPs. Model emergency laws, such as MSEHPA and the Model Intrastate Mutual Assistance Law (MIMAL), explicitly grant immunity from civil liability to emergency responders during a declared emergency.<sup>153</sup> MSEHPA provides broad immunity from civil liability for out-of-state emergency health professionals.<sup>154</sup> MIMAL employs a similar immunity scheme for VHPs responding within a state. Under MIMAL, all persons, including VHPs, responding under the

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actions that occur in a hospital, are pre-arranged, or in which the person receives compensation. *See generally* Daniel R. Veilleur, Annotation, *Construction and Application of "Good Samaritan" Statutes*, 68 A.L.R. 4th 294 (2005).

151. *See, e.g., Villamil*, 628 N.E.2d 568; *Gordin*, 447 N.W.2d 793; *see generally*, FURROW, *supra* note 128, at 292-94. *See generally* Veilleur, *supra* note 150.

152. Most Good Samaritan statutes remove civil liability for ordinary medical negligence, but not for acts of gross negligence or wanton misconduct. *See e.g.*, 745 ILL. COMP. STAT. ANN. 49/1-120 (West 2002); MINN. STAT. ANN. § 604A.01 (West Supp. 2004); OHIO REV. CODE ANN. § 2305.23 (LexisNexis 2005). Texas' Good Samaritan statute, for example, provides immunity from suit for care rendered in an emergency, outside the hospital, unless the acts were willfully or wantonly negligent. TEX. CIV. PRAC. & REM. CODE ANN. § 74.001(a) (Vernon 2005).

153. *See, e.g.*, NATIONAL EMERGENCY MANAGEMENT ASS'N, *Model Intrastate Mutual Aid Legislation*, Art. X, available at <http://emacweb.org/docs/Wide%20Release%20Intrastate%20Mutual%20Aid.pdf> [hereinafter MIMAL]; MSEHPA, *supra* note 75, at § 804.

154. MSEHPA, *supra* note 75, at § 608(b)(3). These professionals cannot "be held liable for any civil damages as a result of medical care or treatment related to the response to the public health emergency unless such damages result from providing, or failing to provide, medical care or treatment under circumstances demonstrating a reckless disregard for the consequences so as to affect the life or health of the patient." *Id.* MSEHPA's model provisions also establish immunity from civil liability for (1) the state medical examiner; (2) state and local officials engaging in a public health emergency responses (except in cases of gross negligence or willful misconduct); (3) persons owning real estate who voluntarily and without compensation grant a license or privilege to use their land; (4) private persons, firms, corporations, and their agents and employees who perform their duties under a contract with the state; and (5) private persons, firms, corporations, and their agents and employees who render assistance or advice at the state's request. *Id.* at §§ 608(c)(3), 804(a), 804(b).

operational control of the government entity requesting aid will be considered to be employees of that government entity.<sup>155</sup> Therefore, for purposes of emergency response, any sovereign immunity protections that apply to government employees in the jurisdiction would apply to the volunteers for the duration of their volunteer service. Additionally, MIMAL features an explicit immunity provision providing that government employees shall not be liable for personal injury or death, or property damage while complying with the mutual aid response. Immunity will not apply to acts found to entail willful misconduct, gross negligence, or bad faith.<sup>156</sup>

Other state and federal emergency statutes provide specific legal protection to VHPs.<sup>157</sup> For example, Connecticut grants immunity (except in cases of willful misconduct) to volunteer members from identified entities comprised of medical and public health volunteers.<sup>158</sup> Oregon grants immunity to emergency service workers for acts related to the provision of emergency services, provided that the individual did not engage in willful misconduct, gross negligence, or bad faith.<sup>159</sup> Emergency service workers protected under these provisions include VHPs registered in the state's volunteer registry.<sup>160</sup> Louisiana grants immunity to health care providers, including individuals and health care entities, who provide assistance during a declared emergency or public health emergency.<sup>161</sup> Under federal law, intermittent disaster-response personnel are considered to be employees of the federal government, which entitles them to the immunity protections available under the Federal Tort Claims Act.<sup>162</sup>

Finally, civil liability protections for volunteers may be authorized by emergency compacts such as the Emergency Management Assistance Compact (EMAC). EMAC provides that “[o]fficers or employees of a party

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155. See MIMAL, *supra* note 153, at art. X.

156. See *id.* (“Neither the participating political subdivisions nor their employees... shall be liable for the death of or injury to persons, or for damage to property when complying or attempting to comply with the statewide mutual aid system.” *Id.*)

157. For example, in Minnesota, VHPs who are registered with the state are considered employees of the state for purposes of tort claims defenses and indemnification. MINN. STAT. ANN. § 12.22, Subd. 2a (West 2005).

158. Immunity is granted specifically to the Connecticut Disaster Medical Assistance Team, the Medical Reserve Corps, the Connecticut Urban Search and Rescue Team, and the Connecticut Behavioral Health Regional Crisis Response Teams, members of which may also be VHPs through an advance registration system. CONN. GEN. STAT. ANN. 28-13 (West 2003).

159. OR. REV. STAT. § 401.515 (2003).

160. OR. REV. STAT. § 401.025(9) (2003).

161. LA. REV. STAT. ANN. §§ 29:762(4), 29:771(B)(2)(c) (West Supp. 2005).

162. 42 U.S.C.A. § 300hh-11(d)(2) (West 2003).

state rendering aid in another state pursuant to this compact shall be considered agents of the requesting state for tort liability and immunity purposes.”<sup>163</sup> Those rendering aid are protected from civil liability by EMAC, provided that they act in good faith and without “willful misconduct, gross negligence, or recklessness.”<sup>164</sup> Since EMAC is a prominent vehicle through which state government employees can assist in other states during emergencies, it is unclear whether a volunteer that is not a state employee in their home state would be eligible for EMAC liability protections. International mutual aid compacts raise similar questions.<sup>165</sup>

## *2. Liability of Public or Private Health Care Entities that Provide or Accept Volunteer Health Professionals*

Health care entities that provide or accept VHPs may face civil liability in several ways. The theory of corporate negligence states that a hospital may incur civil liability for its own negligent activities. Hospitals may also be held vicariously liable for the negligent actions of VHPs through the theories of respondeat superior and ostensible agency.<sup>166</sup> In relation to ESAR-VHP, hospital negligence may range from the failure to take advantage of ESAR-VHP for recruiting VHPs to increase surge capacity, to negligent credentialing by failing to confirm a VHP’s credentials. These avenues of liability concern hospitals utilizing VHPs because relatively few legal protections are available to immunize or indemnify them for their liability related to the use of VHPs.

### *a. Corporate Negligence*

Theories of corporate negligence can subject a hospital to civil liability for the acts of negligent health professionals and for its own failures to adopt

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163. EMAC, *supra* note 50, at art. VI.

164. *Id.*

165. *See, generally*, Fox, *supra* note 50, at 77. The International Emergency Management Assistance Compact (IEMAC) uses slightly different language, immunizing from liability any “person or entity of a party jurisdiction.” *See* IEMAC, *supra* note 50, at art. VI.

166. *See* Thompson v. Nason Hospital, 591 A.2d 703, 707 (Pa. 1991) (citing Ramone v. Mani, 535 S.W.2d 654 (Tex.Civ.App.—Eastland 1975) (nurses’ negligence during surgery imputed to hospital under doctrine of respondeat superior), *aff’d*, 550 S.W.2d 270 (Tex.1977); Seneris v. Haas, 45 Cal.2d 811, 291 P.2d 915 (1955) (anesthesiologist who negligently paralyzed patient was ostensible agent of hospital)).

appropriate policies and procedures to protect patients.<sup>167</sup> The law recognizes that hospitals have a duty to their patients stemming from the relationship formed between the hospital and the patient once the patient presents for care.<sup>168</sup> Since hospitals have come to be seen by many as community centers for health care, patients generally expect that the hospital will deliver competent, high-quality medical care.<sup>169</sup> Under the theory of corporate negligence, a hospital generally has four duties:

- (1) a duty to use reasonable care in the maintenance of safe and adequate facilities and equipment;
- (2) a duty to select and retain only competent physicians;
- (3) a duty to oversee all persons who practice medicine within its walls as to patient care; and
- (4) a duty to formulate, adopt, and enforce adequate rules and policies to ensure quality care for the patients.<sup>170</sup>

Courts have used the corporate negligence doctrine to recognize a duty on the part of hospitals to properly investigate the credentials of health professionals providing medical care at their facilities.<sup>171</sup> This duty arises from the superior ability of the hospital to investigate, supervise, and monitor physician performance.<sup>172</sup> Failing to do so results in a foreseeable risk that patients will be harmed as a result of treatment from incompetent medical professionals.<sup>173</sup> This concept is particularly important with respect to the use of VHPs in emergencies. Given the exigencies of an emergency

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167. *Darling v. Charleston Cmty. Memorial Hospital*, 33 Ill.2d 326, 211 N.E.2d 253,258 (Ill. 1965), *cert. denied* 383 U.S. 946, 86 S.Ct. 1204, 16 L.Ed.2d 209 (1966) (corporate negligence of hospital based on holding that hospital owed patient an independent duty of care).

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

169. *See id.* at 396; *Moore v. Board of Trustees*, 495 P.2d 605, 608 (Nev. 1972), *cert. denied*, 409 U.S. 879 (1972).

170. *Thompson*, 591 A.2d at 707 (citations omitted).

171. *Bickham v. Imphynet, Inc.*, 894 So.2d 15, (La. App. 1st Cir. 2004); *Bost*, 262 S.E.2d at 396; *Robinson v. Duszynski*, 243 S.E.2d 148, 151-52 (N.C. App. 1978).

172. *See Insinga v. LaBella*, 503 So. 2d 209, 214 (Fla. 1989); *Pedroza v. Bryant*, 101 Wash.2d 226, 677 P.2d 166, 169 (1984).

173. *See id.* at 168-69; *Wellstar Health Systems v. Green*, 258 Ga. App. 86, 91, 572 S.E.2d 731, 735 (Ga. Ct. App. 2002) (holding that the duty to provide patients with competent medical providers includes nurses). *See also Johnson v. Misericordia Cmty. Hosp.*, 99 Wis. 2d 708, 301 N.W.2d 156 (Wis. 1981); *Ferguson v. Gonyaw*, 64 Mich. App. 685, 236 N.W.2d 543 (1975); *Corleto v. Shore Mem'l Hosp.*, 138 N.J. Super. 302, 350 A.2d 534 (N.J. Super. Ct. Law Div. 1975); *Mitchell Cy. Hosp. Auth. v. Joiner*, 229 Ga. 140, 189 S.E.2d 412 (Ga. 1972); *Purcell v. Zimbelman*, 18 Ariz. App. 75, 500 P.2d 335 (Ariz. Ct. App. 1972); *Moore*, 88 Nev. 207, 495 P.2d 605.

situation, the hospital may not be able to undertake a full investigation of a VHP's credentials prior to putting her to work. In recognition, the Joint Commission for the Accreditation of Health Care Organizations (JCAHO)<sup>174</sup> has enacted disaster credentialing standards designed to provide criteria for hospitals to quickly assess the qualifications of a VHP.<sup>175</sup> These standards may be relevant to the legal determination of the appropriate standard of care for hospital disaster credentialing.

