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Service by Health Care Providers in a Public Health Emergency: The Physican's Duty and the Law

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SERVICE BY HEALTH CARE PROVIDERS IN A PUBLIC HEALTH EMERGENCY: THE PHYSICIAN'S DUTY AND THE LAW

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I. INTRODUCTION

A. Natural and Man-Made Disasters Affecting the United States

Natural and man-made disasters in the United States have been an important focus of attention within the law and the health care system, particularly since the September 11, 2001 terrorist attacks, the Hurricane Katrina catastrophe four years later, and more recently the appearance of two novel influenza viruses,[1] one of which had produced an influenza pandemic by mid-2009.[2]

The Joint Commission, the national accreditation agency for health care organizations, now requires that hospitals consider the impact of a variety of terrorist events in developing policies, and has substantially revised its emergency preparedness accreditation standards, which apply to human-made as well as natural disasters.[3] A model statute has been created that would confer specific state powers during a public health emergency,[4] and many states have introduced or adopted legislation containing provisions from this statute.[5] The Interstate Emergency Management Assistance Compact (EMAC), ratified by Congress in

1. Ctrs. for Disease Control & Prevention, Case Definitions for Infectious Conditions Under Public Health Surveillance, *available at* http://www.cdc.gov/ncphi/disss/nndss/casedef/novel_influenzaA.htm (defining a "novel" influenza A virus causing human cases of influenza as "[a] virus subtype that is different from currently circulating human influenza H1 and H3 viruses . . . [or] H1 and H3 subtypes originating from a non-human species or from genetic reassortment between animal and human viruses . . .").

2. Margaret Chan, Director-General, World Health Org., Transcript of Statement by Margaret Chan, Director-General of the World Health Organization 1 (June 11, 2009), *available at* http://www.who.int/mediacentre/influenzaAH1N1_presstranscript_20090611.pdf (updating the status of novel influenza A (H1N1) virus (commonly called "swine flu") infections, declaring that "the scientific criteria for an influenza pandemic have been met").

3. *See generally* JOINT COMM'N ON ACCREDITATION OF HEALTHCARE ORGS., ACCREDITATION PROGRAM: HOSPITAL EMERGENCY MANAGEMENT (pre-publ'n ver. 2008) [hereinafter JOINT COMM'N] (establishing standards for hospital operational plans during emergencies and disasters).

4. MODEL STATE EMERGENCY HEALTH POWERS ACT § 103 (Ctr. for Law and Pub.'s Health at Georgetown and John Hopkins Univs., Proposed Draft 2001), *available at* http://www.publichealthlaw.net/MSEHPA/MSEHPA2.pdf [hereinafter MSEHPA].

5. *See* CTR. FOR LAW & PUB.'S HEALTH AT GEORGETOWN & JOHNS HOPKINS UNIVS., THE MODEL STATE EMERGENCY HEALTH POWERS ACT: LEGISLATIVE SURVEILLANCE TABLE 1 (2006), http://www.publichealthlaw.net/MSEHPA/MSEHPA%20Surveillance.pdf (listing the states that have incorporated aspects of the Model Act).

1996,[6] provides a mechanism for states to supply mutual aid, including, among other things, license reciprocity or waiver of state licensure, and liability protection for out-of-state health care providers;[7] to date, all fifty states and four territories have ratified the Compact.[8] Federal initiatives have fostered the creation of local volunteer provider organizations, such as the Medical Reserve Corps (MRC), which registers, trains, and would mobilize health care professionals in the event of a public health emergency or other disaster.[9] As of November 2009, there were approximately 865 MRC units in the United States and its territories.[10]

Under the Public Health Security and Bioterrorism Preparedness and Response Act of 2002,[11] Congress provided for creation of an Emergency System for Advance Registration of Health Professional Volunteers (ESAR-VHP), "a single national interoperable network of systems" to facilitate interstate license reciprocity and credentialing when out-of-state volunteers wish to provide health care services during a public health emergency.[12] Finally, the Pandemic and All-Hazards Preparedness Act (PAHPA)[13] was enacted in 2006 with the intent of improving the coordination and management of emergency preparedness and response,[14] which had been highly criticized by local governments and the public at large following hurricane Katrina.[15]

These efforts and others are intended to build on recent lessons learned, and hopefully to prevent or solve problems that Americans in the second half of the twentieth century largely avoided. However, the success of these efforts would depend on the realities of the health care system, including the adequacy and availability of supplies and the capabilities and intentions of health care workers. This Article will focus primarily on the role of physicians, although many

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6. Emergency Management Assistance Compact, Pub. L. No. 104-321, 110 Stat. 3877 (1996).

7. *Id.* § 1, 110 Stat. at 3880.