The corporate negligence theory may also be used to hold a hospital liable for the failure to meet proper staffing requirements. During an emergency, with large numbers of patients presenting for care, the hospital may be forced to increase staffing to meet surge capacity needs. This process may include recruiting VHPs though ESAR-VHP. If the hospital fails to do so, and as a result the hospital provides substandard medical care to patients, the hospital may be liable for any resulting injuries to patients. Such liability would derive not only from a statutory duty to provide emergency care,<sup>176</sup> but also from the hospital's "duty to formulate, adopt, and enforce adequate rules and policies to ensure quality care for the patients."<sup>177</sup>

A hospital may also be held civilly liable for the failure to provide adequate supervision of its staff, which is analogous to the failure to adopt adequate rules and policies to ensure the quality of care provided to patients. In many jurisdictions, hospital staff members have an ongoing duty to ensure the quality of patient care by reporting abnormalities in the treatment of patients.<sup>178</sup> Thus, if any staff member believes that a health care professional is failing to adhere to proper standards of care, they are obligated to advise hospital authorities accordingly so that appropriate action might be taken.<sup>179</sup>

A hospital's duty under the theory of corporate negligence is limited. Hospitals are not required to insure the safety of their patients against all acts of negligence or physician misconduct.<sup>180</sup> Rather, hospitals "must exercise a

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174. JCAHO sets the standards for patient safety and quality of care for hospitals and other health care organizations. Although not a governmental entity, JCAHO's standards for patient safety and quality of care are nationally accepted. JCAHO credentialing standards differ from licensing regulations in that compliance is strictly voluntary and does not carry any penalties for non-compliance. Joint Comm'n for the Accreditation of Healthcare Org., COMPREHENSIVE ACCREDITATION MANUAL FOR HOSPITALS: THE OFFICIAL HANDBOOK MS-1 (2004) (hereinafter CAMH).

175. *Id.* at MS-4.

176. 42 U.S.C. § 1395dd.

177. *Thompson*, 591 A.2d at 707.

178. *Rauch*, 783 A.2d at 828.

179. *Id.*

180. *Decker v. St. Mary's Hospital*, 249 Ill. App. 3d 802, 808 (5th Dist. 1993).

degree of reasonable care as the patient's known condition requires."<sup>181</sup> This obligation requires the hospital to act consistently with its status as an institution that holds itself out as a provider of life saving medical care.<sup>182</sup> Thus, the hospital must "make a reasonable effort to monitor and oversee the treatment which is prescribed and administered by physicians practicing at the facility."<sup>183</sup>

*b. Vicarious Liability and Ostensible Agency*

An organization can potentially be responsible for the tortious actions of volunteers due to the principle of vicarious liability. Vicarious liability holds employers liable for the acts of their employees, "despite the fact that the employer itself may not have engaged in any negligent activities."<sup>184</sup> Since physicians are usually considered to be independent contractors, hospitals are protected from vicarious liability for their actions.<sup>185</sup> Yet courts have recognized the importance of giving plaintiffs recourse for their injuries and crafted the theory of ostensible agency.<sup>186</sup> Under this doctrine, applicable in some jurisdictions, "the 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."<sup>187</sup> The theory of ostensible agency particularly applies in the context of emergency medical treatment provided by health professionals

181. *Id.*

182. *Id.*

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

184. LEGAL AND REGULATORY ISSUES REPORT, *supra* note 10, at 51. Two theories—*respondeat superior* and ostensible agency—can create vicarious civil liability:

*Respondeat superior* presumes that an employer has control over and is therefore responsible for the acts of its employees. Typically, the extent of this civil liability depends on the level of control exerted by the employer over the actions of the employee. In most jurisdictions, the employer will only be liable for acts of the employee undertaken within the 'scope of employment.' Hospitals may be held liable for the acts of nurses, residents, interns, and certain behavioral health professionals under *respondeat superior*, since these health professionals are often considered employees.

*Id.*

185. *Id.*

186. *Id.*

187. *Simmons v. St. Clair Memorial Hospital*, 481 A.2d 870, 874 (Pa. Super. 1984). See also *Burless v. West Virginia University Hosp., Inc.*, 601 S.E.2d 85, 93 (W.Va. 2004); *Mejia v. Community Hospital of San Bernardino*, 122 Cal. Rptr. 2d 233, 236 (Cal. App. 4th Dist. 2002); *Petrovich v. Share Health Plan of Illinois, Inc.*, 719 N.E.2d 756, 765 (Ill. 1999); *Capan v. Divine Providence Hosp.*, 430 A.2d 647, 649 (Pa. Super. 1981).

within health care facilities.<sup>188</sup> Generally, when a patient enters the emergency room, he looks to the institution to provide him with medical care. The very nature of the need for emergency medical treatment places the hospital in a superior position of knowledge and power regarding the manner in which the care will be provided as well as the evaluation of the identity and qualifications of the health professionals providing medical care. In all likelihood, the patient will not be in a position to negotiate any of the aspects of their care under these circumstances. The patient is not expected to understand the nature of the employment relationship between the physician caring for him in the emergency department and the hospital. Thus, by the permitting the physician to practice in the emergency department, the hospital is holding the physician out as its agent.

The utilization of VHPs to increase surge capacity during an emergency implicates theories of vicarious civil liability.<sup>189</sup> Depending on the nature of the relationship between the host entity and the VHP and the manner in which the VHP is being utilized, the host entity may be exercising a supervisory role sufficient to expose them to vicarious liability for the VHP's actions. Such vicarious liability may also be grounded in the theory of ostensible agency.

### *c. Immunity and Indemnification of Health Care Entities*

While multiple statutes may provide immunity from civil liability for individual VHPs, "organizational entities do not typically qualify for immunity."<sup>190</sup> Immunity statutes (e.g., VPAs, Good Samaritan laws, and emergency provisions) rarely extend their protections to non-governmental organizational entities like hospitals or other health care organizations. Health care entities may be immunized via sovereign immunity if they are considered to be a government entity or government contractor (but only in jurisdictions that extend sovereign immunity to government contractors). Some states have legislated direct liability protections for entities utilizing

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188. See *Torrence v. Kusminsky*, 408 S.E.2d 684, 692 (W. Va. 1991) which holds: where a hospital makes emergency room 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.

*Id.* See also *Adamski v. Tacoma General Hospital*, 579 P.2d 970, 979 (Wash. App. 1978); *Mduba v. Benedictine Hospital*, 384 N.Y.S.2d 527, 529-30 (A.D. 1976).

189. FURROW, *supra* note 128, at 375-81.

190. LEGAL AND REGULATORY ISSUES REPORT, *supra* note 10, at 52.



volunteers. For example, Minnesota extends liability protections to organizations providing health care or related services during an emergency for good faith acts or omissions occurring while rendering emergency care, advice or assistance.<sup>191</sup> Some states may also indemnify health care entities that provide emergency assistance.<sup>192</sup> Health care organizations must carefully select, evaluate, and supervise the actions of employees and agents to minimize their risk of civil liability.<sup>193</sup>

### C. Ensuring Surge Capacity and Portability of Qualified Volunteer Health Professionals

Licensing, credentialing, and privileging standards form the backbone of the state-based system of professional regulation for health professionals. These standards, enacted ostensibly to ensure quality control in the health professions, often involve rigorous and time-consuming assessments of a practitioner's background, qualifications, and experience. Consequently, licensure laws and credentialing standards may complicate hospital staffing to meet surge capacity during an emergency, particularly if personnel from other states are needed.

State licensing requirements set minimum competencies and prerequisites for entry into each health profession, determining the scope of practice for each profession.<sup>194</sup> Credentialing and privileging "play a vital role in the ability of health care organizations and public health agencies to assess the qualifications and shape the practice of health professionals."<sup>195</sup> Hospitals

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191. Minn. Stat. § 12.61 (2005). These protections do not apply in cases of "malfeasance in office or willful or wanton actions." MINN. STAT. § 3.76 Subd. 9(iv) (LexisNexis 2005).

192. LEGAL AND REGULATORY ISSUES REPORT, *supra* note 10, at 52.

193. *Id.*

194. *Id.* at 30.

195. *Id.* at 57. There is a distinct difference between credentialing and privileging: Credentialing provides a framework for assuring that health professionals have certain skills and competencies. The credentialing process involves "obtaining, verifying, and assessing the qualifications of a health care practitioner to provide patient care, treatment, and services in or for a health care organization." Credentialing determinations utilize criteria such as the health professional's licensure, education, training, experience, and other qualifications. Hospitals and other health organization may engage in credentialing internally or accept credentialing determinations made by external organizations, such as credential verification organizations (CVO).

LEGAL AND REGULATORY ISSUES REPORT, *supra* note 10, at 37 (citing CAMH, *supra* note 174, at GL-5 - GL-6). Privileging processes, however, are integral to relationship between a physician (usually) and a health care organization. Clinical privileges differ

and other health care organizations are usually required by state law to develop credentialing and privileging procedures for health professionals.<sup>196</sup> These procedures can often be found in a hospital's medical staff bylaws<sup>197</sup> and can represent a significant barrier to the ability of VHPs to provide medical care at host facilities during emergencies. Even during emergencies, host facilities will be required to obtain some verification of the VHP's licensure and credentials prior to granting privileges to practice medicine at the facility.<sup>198</sup>

The advance registration model for volunteers proposed under ESAR-VHP seeks to address this problem by establishing an advance list of VHPs who meet the state's quality and professional standards; and by creating a system for the rapid evaluation of the volunteers' knowledge and capabilities.<sup>199</sup> This section examines how state laws and regulations that apply to licensing may impact the implementation and functioning of ESAR-VHP and efficient use of VHPs during emergencies.

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from credentials in that they are a form of "[a]uthorization granted by the appropriate authority (for example, the governing body) to a practitioner to provide specific care, treatment, and services in an organization with well defined limits, based on the following factors, as applicable: license, education, training, experience, competence, health status and judgment." CAMH, *supra* note 174, at GL-4. Thus, privileging allows a health care organization to evaluate a health professional's credentials and qualifications, and to grant permission for this professional to engage in a defined scope of practice at a specific health care organization (with or without supervision) based upon these qualifications. *See id.* at GL-19. Practitioners need clinical privileges so that the care, treatment, and services they provide while within an organization are authorized by that organization. LEGAL AND REGULATORY ISSUES REPORT, *supra* note 10, at 37. The health care entity may make privileging decisions based on its determination of the practitioner's credentials, experience, and performance, in accordance with its medical staff bylaws. *See e.g.*, WIS. ADMIN. CODE § HFS 124.12(4)(c) (2004). Hospitals will determine privileges "in accordance with their duty to provide for the safety and quality of care of their patients." LEGAL AND REGULATORY ISSUES REPORT, *supra* note 10, at 37; *see also* Mary E. O'Connor, *Medical Staff Appointment and Delineation of Pediatric Clinical Privileges in Hospitals*, 110 PEDIATRICS 414 (2002).

196. *See, e.g.*, MO. CODE REGS. tit. 19, § 30-20.021(2)(A)(13) – (19) (2004). Massachusetts, for example, has over four pages of specific regulations, promulgated by the Board of Registration in Medicine, setting forth what health care facilities must do before granting privileges to any doctor. *See* MASS. REGS. CODE tit. 243, § 3.05 (2005). Other health professionals, including nurses and behavioral health professionals, may also undergo credentialing, and in some cases, privileging depending on the location and local requirements.

197. *See, e.g.*, MO. CODE REGS. tit. 19, § 30-20.021(2)(A)(13) – (19) (2004).

198. *See* LEGAL AND REGULATORY ISSUES REPORT, *supra* note 10, at 40.

199. *Id.* at 30.

### 1. State Licensure Requirements

State licensure requirements dictate the nature, extent, and scope of practice for health professionals.<sup>200</sup> Licensure and/or professional certification is mandated in all states for virtually all health care professionals.<sup>201</sup> Despite current efforts to bring about national uniformity as to licensure qualifications, terminology, and procedural requirements, great variation still exists among states. Since one of the goals of ESAR-VHP is to facilitate interstate participation in emergency response efforts, variations in licensure requirements between states must inform efforts to conceptualize and implement the systems. The practical and legal challenges associated with the state to state variations in licensure requirements and terminology will affect ESAR-VHP policies and procedures for the evaluation and utilization of VHPs. "States' use of divergent terminology and scopes of practice may complicate the practical development of an interoperable and useful ESAR-VHP database. Inconsistency in state laws can also engender significant confusion about the appropriate scope of practice for licensed professionals volunteering across state lines."<sup>202</sup>

Additionally, within a state there may be different licensure requirements for health care practitioners with different levels of skill or who elect certain specialties. For example, medical residents and physicians must both be licensed to provide medical care, however their licenses differ in their scope. Similarly, there are typically three different categories of nurses: advanced practice nurses (APN), registered nurses (RN), and licensed practical nurses (LPN) (sometimes referred to as vocational nurses (VN)).<sup>203</sup> The scope of practice of each of these specializations is defined by state law and entails

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200. Licensure of health professionals is a core state function, since such licensure is one means to protect the public health and safety. State laws to protect public health and safety are authorized pursuant to the state's police powers. See LAWRENCE O. GOSTIN, PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT 47 (2000).

201. Some states require certification rather than licensure to practice within the state. To the extent that

certification is done by a state entity and required to practice in a certain area of medicine, it is akin to licensure. Certification which is carried out by private entities that govern professional practice applies across all states provided it is not tied to the ability to practice in a particular state. For example, if a physician is certified by the American Board of Emergency Medicine, his certification is an important element of his credentials and may be tied to privileging decisions, but may not relate to his state licensure status.

LEGAL AND REGULATORY ISSUES REPORT, *supra* note 10, at 32.

202. LEGAL AND REGULATORY ISSUES REPORT, *supra* note 10, at 31.

203. *Id.* at 33.

different licensure regulations.<sup>204</sup> Other health practitioners who may be instrumental in assisting in emergency response efforts, including pharmacists, physician assistants, paramedics, and mental health professionals, are subject to individual state licensing and certification requirements.

A physician or nurse with a valid, unrestricted state license may freely practice throughout that state, so long as their actions remain within their licensed scope of practice.<sup>205</sup> Health professionals who practice without a license or outside its scope are subject to criminal or civil penalties,<sup>206</sup> as well as disciplinary actions.<sup>207</sup> Licensing issues thus arise when a health professional desires to practice or volunteer in a state where she is not licensed or seeks to practice outside the scope of her license restrictions.

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204. APNs generally have the broadest scope of practice, including the power to prescribe certain medications, make diagnoses, and administer certain types of treatments, which consequently entails stricter licensing requirements in terms of educational requirements and experience. See PATRICIA A. POTTER & ANNE GRIFFIN PERRY, *FUNDAMENTALS OF NURSING*, at 392 (5th ed. 2001). Within advanced practical nursing, there are a number of sub-specialties, including nurse-midwives, nurse anesthetists, clinical nurse specialists, and nurse practitioners. See *id.* Registered nurses have a narrower scope of practice, which entails “assisting clients to attain or maintain optimal health, implementing a strategy of care to accomplish defined goals within the context of a client-centered health care plan, and evaluating responses to nursing care and treatment.” MODEL NURSE PRACTICE ACT (MNPA), Art. II. An LPN or VN generally has to work “under the supervision of a registered nurse in a hospital or community health clinic setting.” See POTTER & PERRY, *supra*, at 383. Given this narrower scope of practice, an LPN or VN “generally only receives one year of education and training in a hospital, community college, or other institutional setting.” *Id.*

205. LEGAL AND REGULATORY ISSUES REPORT, *supra* note 10, at 31.

206. See FURROW ET AL., *supra* note 129, at 66. In Illinois, for example, an individual who engages in the unauthorized practice of medicine may be fined up to \$5,000 for each offense. See 225 ILL. COMP. STAT. 60/3.5(a) (LexisNexis 2003). Missouri classifies the unauthorized practice of medicine as a class C felony, punishable by up to ten years imprisonment. See MO. REV. STAT. §§ 334.010, 334.250, 557.021(3)(1)(c) (2000). In Wisconsin, a physician may be fined up to \$25,000 or 9 months imprisonment or both for engaging in the unauthorized practice of medicine. See WIS. STAT. § 448.09(1m) (2005). Similarly, in Massachusetts, the unauthorized practice of nursing is punishable by a fine of up to \$500. See MASS. GEN. LAWS ch. 112, § 80 (2004).

207. See FURROW, *supra* note 128, at 75-91. Texas law provides that the practice of medicine without a license is a third degree felony, the conviction for which requires forfeiture of all medical rights and privileges conferred by medical licensure. See TEX. OCC. CODE § 165.152 (Vernon 2004).

## *2. License Reciprocity and Exceptions to Licensure Requirements During Public Health Emergencies and Disasters*

In emergencies, states may take several legal approaches to circumvent licensing requirements for medical professionals. As mentioned in Part III.A.1, some states provide waivers of professional licensure requirements during declared emergencies.<sup>208</sup> These jurisdictions enable professionals with a valid license in other specified states to volunteer without prior licensure in the host state. Such license reciprocity may be established by state statutes or regulations,<sup>209</sup> an executive order issued by the governor,<sup>210</sup> or legislatively-enacted interstate agreements, such as the EMAC and IEMAC.<sup>211</sup> These reciprocity provisions give VHPs the authority to practice as if they were licensed in the jurisdiction where they are volunteering for the duration of the emergency, although they are still subject to restrictions on the scope of practice set forth by the state or political subdivision.<sup>212</sup> Some states feature broader reciprocity provisions that are not tied to emergency declarations. For example, the Nurse Licensure Compact (NLC) creates extensive inter-state license reciprocity among party states.<sup>213</sup> Many

208. MSEHPA, *supra* note 75, at § 608(b). 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 (West 2001).

209. See MIMAL, *supra* note 153, at Art VI; MSEHPA, *supra* note 75, at § 608(b); CAL. BUS. & PROF. CODE § 900 (West 2003).

210. See, e.g., FLA. STAT. ANN. § 252.36 (West 2003).

211. EMAC, *supra* note 50, at Art. V. The International Emergency Management Assistance Compact (IEMAC) is an agreement between six New England states and five Canadian provinces. See IEMAC, *supra* note 50. See also Fox, *supra* note 50, at 77. Like EMAC, the agreement provides for licensure reciprocity for volunteer health professionals providing assistance as a part of a government emergency response. See IEMAC, *supra* note 50.

212. The Emergency Management Assistance Compact (EMAC) is an agreement between states that provides for mutual assistance in responding to and training for emergency situations. Currently, EMAC has been executed by forty-nine states, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands. Only Hawaii has not signed onto EMAC. The provisions of EMAC can only be activated in response to a government-declared emergency or the commencement of organized drills or training exercises. EMAC provides for reciprocity of licenses, certificates, and permits for individuals responding to an emergency when its protections have been activated, but this reciprocity is "subject to such limitations and conditions as the governor of the requesting state may prescribe by executive order or otherwise." EMAC, *supra* note 50, at Art. V.

213. The Nurse Licensure Compact (NLC) is an agreement entered into by twenty-one states that focuses on increasing cooperation and information exchanges between states regarding nursing licensure. NAT'L COUNCIL OF STATE BOARDS OF NURSING, NURSE LICENSURE COMPACT, available at [http://www.ncsbn.org/nlc/mlpvncompact\\_mutual\\_](http://www.ncsbn.org/nlc/mlpvncompact_mutual_)

states have extended waivers of licensure requirements to nurses and other health care practitioners by statute.<sup>214</sup> Furthermore, some jurisdictions have enacted provisions specifically allowing physicians holding licenses or permits from other states to provide care within the state in circumstances other than a declared emergency.<sup>215</sup>

Model emergency statutes such as MSEHPA, MIMAL, and the Model Nurse Practice Act (MNPA) suggest statutory language that authorizes license reciprocity for health professionals during a declared emergency. Many states have used these model acts to fashion their own emergency response laws.<sup>216</sup> MIMAL authorizes the sharing of emergency responders employed by a governmental entity across local jurisdictional lines within a state.<sup>217</sup> MNPA permits a nurse licensed in one state to engage in limited practice in another state during an emergency or disaster<sup>218</sup> or in other circumstances requiring interstate practice.<sup>219</sup> The NLC allows a nurse

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recognition\_nurse.asp [hereinafter NLC]. Under the NLC, one state's license to practice nursing will be recognized by all member states that authorize multi-state licenses. *Id.*, at Art. III(a). A nurse acting under the NLC must practice in accordance with the laws of the state where the patient is located and will be subject to the jurisdiction, licensing board, courts, and laws of that state. *Id.*, at Art. III(c).

214. West Virginia has adopted a provision permitting the unlicensed practice of nursing in emergency situations. *See* W. VA. CODE § 30-7-12(a) (2002). Massachusetts' Good Samaritan Law provides liability protection to health care practitioners who are licensed in Massachusetts, Canada or another state when they render emergency care outside the ordinary course of practice and without fee. *See* MASS. GEN. LAWS ch. 112, § 12B (2003).

215. For example, in Connecticut, a physician licensed in another state is permitted to practice medicine in Connecticut if they are acting within the scope of their employment with the U.S. government, if they are rendering temporary assistance to a physician licensed within the state, or if an individual within the state employs the out of state physician to treat condition that he is suffering from at the time of the employment CONN. GEN. STAT. § 20-9 (1999). Similarly, West Virginia permits an out of state physician to practice medicine for three months, on a one time only basis, if he is acting as a consultant for a physician licensed within the state. W. VA. CODE ANN. § 30-3-13(b)(2) (LexisNexis 2002).

216. MIMAL has been enacted by 22 states, including Connecticut, Illinois, Missouri, Ohio, and Texas. *See* MIMAL, *supra* note 153.

217. *Id.* at Art. VI.

218. MNPA, at Art. VII(d).

219. Additional bases for reciprocity include: "provid[ing] care to a client being transported into, out of, or through the state. . . provid[ing] professional consulting services. . . attend[ing] continuing nursing education programs . . . provid[ing] other short-term or non-clinical nursing services," and fulfilling other governmental duties. *Id.* at Arts. VII(g), (h). Several states, including Illinois, Minnesota, Missouri, and Ohio have adopted relevant provisions of the MNPA regarding license reciprocity in

licensed in a participating state to practice in any of the other participating states whether or not there is an emergency situation.<sup>220</sup>

#### *D. Compensation for Harms to Volunteer Health Professionals and Other Protections*

In addition to liability concerns, VHPs face risks of injury and job loss as a result of their volunteer work. VHPs may encounter a number of physical risks in the course of carrying out their duties, related to the nature of the emergency itself and the general physical and mental risks associated with providing medical care. For example, in the response to Hurricane Katrina many volunteers faced hazards related to exposure to toxic chemicals and human waste in the flood waters in New Orleans.<sup>221</sup> Likewise, many volunteer responders to the September 11 attacks on the World Trade Center were exposed to hazardous materials in the air following the collapse of the towers.<sup>222</sup> This section describes the legal provisions in place to protect or compensate VHPs if they are injured, disabled, or killed during an emergency response, including workers' compensation benefits and job protection provisions.

##### *1. Workers' Compensation Protections for Volunteers*

"Workers' compensation is a government administered system for providing limited benefits [to persons] for work-related injuries [or death], regardless of fault."<sup>223</sup> Employers are generally responsible if their employee

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emergency situations. See 225 ILL. COMP. STAT. 65/5-15 (West 2004 & Supp 2005); MINN. STAT. § 148.271(1) (West 2005); MO. REV. STAT. § 335-081(5) (West 2003); OHIO REV. CODE § 4723.32(f) (Anderson 2004). In Wisconsin, a nurse licensed in another state may obtain a waiver of the licensure requirements for a period of 72 hours to provide care to a person being transported through the state or to a resident of the nurse's home state, upon giving the State Board of Nursing seven days notice and a showing that the nurse's credentials are substantially similar to those required in Wisconsin. WIS. STAT. § 441.115(b), (c) (West 2005).

220. See generally NLC, *supra* note 213, at Art. III(a).

221. *Officials: Chemicals Bigger Concern than Cholera*, CNN.COM (Sept. 7, 2005), <http://www.cnn.com/2005/HEALTH/09/06/katrina.water/index.html>.

222. See generally, G.I. Banauch, et al., *Pulmonary Disease in Rescue Workers at the World Trade Center Site*, 11 CURRENT OPINION IN PULMONARY MED. 160 (2005).

223. James G. Hodge, *The Intersection of Federal Health Information Privacy and State Administrative Law: The Protection of Individual Health Data and Worker's Compensation*, 51 ADMIN. L. REV. 117, 119 (1999). Most states and the federal government have enacted workers' compensation laws, which require work-related

sustains an injury that arises out of or occurs in the course of employment.<sup>224</sup> The nature of the injury or death is inconsequential. All harms occurring at work to covered employees are subject to workers' compensation, including "occupational diseases" such as infectious diseases contracted by health care workers.<sup>225</sup> Workers' compensation benefits are critical because they are often the exclusive remedy for injured, disabled, or killed employees and their families.<sup>226</sup> Anyone, including VHPs, in the workplace may desire workers' compensation coverage, especially during emergencies when risks of harm may be heightened.

Application of workers' compensation benefits to VHPs, however, is complicated. Typically workers' compensation laws only cover "employees" and thus exclude unpaid volunteers or gratuitous workers. States may legislatively extend explicit coverage to certain volunteers, but the default is to exclude these workers from coverage. Even if a VHP is considered an employee, who is his employer during an emergency (e.g., his current employer, his temporary host entity through which he volunteers, the organizational entity that placed him as a volunteer, or state government in general)? Which state's laws (or federal law) will apply if the volunteer leaves her regular place of employment or crosses state lines to provide services? When does an occupational injury related to infectious disease or mass exposure to harm occur at work (thus implicating workers' compensation) as contrasted with the environment in which the VHP serves

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injuries to be reported and compensated in accordance with specific guidelines. See generally JACK B. HOOD, ET AL., *WORKERS' COMPENSATION AND EMPLOYEE PROTECTION LAWS IN A NUTSHELL* 13-14 (2d ed. 1990); W.R. SCHNEIDER, *THE LAW OF WORKMEN'S COMPENSATION* §3 (1941).

224. The "injured employees typically file claims for limited reimbursement for direct costs of medical treatment, lost wages, and resulting disabilities." 4 ARTHUR LARSON & LEX K. LARSON, *LARSON'S WORKERS' COMPENSATION LAW* §80.01 (2005).

225. See 1 ARTHUR LARSON & LEX K. LARSON, *LARSON'S WORKERS' COMPENSATION LAW* §12.01 (2005); HOOD, *supra* note 223, at 82-85.

226. Direct lawsuits against employers outside the workers' compensation system for work-related injuries are forbidden in most instances. 6 ARTHUR LARSON & LEX K. LARSON, *LARSON'S WORKERS' COMPENSATION LAW* §100.01 (2005). In most states:

employers cannot unilaterally settle workers' compensation claims with injured employees without the approval of state workers' compensation administrators. ... [In addition,] financial considerations necessitate such claims when injuries are significant. Other providers of health insurance, including private insurers, Medicaid and Medicare, and automobile personal injury insurers, [may] deny claims for medical charges where a workers' compensation carrier is principally liable for these costs. Lost wages for time off work due to injury are compensable only where a claim is filed. Disabilities can only be compensated through the filing of a [workers' compensation] claim.

HODGE, *supra* note 223, at 125.



(resulting in no benefits)? These and other questions are addressed in the sections below.

*a. Limits on Activities within Scope of Employment*

A threshold question is whether VHPs are considered covered “employees” under the applicable state statutes. Each state’s law defines who is considered an employee. These definitions center on obvious criteria: an employee is someone who the employer hires and compensates to provide services in the workplace. Employees do not include independent contractors or other persons in the workplace that do not have an employment agreement. They also do not typically include volunteers because they have not been “hired” for pay.<sup>227</sup> While payment does not have to be in the form of cash (e.g., discharge of debt, training, board, etc.) and while it does not need to go directly to the worker, some significant form of compensation for services must be provided by the employer for a person to be considered an employee.<sup>228</sup>

However, many states extend workers’ compensation coverage to some types of volunteer emergency responders. Wisconsin, for example, extends the definition of employee broadly to include all “emergency management workers” even if they are volunteers,<sup>229</sup> so long as they have registered with the state’s emergency management program.<sup>230</sup> Minnesota’s Emergency

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227. See 3 ARTHUR LARSON & LEX K. LARSON, *LARSON’S WORKERS’ COMPENSATION LAW* §65.01 (2005).

228. Courts have narrowly held that some emergency situations may create a presumption of employment through an implied contract. The rationale is that in an emergency there is not time to pursue ordinary channels of hiring, and the worker coming to aid the employer is advancing the employer’s interests, implicating an implied contract for hire. However, this limited reasoning may not apply when the volunteer registers her willingness to offer services in an emergency before the emergency situation arises. If the relationship is created prior to the emergency, arguably traditional channels of employment could be followed. Thus, the general proposition that volunteers are not employees for workers’ compensation purposes may stand unless statutory provisions provide otherwise. See, e.g., *Michaels Pipeline Const., Inc. v. Labor & Indus. Review Comm’n*, 541 N.W. 2d 241 (Wis. Ct. App. 1995).

229. WIS. STAT. ANN. §§ 102.07(7m), 166.03(8)(d), 166.215(4) (West 2004).

230. WIS. STAT. ANN. § 166.03(8)(d) (West 2004). Statutes in Connecticut, Illinois, and Ohio contain similarly broad provisions to include a range of volunteers responding to emergency situations within the definition of employee. See, e.g., CONN. GEN. STAT. ANN. §§ 28-1(e), 28-14(a) (West 2003); 20 ILL. COMP. STAT. 3305/10 (West 2001); OHIO REV. CODE ANN. §§ 4123.01 (LexisNexis 2001). These volunteers are usually coordinated in established state programs for “civil preparedness” or “emergency management.” Their injuries would be covered whether they occurred in training

Management Act provides that volunteers are considered employees of the government subdivision to which they are providing assistance for purposes of determining workers' compensation coverage.<sup>231</sup> Minnesota volunteers must be registered with a specific government entity providing assistance in the emergency response in order to be entitled to workers compensation coverage.<sup>232</sup> Within the Gulf Coast Region, Alabama extends workers' compensation coverage to emergency management volunteers.<sup>233</sup> Mississippi and Louisiana provide coverage for state personnel participating in emergency management activities.<sup>234</sup> Although these provisions do not extend to volunteers, the state may opt to provide coverage to volunteers through services agreements which give volunteers state employee status for the period of their service.<sup>235</sup>

In other states, volunteer health professionals may be excluded from coverage under a narrow statutory approach. For example, West Virginia extends coverage to volunteers that further its Emergency Medical Services Act, but employer coverage is permissive, rather than mandatory.<sup>236</sup> Similarly, Texas provides medical benefits, but not lost wages or disability benefits, for injuries sustained by volunteers responding to state disasters that are not otherwise covered by workers' compensation benefits in the

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exercises, preparation, or emergency responses. These volunteers usually have to meet certain requirements to be considered covered, such as the requirement for registration and oath of loyalty in Ohio and Illinois. *See* OHIO REV. CODE ANN. § 4123.036 (2005); 20 ILL. COMP. STAT. 3305/10 (2005).

231. MINN. STAT. § 176.011, Subd. 17 (West 2003).

232. Volunteers are afforded workers' compensation coverage for personal injuries arising out of or experienced in the course of performing their volunteer duties. Covered injuries are those which occur while the volunteer was engaged in, on, or about the premises of the host hospital, and during the hours when the volunteer was providing medical services in accordance with the government's request for medical assistance. MINN. STAT. § 176.011, Subd. 17 (2004). Injuries which have a direct causal connection with the work environment are compensable. An injury is considered to be directly related to the work environment when it is associated with a hazard or risk connected with the employment or flows directly from an exposure occasioned by the nature of the work. This includes injuries sustained while traveling to and from work. *See* Johannsen v. Acton Const. Co., 119 N.W.2d 826, 829 (Minn. 1963).

233. *See* ALA. CODE §§ 31-9-21, 31-9-16 (Michie 2005).

234. *See* LA. REV. STAT. ANN. § 29:735(b) (West Supp. 2005); MISS. CODE ANN. § 33-15-15 (West 2005).

235. *See generally* Memorandum from the Center for Law & the Public's Health at Georgetown and Johns Hopkins universities, Incorporation of Local Assets into a State Emergency Management Assistance Compact (EMAC) Response (Sept. 7, 2005), available at <http://www.publichealthlaw.net/Research/PDF/Katrina%20-%20Local%20Assets%20and%20EMAC.pdf>.

236. W. VA. CODE § 23-2-1 (LexisNexis Supp. 2005).

volunteer's host state.<sup>237</sup> Other jurisdictions lack statutory provisions to extend workers compensation coverage to volunteers of any sort.<sup>238</sup>

In addition, unlike other types of employees, the "employee" status of VHPs may not apply across state lines, because state laws differ on the employee status of VHPs. Unless volunteers stay within the state in which they are registered and that state explicitly covers such volunteers as employees, VHPs may lack workers' compensation coverage, exposing them to potential significant uncompensated harms.

### *b. Coverage Issues Related to Existing Employment*

Generally, VHPs will not be able to look to their existing employers for workers' compensation coverage for injuries sustained while performing volunteer duties for another entity. The existing employer is not liable for injuries that its employees sustain while volunteering services elsewhere if the employee's action is outside the course of employment. To determine when the actions of a VHP are outside her course of employment, courts will often look to whether the action is undertaken to advance the employer's interests. It is unlikely that the act of volunteering to provide health services in a setting outside the usual place of employment (different hospital, different municipality or state) would be construed as advancing the existing employer's interests. Public service activities are not typically considered to be in the course of employment.<sup>239</sup> Conversely, if the employer itself directed the employee to become a VHP or if the activities were conducted at the home employer's premises, the employee's actions would likely be found to be within the course of employment because of the direct benefits to the employer.

### *c. Coverage Issues Related to Temporary Volunteer Status*

As discussed in the previous section, the existing "home" employer is not typically liable for injuries or death sustained by a VHP providing services in a different setting. What about the "host" employer? Assuming the VHP is considered an employee under state law, questions arise as to which entity

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237. TEX. LAB. CODE ANN. § 501.026 (West 2003).

238. Missouri specifically excludes from workers' compensation all volunteers for non-profit organizations. Massachusetts excludes certified Red Cross volunteers who take time off to respond to disasters. See MO. REV. STAT. § 287.090 (West 2005); MASS. GEN. LAWS ANN. ch. 30, § 9I (West 2005). The District of Columbia lacks any provision for volunteers, so the default standard that unpaid volunteers are not employees will likely apply. See LEGAL AND REGULATORY ISSUES REPORT, *supra* note 10, at 57.

239. LEGAL AND REGULATORY ISSUES REPORT, *supra* note 10, at 58.

(the health care entity hosting the VHP, state or local government, or others) could be liable for these injuries. Some jurisdictions consider volunteer emergency management workers as employees of the applicable governmental subdivision—state, county, or municipality—that organizes the emergency response program.<sup>240</sup> Other states do not extend workers' compensation protections to volunteers unless they are already state employees.<sup>241</sup> In the event that a statute defines VHPs as employees, but does not define the state or municipality as the employer, the health care entity in which the VHPs are temporarily working may be found to be their employer for workers' compensation purposes.<sup>242</sup> VHPs who render medical services for which other health professionals are ordinarily paid could be deemed employees of their host institution. These issues will likely be resolved through the application of law in the state in which the VHP volunteers.<sup>243</sup>

#### *d. Coverage Issues for Occupational Diseases*

Usually included within workers' compensation coverage are harms to workers who contract occupational diseases.<sup>244</sup> The degree of coverage for these conditions is of particular concern for VHPs responding to public health emergencies that may involve the mass spread of infectious conditions or potential exposure to dangerous chemicals or other contaminants. Definitions of occupational disease and breadth of coverage vary across states. In the broadest sense, occupational diseases are diseases contracted in the course of and resulting from employment. However, to receive compensation, most states also require (1) the employment involve peculiar or unusual risks of the disease—beyond that of the general population; and (2) the disease must be attributable to a contact that occurred

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240. See e.g., WIS. STAT. ANN. § 166.03(8)(d) (West 1997); OHIO REV. CODE ANN. § 4123.032 (2001); 20 ILL. COMP. STAT. ANN. 3305/10 (West 2001); W. VA. CODE ANN. § 23-1-1 (LexisNexis Supp. 2005).

241. In contrast, Texas does not classify volunteers for state disasters as employees and does not extend the full range of workers' compensation benefits to these volunteers unless the worker is already an employee of a state political subdivision. See TEX. LAB. CODE ANN. § 501.026 (West 2003).

242. For example, VHPs may enjoy protections similar to volunteer firefighters. Some states, through statute or judicial interpretation, find that volunteer firefighters "partake sufficiently of the characteristics of an employee to be covered" as though they were paid employees of the fire company. LEGAL AND REGULATORY ISSUES REPORT, *supra* note 10, at 59; 4 ARTHUR LARSON & LEX K. LARSON, §78.04(3) (2005).

243. LEGAL AND REGULATORY ISSUES REPORT, *supra* note 10, at 59.

244. *Id.*

on the job.<sup>245</sup> Minnesota provides coverage for diseases arising out of the course of employment but specifically excludes coverage for ordinary diseases of life which are not the result of an occupational hazard.<sup>246</sup> Ultimately, there must be a direct and proximate causal connection between the disease and the work related hazards in order to give rise to coverage.<sup>247</sup> As a practical matter, during a disease outbreak or bioterrorist attack, it may be difficult for a VHP to prove that the disease was, in fact, contracted in the course of employment if many individuals in the general population were also susceptible to the disease or condition. The burden of proof to demonstrate that exposure on the job was the proximate cause of the disease generally falls on the worker.<sup>248</sup>

## 2. Right to Reemployment

In emergency situations, a VHP may be called away from his employment to respond for weeks, perhaps even months. He may be concerned that his employment or privileging statuses are not secure. Federal and state governments have enacted laws that provide reemployment protection to

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245. *Id.*

246. Minnesota law defines an occupational disease as:

a disease arising out of and in the course of employment peculiar to the occupation in which the employee is engaged and due to causes in excess of the hazards ordinary of employment and shall include undulant fever. Ordinary diseases of life to which the general public is equally exposed outside of employment are not compensable, except where the diseases follow as an incident of an occupational disease, or where the exposure peculiar to the occupation makes the disease an occupational disease hazard. A disease arises out of the employment only if there be a direct causal connection between the conditions under which the work is performed and if the occupational disease follows as a natural incident of the work as a result of the exposure occasioned by the nature of the employment. An employer is not liable for compensation for any occupational disease which cannot be traced to the employment as a direct and proximate cause and is not recognized as a hazard characteristic of and peculiar to the trade, occupation, process, or employment or which results from a hazard to which the worker would have been equally exposed outside of the employment.

MINN. STAT. ANN. § 176.011 (West Supp. 2005).

247. *See id.*; *also* Gray v. City of St. Paul, 84 N.W.2d 606, 611 (Minn. 1957) (holding that “[a]n occupational disease must be . . . a natural incident of particular occupation, and must attach to that occupation a hazard which distinguishes it from usual run of occupations and which is in excess of that attending employment in general.”).

248. LARSON & LARSON, *supra* note 227, at §52.03(2).

individuals providing emergency response services.<sup>249</sup> Pursuant to the Uniformed Services Employment and Reemployment Rights Act (USERRA), for example, all uniformed service personnel employees who are required to leave their employment due to military obligations enjoy broad rights to reemployment.<sup>250</sup> USERRA provides reemployment protection to non-career members of the uniformed services, such as members of the National Guard, who are called up for duty.<sup>251</sup> Volunteers are generally entitled to reemployment upon the termination of their uniformed service unless doing so “would impose an undue hardship on the employer” or the “employer’s circumstances have changed so much as to make reemployment impossible or unreasonable.”<sup>252</sup> USERRA also provides for protection from termination after the volunteer returns to work, based on the employee’s length of military service,<sup>253</sup> and protects an employee’s seniority rights and benefits during the employee’s absence.<sup>254</sup>

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249. 44 C.F.R. § 206.43 (2004). For example, individuals who are members of federal governmental emergency response teams, such as a Disaster Management Assistance Team or Disaster Assistance and Response Team composed of civilian medical personnel, are given job, seniority, and wage protection in accordance with federal law when they are deployed for disaster response. *Id.* See also WIS. STAT. ANN. § 21.80 (West Supp. 2004).

250. 38 U.S.C. § 4312(a) (2002); “Uniformed service” personnel includes members of the “Armed Forces, the Army National Guard and the Air National Guard..., the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.” 38 U.S.C. § 4302 (2002).

251. 38 U.S.C. 4312 (2002). To take advantage of the protections provided by USERRA, an employee must give his employer proper written or verbal notice prior to taking a leave of absence for uniformed service. *Id.* Generally, USERRA will preempt state law, unless state law provides greater protections to non-career members of the National Guard or Reserves. 38 U.S.C. § 4302 (2002).

252. 38 U.S.C. § 4312(d) (2002).

253. An employee must comply with notification requirements before being entitled to reemployment. 38 U.S.C. § 4312(a)(3) (2002). If the employee’s uniformed service is for less than 31 days, the employee must report to the employer immediately upon return from service in order to qualify for reemployment rights. 38 U.S.C. § 4312(e)(1)(A) (2002). If the employee’s service is for 31 to 180 days, the employee must ordinarily apply to his employer for reemployment within 14 days of the completion of uniformed service. A period of service of more than 180 days requires the employee to submit an application for reemployment within 90 days of the completion of service. 38 U.S.C. § 4312(e)(1)(B) (2002). Failure to meet notification requirements submits the employee to the employer’s policies and procedures for absence from work; the employee does not automatically forfeit right to return to former employment. 38 U.S.C. § 4312(e)(3) (2000). When the employee’s period of service is for more than 180 days, his employer may not terminate him for at least one year following his return from service, except for

Some states also have offered limited employment protections for practitioners responding to a public health emergency. Wisconsin, for example, has enacted a statutory scheme to provide job protection to individuals called up for active service with the National Guard or with the State Laboratory of Hygiene.<sup>255</sup> Protection for active service with the State Laboratory of Hygiene applies to service provided to the Department of Health and Family Services during a public health emergency.<sup>256</sup> Wisconsin requires employers to “promptly” reemploy individuals called up for active service for a period of less than 91 days in the same position they had held before going on leave.<sup>257</sup> States may also feature Disaster Service Volunteer Leave Acts, which provide job protection for short periods to encourage individuals to participate in response efforts. Unless otherwise stated, the scope of these statutes is usually limited to a short period of service and applies only to employees of state agencies who are also volunteers with the American Red Cross.<sup>258</sup>

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cause. 38 U.S.C. § 4316(c) (2002). If the employee’s period of service was between 30 and 181 days, the employee may not be discharged for at least 180 days upon his return from work. *Id.*

254. 38 U.S.C. § 4316 (2002). For employees absent less than 91 days, USSERA anticipates that some employees may have missed advancement opportunities during their absences, and it includes such seniority rights as the right to be reemployed in the position that the employee would have held had the employee not left employment, so long as the employee is “qualified to perform” in the position. 38 U.S.C. § 4313 (2002). Otherwise, the employee must be reemployed in the same position that he held before leaving for service. *Id.*

255. WIS. STAT. ANN. § 21.80 (West Supp. 2004).

256. WIS. STAT. ANN. § 21.80(1)(a)(2) (West Supp. 2004).

257. WIS. STAT. ANN. § 21.80(4)(a)(1) (West Supp. 2004). Wisconsin also anticipated that some employees may miss potential advancement opportunities during active service, and it requires employers to reemploy individuals in the position they would have occupied, had the leave never occurred; the employee might also be put in a “position of employment of like seniority, status and pay so long as the person is qualified to perform the duties of that position. WIS. STAT. ANN. § 21.80(4)(a)(2) (West Supp. 2004). Additionally, employers are required to provide health benefits for the first eighteen months of service. WIS. STAT. ANN. § 21.80(6) (West Supp. 2004).

258. *See, e.g.* ALA.CODE § 36-1-9 (West 2005); ARK. CODE ANN. §12-85-102 (West 2003); GA. CODE ANN., § 38-3-91 (West 2005); N.C.GEN. STAT. ANN. Ch. 166A-30 (West 2003). Illinois’ Disaster Service Volunteer Leave Act extends protections to “certified disaster service volunteer of the American Red Cross or assigned to the Illinois Emergency Management Agency in accordance with the Illinois Emergency Management Agency Act, the Emergency Management Assistance Compact Act, or other applicable administrative rules.” 5 ILL. COMP. STAT. ANN. 335/3 (West 2005).

*E. Privacy of Volunteer and Health Information*

Planning, preventing, and responding to a potential or actual emergency event requires coordination and information sharing among public health and environmental authorities, law enforcement and national security officials, private sector health care workers and hospitals, medical suppliers, pharmacists, and the media. They and others must be able to effectively communicate and exchange an array of vital information about potential or existing threats or agents of bioterrorism and the manifestation and spread of a disease, condition, or bioagent among human populations. A large subset of this information is health data, including data about the specific health status of identifiable individuals or known groups (e.g., families, assemblies, employees, or persons within defined geographic boundaries). In many cases, individually-identifiable health information must be shared, especially among health care workers, VHPs, and public health authorities. Health care professionals need identifiable data to provide clinical, therapeutic, or pharmaceutical care, as well as to avoid potential exposures to infectious agents when universal protections may be inadequate. Public health authorities need identifiable data to protect the public's health through epidemiologic or environmental investigations, surveillance, laboratory testing, and other tools.

In public health emergencies options for exchanging non-identifiable data may be limited, or there may be little time to remove identifiers from data. The use of non-identifiable health data may also lead to inaccuracies or duplications that may thwart prevention or response efforts. Amidst strong justifications and practical realities favoring the exchange of identifiable health data arise implications of health information privacy laws and policies, as discussed below.

*1. Health Insurance Portability and Accountability Act (HIPAA) of 1996*

Pursuant to the Health Insurance Portability and Accountability Act (HIPAA) of 1996,<sup>259</sup> the Department of Health and Human Services (DHHS) developed a detailed, national standard for health information privacy protections.<sup>260</sup> Known as the HIPAA Privacy Rule, these regulations

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259. Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-191, 110 Stat. 1936 (codified as amended at 42 U.S.C. § 210 (2000)).

260. *HIPAA Privacy Rule and Public Health: Guidance from the Centers for Disease Control and the Department of Health and Human Services*, MORBIDITY & MORTALITY WKLY. REP., Apr. 11, 2003, at 1. See also James G. Hodge, *Health Information Privacy and Public Health*, 31 J. L. MED. & ETHICS 670, 670 (2004) [hereinafter *Health*



provide comprehensive privacy protections of identifiable health data for most individuals seeking health care or health insurance in the United States.<sup>261</sup> Although the Rule limits access to and disclosures of health data, it also allows disclosures without individual authorization for limited purposes such as treatment, public health, and national security.<sup>262</sup> Collectively, these provisions allow for many exchanges of identifiable health data to prevent or respond to a bioterrorism or other emergency event without infringing individual privacy.

Congress expressly limited the application of the HIPAA Privacy Rule to “covered entities”<sup>263</sup> or anyone who conducts “functions” as part of the provision or payment for these services.<sup>264</sup> The Rule protects most individually-identifiable health information, also called protected health information (PHI), created or received in any form by covered entities, including electronic and paper records.<sup>265</sup> Covered entities are responsible

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*Information Privacy and Public Health*]; Lawrence O. Gostin, *Health Information Privacy*, 80 CORNELL L. REV. 451 (1995).

261. 45 C.F.R. § 160.203 (2004). As a federal regulatory standard, the HIPAA Privacy Rule serves as a federal floor of protections for protected health information (PHI). It thus preempts contrary state or local laws (e.g., state laws that provide less privacy protections or interfere with Privacy Rule requirements). *Id.* However, the Rule does not preempt state or local health information privacy laws that offer more stringent protections. State or local laws that are more protective of health information privacy rights than the Rule remain in effect. *Id.* In addition, state public health laws that provide for the disclosure of PHI for public health purposes or govern the privacy and confidentiality of public health information are not affected by the HIPAA Privacy Rule. *Id.* Specifically, the Rule leaves intact public health laws that provide for “the reporting of disease or injury, child abuse, birth, or death, or for the conduct of public health surveillance, investigation, or intervention.” 45 C.F.R. § 160.203(c) (2004).

262. See James G. Hodge et al., *The HIPAA Privacy Rule and Bioterrorism Planning, Prevention and Response*, 2 BIOSECURITY & BIOTERRORISM 73, 74 (2004).

263. 45 C.F.R. § 160.103 (2004). DHHS also carried forward the application of the HIPAA Privacy Rule to covered entities’ business associates (e.g., claims processors, billing managers, data analyzers, and others). *Id.*

264. 45 C.F.R. § 160.501 (2004). Covered functions are functions that assimilate the provision of health care or insurance services. Others who acquire, use, disclose, or store PHI such as employers; auto, life, and worker compensation insurers; and social welfare agencies are not directly covered by the Rule. See MORBIDITY & MORTALITY WKLY. REP., *supra* note 260.

265. 45 C.F.R. § 164.501 (2004); “Protected health information” (PHI) includes individually-identifiable data that relate to the past, present, or future physical or mental health condition of a person, the provision of health care to a person, or the payment for health care services. *Id.* PHI does not include non-identifiable health information or “de-identified data.” 45 C.F.R. § 164.514(a) (2004). Non-identifiable health information is any collection of “health information that does not identify an individual and with respect

for establishing and adhering to various privacy protections related to PHI. These include:

Notifying individuals regarding their privacy rights and how their PHI is used or disclosed;<sup>266</sup>

Adopting and implementing internal privacy policies and procedures, including accounting requirements for many disclosures;<sup>267</sup>

Training employees to understand privacy policies and procedures;<sup>268</sup>

Designating persons who are internally responsible for implementing privacy policies and procedures;<sup>269</sup>

Establishing “appropriate administrative, technical, and physical safeguards to protect the privacy of [PHI];<sup>270</sup> and

Assisting health consumers in exercising their rights to inspect and request corrections or amendments to their PHI.<sup>271</sup>

Although subject to a series of exceptions, in general, a covered entity may not disclose PHI without individual written authorization.<sup>272</sup> A covered entity *must* disclose PHI regardless of patient authorization when (1) an individual requests a copy or accounting of their PHI, or (2) DHHS needs access to PHI to facilitate a compliance investigation under the HIPAA Privacy Rule.<sup>273</sup> Covered entities *may* disclose PHI without individual authorization to other entities “for treatment, payment, and health care operations purposes,”<sup>274</sup> or to locate and notify family members or close personal friends “of the individual’s location, general condition, or death.”<sup>275</sup>

Prior to the declaration of an emergency, the Privacy Rule allows covered entities to use or disclose PHI without individual authorization to avert “a

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to which there is no reasonable basis to believe that the information can be used to identify an individual.” *Id.* De-identified data is required to be stripped of unique identifiers, including names, or certified by a qualified statistician as incapable of identifying an individual. 45 C.F.R. § 164.514(b) (2004).

266. 45 C.F.R. § 164.520 (2004).

267. 45 C.F.R. §§ 164.528(a), 164.530(i) (2004).

268. 45 C.F.R. § 164.530(b)(1) (2004).

269. 45 C.F.R. § 164.530(a)(1)(i) (2004).

270. 45 C.F.R. § 164.530(c)(1) (2004).

271. 45 C.F.R. §§ 164.524, 164.526 (2004).

272. 45 C.F.R. §§ 164.508(a), 164.508(b)(6) (2004).

273. 45 C.F.R. § 164.502(a)(2) (2004).

274. 45 C.F.R. § 164.506 (2004).

275. 45 C.F.R. § 164.510(b)(1)-(3) (2004).

serious . . . threat to the health or safety of a person or the public.”<sup>276</sup> In such cases, PHI may be disclosed to a person who is reasonably able to abate the threat.<sup>277</sup> When covered entities disclose PHI to avert what is believed to be an imminent threat, the Privacy Rule dictates that the covered entities are “presumed to have acted in good faith.”<sup>278</sup> This exception could apply when a health care provider or other covered entity identifies an unexplained disease outbreak suspected to be the result of a bioterrorist attack. By providing public officials with information about infected individuals, health care providers could assist in controlling an outbreak and preventing further infection. Public health authorities may use this information to locate and quarantine or isolate infected individuals, in addition to tracking the infection and locating its source.

Assuming that VHPs are covered entities, must they be wary of health information privacy concerns related to their internal exchanges of PHI about their patients? In most cases, no. The HIPAA Privacy Rule permits the flow of this information among health care providers when necessary for appropriate treatment.<sup>279</sup> Covered entities may thus exchange PHI without individual authorization for treatment or payment activities in preparation for and during public health emergencies.<sup>280</sup> The Rule also allows covered entities to disclose PHI without individual authorization in multiple ways to protect the public’s health, including (1) disclosures to public health or other authorities when required by law;<sup>281</sup> (2) permissive disclosures to public health authorities when requested;<sup>282</sup> (3) disclosures to notify individuals “who may have been exposed to a communicable disease” or who might be at risk to contract or spread a disease (e.g., partner notification provision) when authorized by law for public health purposes;<sup>283</sup> and (4) disclosures to a “public or private entity authorized by law or by its charter to assist in disaster relief efforts,” although the individual with capacity to make health care decisions must be given the right to object if it would not “interfere with the ability to respond to the emergency circumstances.”<sup>284</sup> By allowing disclosures of PHI to public health authorities without individual written

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276. 45 C.F.R. § 164.512(j) (2004); see DEP’T OF HEALTH AND HUMAN SERVS. OFFICE FOR CIVIL RIGHTS, HURRICANE KATRINA BULLETIN: HIPAA PRIVACY AND DISCLOSURES IN EMERGENCY SITUATIONS 2 (Sept. 2, 2005), available at <http://www.hhs.gov/ocr/hipaa/KATRINAnHIPAA.pdf>.

277. *Id.*

278. 45 C.F.R. § 164.512(j)(4) (2004).

279. See Hodge, *supra* note 262, at 76-77.

280. 45 C.F.R. § 164.506(b)-(c) (2004).

281. 45 C.F.R. § 164.512(a) (2004).

282. 45 C.F.R. § 164.512(b) (2004).

283. 45 C.F.R. § 164.512(b)(1)(iv) (2004).

284. 45 C.F.R. § 164.510(b)(4) (2004).

authorization during emergencies, the Rule seeks to maximize the flow of essential health data for public health purposes.

## *2. Acquisition of Identifiable Health Data About VHPs within a State Administered Volunteer Registry*

ESAR-VHP registries require the acquisition of a great deal of identifiable data regarding individual volunteers, including specific health data concerning a particular volunteer's medical condition. System users may need to know about a volunteer's potential medical susceptibilities, drug allergies, vaccination records, or other conditions. The collection and storage of these types of data regarding volunteers may raise privacy concerns for VHPs. These concerns, however, are not addressed by the Privacy Rule. The systematic collection of data, such as identifiable health data about potential volunteers, by a state health authority for a defined public health purpose, such as to provide an advance system of registered volunteers for emergency purposes, is outside the reach of the Privacy Rule. This is not to say that the privacy of this data will be unprotected. Other privacy laws, specifically state statutory equivalents of the federal Privacy Rule or public health privacy provisions, may protect the confidentiality of health data contained within the system, although these laws vary extensively among states. Furthermore, an individual volunteer may provide her informed consent for the acquisition and use of her identifiable health data within the system, thus satisfying statutory or other legal privacy protections and providing the volunteer advance notice of the ways her data may be used.

## *F. Fulfilling a Duty to Care: The Emergency Medical Treatment and Labor Act*

The need to meet surge capacity during a public health emergency raises the issue of whether a hospital has an obligation to treat every one of these patients. Recognizing the community interest in access to medical care, the Emergency Medical Treatment and Labor Act (EMTALA) operates as a type of anti-discrimination statute regarding the provision of emergency medical care.<sup>285</sup> EMTALA prevents hospitals from turning patients away

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285. See *Miller v. Med. Ctr. of Sw. La.*, 22 F.3d 626, 628, n. 4 (5th Cir. 1994); *Burditt v. U.S. Dep't of Health and Human Services*, 934 F.2d 1362, 1366 (5th Cir. 1991). While differentiating between hospitals may be necessary in the course of the emergency response efforts, EMTALA does not contain any provisions for local officials to make exceptions to its provisions in the case of declared emergencies. Thus, even hospitals that are affected by the emergency itself, as in the case of structural damage resulting

based on their ability to pay<sup>286</sup> or based upon the type of care they need. Its protections arise when an individual comes to the emergency room for care.<sup>287</sup> Specifically, hospitals are first required to determine whether the presenting patients have an emergency medical condition; then they are required to provide treatment to stabilize the patient's medical condition.<sup>288</sup> Assuming that hospitals are required to provide medical care to all patients who present during emergencies, EMTALA establishes a minimum standard of care for every patient who enters a hospital's emergency department.<sup>289</sup> This may necessitate the utilization of VHPs to allow a hospital to fulfill its statutory duty to provide patients with quality emergency care.

Though broad, EMTALA's mandate is not unlimited. Hospitals are only required to screen and stabilize patients "within the capability of [their] emergency department."<sup>290</sup> Courts have yet to interpret whether hospitals are required to increase surge capacity during an emergency to treat and screen all patients who present for care. A strict statutory construction may not impose a duty upon hospitals to recruit additional staff to meet the increasing demand for emergency care during a public health emergency. However, under state law, hospitals may have an additional statutory duty to provide emergency care.<sup>291</sup> Fulfilling this duty may include recruiting additional volunteer medical staff to increase surge capacity. Additionally, the corporate negligence doctrine may impose a duty on hospitals to provide

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from an earthquake or radiation exposure from a dirty bomb attack, will be required to screen and stabilize all patients presenting for emergency care. See James D. Bentley, *Hospital Preparedness for Bioterrorism*, 116 PUB. HEALTH REP. Supp. 2, 36, 38 (2001).

286. Michael S. Shin, *Redressing Wounds: Finding a Legal Framework to Remedy Racial Disparities in Medical Care*, 90 CAL. L. REV. 2047, 2080 (2002).

287. 42 U.S.C. § 1395dd(a) (2000). Courts have interpreted this element broadly to include physical presence at the hospital and transport to the hospital in non-hospital-owned ambulances. *Compare* Arrington v. Wong, 237 F.3d 1066, 1072 (9th Cir. 2001) (holding that a hospital was required to provide emergency treatment to a patient traveling to the hospital in a non-hospital-owned ambulance, when the hospital was not on diversionary status), *with* 42 C.F.R. § 489.24(b) (2004) (discussing hospital-owned ambulances).

288. 42 U.S.C. § 1395dd (2000). Emergency medical conditions are defined in the statute as those which manifest with acute severe symptoms, including pain, which may result in a threat to the patient's health, serious bodily impairment, or death. 42 U.S.C. § 1395dd(e)(1)(A) (2000).

289. See *Kilroy v. Star Valley Med. Ctr.*, 237 F. Supp. 2d 1298, 1303 (D. Wyo. 2002) (finding that EMTALA is not intended to ensure that every patient receives the correct diagnosis, but rather to ensure that every patient is given the same level of medical treatment as is provided to other patients in similar circumstances).

290. 42 U.S.C. § 1395dd(a) (2000).

291. See, e.g., 210 ILL. COMP. STAT. 80/1 (2004); 28 PA. CODE § 117.1 (2005); 25 TEX. ADMIN. CODE 133.41(e) (2005).

quality medical care to the community, giving rise to a broad interpretation of the hospital's statutory duty to provide emergency care.<sup>292</sup>

#### IV. ENHANCED LEGAL PROTECTIONS FOR VHPs AND THEIR HOSTS

The existing legal framework underlying the registration, deployment, and use of VHPs during emergencies is complex, inconsistent, and at times ambiguous. Lacking legal clarity and assurances, volunteers, host entities, and governments must venture cautiously, speculating as to their potential risks, liability, and protections. Such guesswork may lead to significant gaps in VHP availability and willingness to participate in times of emergencies, potentially leaving patients and others without adequate treatment or access to public health services. This Part discusses a series of recommendations to transform and improve the legal landscape. Each of these recommendations is made with the intent of optimizing the deployment, use, and participation of VHPs while balancing legitimate trade-offs based on the needs and limits of government, employers, and volunteers themselves.

##### *A. Enacting Comprehensive Emergency Powers and Protection Laws*

Comprehensive emergency management laws underlie the authorization and use of VHPs during emergencies. In addition to providing for the declaration of an emergency, these laws can further the implementation of state emergency response plans that fully utilize VHPs to bolster surge capacity and fill many vital roles in the health responder workforce. Emergency powers laws govern the conditions in which volunteers can be used, authorize the use and administration of ESAR-VHP registries,<sup>293</sup> and offer, in some cases, comprehensive legal protections for volunteers, including reciprocity for licensure and certification, immunity from civil liability, and workers' compensation protections. However, in many states, these protections are neither uniform nor cohesive.<sup>294</sup> Integrating these protections in a single statutory source governing the use of volunteers in any emergency setting may clarify legal protections in an unambiguous and contiguous format. States should consider adoption of comprehensive emergency powers and protection laws like the MSEHPA to improve overall

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292. See *supra* Section III.B.2.a.

293. Oregon's emergency declaration law provides for a registry of emergency health care providers and sets forth the circumstances under which the registry can be activated. OR. REV. STAT. § 401.654 (2003).

294. See *supra* Section III.A.

emergency preparedness and encourage the participation of VHPs in emergency response efforts.

### *B. Creating a Floor of Minimum Standards*

Although cohesive emergency protections for VHPs at the state level may greatly facilitate intra-state responses, many emergencies, particularly public health emergencies like Hurricane Katrina, will extend across multiple state boundaries. To ensure comparable interjurisdictional emergency responses, a basic floor of national legal protections is needed. Federal regulations encouraging minimum standards for cross-border licensure reciprocity and civil liability protections for all volunteers may further interjurisdictional emergency responses. While creating national protections through federal laws or use of resources may be desired, other non-federal options exist. For example, states could extend EMAC beyond government employees to waive licensure requirements and expand liability protections for non-governmental VHPs participating in emergency response efforts.

The current framework of legal protections for volunteers and their hosts contains great variation in the legal protections available amongst the states. The response to Hurricane Katrina demonstrated, with devastating consequences, how the disjuncture of these legal protections amongst states and federal laws results in confusion and delay when attempting to implement an orderly emergency response effort. As discussed above, some states provide for liability protection and workers' compensation coverage for VHPs, while others do not. The availability of legal protections may depend on the specific profession or affiliation of the volunteer, to whom the volunteer is providing services, the circumstances under which the services are rendered, or whether or not there is a declared emergency. Health professionals and their hosts may be reluctant to volunteer and face the risks of participating in an emergency response without the assurance of legal protection. A minimum, consistent level of protections is necessary across all states to ensure that the risks of liability, professional admonishment, or uncompensated harm do not outweigh the altruistic instincts of potential volunteers. Presently, the lack of a minimum standard of legal protections is a significant barrier to the use of volunteers because state and local governments are forced to wrestle with the legal issues rather than working towards the design and implementation of effective and efficient systems to facilitate their participation in emergency response efforts.

The establishment of a floor of minimum legal standards for volunteers would achieve several results. By setting a baseline level of legal protections, it would guarantee that all VHPs and their hosts would have a foundation of protection from risks of physical and economic harm resulting from their volunteer efforts. This guarantee encourages greater participation by VHPs, which would bolster the workforce to meet surge capacity and

improve overall emergency response efforts. A floor of protections will clarify the resolution of many legal issues, thereby encouraging hospitals and other health care entities to be active in the recruitment and use of volunteers in emergencies and facilitate their participation in governmental emergency response efforts. Moreover, implementing a floor of legal protections will guarantee VHPs a predictable baseline level of protections that furthers their interjurisdictional use.

Key minimum standards include cross-border licensure reciprocity, civil liability protections except in cases of willful, wanton, or criminal misconduct for volunteers and their hosts, and workers' compensation coverage for *all* volunteers.<sup>295</sup> Several approaches may be taken to achieve a uniform floor of legal standards across the nation. Congressional action may be utilized to (1) delegate regulatory authority to DHHS; or (2) devote new grant resources to states that include the implementation of these standards as core conditions on receipt of these funds. Promulgating federal standards is an attractive policy option because they are influential and can be attached to spending allocations distributed to the states. Federal standards should not preempt state laws that grant broader legal protections during emergencies.

A floor of legal standards can be implemented through other non-federal options as well. For example, interstate emergency management compacts, including EMAC, could be expanded beyond their current scope. The existing structure of EMAC limits legal protections to "officers or employees of a party state."<sup>296</sup> This excludes many potential volunteers and their host entities. The language of EMAC could be amended to extend legal protections to all volunteers responding to an emergency, whether or not they are officers or employees of the state. Furthermore, its language could be extended to provide protection for host entities, like hospitals, which would otherwise enjoy very little legal protection. Alternatively, VHPs could be considered government employees for the duration of the emergency so that they would come within the existing EMAC definition. Amending EMAC would be politically challenging endeavor; however, it would yield significant advantages given its wide adoption among states and territories.

### *C. Balancing Liability Protections*

To reduce the risk of harms to patients that may result in civil liability, laws should embrace proactive planning and training activities for VHPs and

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295. This proposed baseline goes beyond the current floor of protections provided by the Federal Volunteer Protection Act, which only applies liability protections to uncompensated volunteers working for government or non-profit entities. For a discussion of the Federal Volunteer Protection Act, see *supra* section III.B.1.

296. EMAC, *supra* note 50, at art. VI.



health care entities that may utilize volunteers. Laws must further balance the need for volunteers to act without fear of liability during emergencies and the rights of patients to some legal recourse for injuries resulting from a VHP's care or treatment. The current state of the law provides only limited liability protections to volunteers and their hosts. VHPs and their host entities should be immune from civil liability for health care services during declared emergencies except when their acts involve willful, wanton, or criminal misconduct. Immunity could be provided to VHPs and entities through explicit liability protections in state emergency health powers laws or through the expansion of volunteer protection acts to cover all VHPs responding to emergencies. Liability protection provisions should also be extended to provide protection to host entities for care and services provided by volunteers during emergencies to encourage them to utilize VHPs as part of an emergency management plan.

This recommendation largely eliminates individual causes of action for medical harms arising from non-criminal, non-egregious actions of VHPs in favor of encouraging full participation of skilled, trained VHPs during emergencies. Limitations on civil liability, however, should not prevent patients injured through medical care during emergencies from receiving some compensation. Federal or state governments could establish alternative compensation mechanisms for exempted claims outside the tort system. These may take the form of a discrete compensation fund, modeled after Social Security Disability Insurance,<sup>297</sup> workers' compensation insurance,<sup>298</sup> or the National Vaccine Injury Compensation Program,<sup>299</sup> to pay claims for persons injured during emergency responses without assigning blame to VHPs or their hosts, or involving costly court fees. The program goal would be to permit persons injured during an emergency to collect compensation for medical injuries, while also providing VHPs with a level of liability protection to encourage them to participate in emergency response efforts. Although such a program would no doubt be costly, such expense is justified by principles of fairness and justice. Individuals who have already been

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297. Edward P. Richards & Thomas R. McLean, *Administrative Compensation for Medical Malpractice Injuries: Reconciling the Brave New World of Patient Safety and the Torts System*, 49 ST. LOUIS UNIV. L. J. 73, 101-102 (2004).

298. Eleanor D. Kinney, *Administrative Law Approaches to Medical Malpractice Reform*, 49 ST. LOUIS U. L. J. 45, 54 (2004).

299. HEALTH RES. AND SERV. ADMIN., NATIONAL VACCINE INJURY COMPENSATION PROGRAM FACT SHEET (2005), available at [http://www.hrsa.gov/osp/vicp/fact\\_sheet.htm](http://www.hrsa.gov/osp/vicp/fact_sheet.htm) (last visited Mar. 30, 2005).

victimized by the circumstances of the emergency should be protected from further losses resulting from negligent medical care.<sup>300</sup>

#### *D. Meeting Surge Capacity and Portability of Qualified Volunteer Health Professionals*

VHPs should be able to practice and assist across jurisdictional boundaries through a framework that allows for the systematic recognition of professional licensure and certification status received in other jurisdictions. This could be accomplished through a variety of approaches. Exemptions from professional licensure or certification requirements or reciprocity arrangements could be tied to emergency declarations. Mutual aid agreements such as EMAC and IEMAC could establish influential standards for sharing of VHPs and authorizing professional licensure reciprocity across state lines. Broad-based reciprocity agreements that operate without an emergency declaration, like the Nurse Licensure Compact,<sup>301</sup> would also be useful. With the implementation of ESAR-VHP, these state agreements should also provide for interstate access to the registries to allow individual states and other host entities to seek out appropriately qualified VHPs.

#### *E. Ensuring Protection from and Compensation for Harms to Volunteer Health Professionals*

Volunteers may understand the nature of risks that confront them in response to emergencies, but few may be able to absorb the costs of significant harms through health insurance benefits or other resources. Furthermore, hospitals and other health care entities that are hosting volunteers will be reluctant to utilize volunteers and bear the burden of providing them with workers' compensation protection because of the significant cost of doing so. States and territories should apply workers' compensation benefits to VHPs that are injured, harmed, or killed during emergencies. They should define VHPs as "employees" of the host jurisdiction during declared emergencies for the purposes of workers' compensation provided that the VHPs are volunteering in some formal capacity, excluding "spontaneous" volunteers. VHPs would thus be covered under the state's workers' compensation plan like any employee. This would also eliminate concerns among the VHP's non-emergency employers and host hospitals that their workers' compensation plans may be impacted.

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300. Michael Greenberger, *The 800 Pound Gorilla Sleeps: The Federal Government's Lackadaisical Liability and Compensation Policies in the Context of Pre-event Vaccine Immunization Programs*, 8 J. HEALTH CARE L. & POL'Y 7, 36 (2005).

301. See *supra* note 213 and accompanying text.

Furthermore, existing limits on workers' protections for occupational diseases should be restructured to expand coverage to VHPs who contract communicable conditions as part of their service during emergencies, regardless whether the infection occurred in the workplace.

#### *F. Providing Privacy Protections for Volunteer and Patient Information*

While individual privacy interests should not trump the societal needs for sharing health data during a bioterrorism event, they cannot simply be dismissed. Protecting individual privacy and communal health and safety are synergistic. Maintaining some standard of privacy of identifiable health data even during emergencies may be essential to accomplishing public health objectives. People disdain privacy abuses or infringements by government or the private sector. Large-scale avoidance of these services or activities during a public health emergency could be disastrous. Conversely, people must be willing to confidentially share their health data for public health purposes during an emergency event if they expect health authorities to be able to effectively respond. To better protect personal health information, laws must provide for robust privacy protections and fair information practices, but also allow for sufficient access and use of information to allow for an effective response. Additionally, regulations governing the implementation of ESAR-VHP must provide privacy protections for volunteer information.

### V. CONCLUSION

The confusion and delays associated with the response to Hurricane Katrina in the Gulf Coast region underscore the importance of VHPs as an element of emergency preparedness. The Hurricane's tragic aftermath reaffirms the necessity of emergency response planners at all levels of government to take proactive steps to ensure the effective use and deployment of VHPs during public health emergencies. As the response to Hurricane Katrina revealed, locally available and government resources may not be adequate to provide medical assistance to all of the victims or to mount an effective public health response to a massive public health emergency. Without a comprehensive medical response plan that addresses surge capacity needs and incorporates organized avenues to call for the assistance of additional volunteer health professionals, federal, state, and local governments will not be able to adequately protect the health and safety of the public in an emergency. Volunteer health professionals can provide additional medical support to meet the needs of potentially massive numbers of patients requiring medical care. Implementation of volunteer registries will ensure that governmentally deployed and spontaneous

volunteers can be smoothly incorporated into medical response plans. However, legal impediments may inhibit the effectiveness and participation of VHPs and the development of effective volunteer registries.

Facilitating the incorporation of VHPs into emergency response plans requires a strong legal infrastructure that directs when they may be utilized, outlines the scope of their practice, and provides for legal protections of their interests. Strong and comprehensive emergency health powers laws will define the legal landscape after the declaration of an emergency. In doing so, they may also heighten volunteer and entity concerns about licensure, credentialing, liability, and harms. Building a strong legal infrastructure for the use of volunteers during emergencies will require a transformation of the legal environment. Applicable laws need to be clarified and expanded, where necessary, to encourage VHPs to provide timely and essential care during emergencies.