8. Nat'l Emergency Mgmt. Ass'n, What is EMAC?, http://www.emacweb.org/?9 (last visited Nov. 25, 2009).

9. Med. Reserve Corps, Office of U.S. Surgeon Gen., http://www.medicalreservecorps.gov/About (last visited Nov. 25, 2009).

10. Office of U.S. Surgeon Gen., Medical Reserve Corps, http://www.medicalreservecorps.gov/HomePage (last visited Nov. 25, 2009).

11. Pub. L. No. 107-188, 116 Stat. 594 (2002).

12. 42 U.S.C. § 247d-7b(a) (2006).

13. Pub. L. No. 109-417, 120 Stat. 2831 (2006).

14. *See* S. REP. NO. 109-319, at 1–2 (2006) ("The purpose of [the Act] . . . is to improve the Nation's public health and medical preparedness and response capabilities for emergencies, . . . [i]mprove[] communication and interoperability, and enhance[] coordination between all levels of government.").

15. *See, e.g.*, GREG KUTZ & JOHN J. RYAN, U.S. GOV'T ACCOUNTABILITY OFFICE, HURRICANES KATRINA AND RITA DISASTER RELIEF: CONTINUED FINDINGS OF FRAUD, WASTE, AND ABUSE (2006), *available at* http://www.gao.gov/new.items/d07252t.pdf (criticizing the Federal Emergency Management Agency's management of the post-Katrina and Rita housing and assistance payments programs).

arguments to be addressed may be applied more broadly to others in the health care field.

B. Potential for Inadequate Health Care Work Force

Although the response of health care workers to the September 11, 2001 terrorist attacks and to Hurricane Katrina was robust,[16] shortage of health care workers in a disaster is always a concern. Disaster-related damage to infrastructure or modes of transportation might prevent workers from reaching their place of employment,[17] or might cut off services or caregivers from their children or dependent elderly family members.[18] These problems could be at least partly alleviated by disaster preparedness efforts to strategically redeploy health care workers throughout the community, or to enlist community volunteers. However, in a deadly epidemic or similar catastrophe, large portions of the health care work force might be sick or injured themselves, or too concerned about risk to themselves to report to work.[19] For example, in an influenza pandemic, the clinical disease attack rate is expected to be 20% among working adults and absenteeism attributable to illness and other pandemic-associated obstacles could rise to 40% during the peak of a community outbreak.[20] In a survey of U.S. physicians conducted in 2002, 80% of physicians stated they would be willing to care for patients during an outbreak of potentially deadly illness, but only 40% stated they would be willing to risk contracting such a disease to save the life of others.[21]

Provider concerns about liability could also pose an obstacle to ensuring a sufficient pool of personnel. Ventilators and isolation beds are already in short supply.[22] Overcrowding exists in hospital emergency departments, especially in metropolitan areas, and bed closures could create crisis conditions in a public

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16. James G. Hodge, Jr., *Legal Triage During Public Health Emergencies and Disasters*, 58 ADMIN. L. REV. 627, 634 (2006).

17. *See generally* TRANSP. RESEARCH BD., NAT'L COOP. HIGHWAY RESEARCH PROGRAM, TRANSPORTATION'S ROLE IN EMERGENCY EVACUATION AND REENTRY: A SYNTHESIS OF HIGHWAY PRACTICE 2 (2009), *available at* http://onlinepubs.trb.org/onlinepubs/nchrp/nchrp_syn_392.pdf (noting a lack of formal planning in many communities for post-emergency reentry of evacuated individuals).

18. *See* K. Qureshi et al., *Health Care Workers' Ability and Willingness to Report to Duty During Catastrophic Disasters*, 82 J. URB. HEALTH 378, 385 (2005) ("[T]he most frequently cited reasons for *not being able* to report to work during a catastrophic event were transportation issues, [and] childcare and elder-care responsibilities . . . .") (emphasis in original).

19. G. Caleb Alexander & Matthew K. Wynia, *Ready and Willing? Physicians' Sense of Preparedness for Bioterrorism*, HEALTH AFF., Sept.–Oct. 2003, at 189, 195; Qureshi et al., *supra* note 18, at 386.

20. U.S. DEP'T OF HEALTH & HUMAN SERVS., PANDEMIC PLANNING ASSUMPTIONS, http://www.flu.gov/professional/pandplan.html (last visited Nov. 25, 2009).

21. Alexander & Wynia, *supra* note 19, at 192 exhibit 2.

22. U.S. GEN. ACCOUNTING OFFICE, HOSPITAL PREPAREDNESS: MOST URBAN HOSPITALS HAVE EMERGENCY PLANS BUT LACK CERTAIN CAPACITIES FOR BIOTERRORISM RESPONSE 14–15 (2003), *available at* http://www.gao.gov/new.items/d03924.pdf.

health emergency.[23] In New York City, which is highly vulnerable to terrorist attack, fiscal constraints have led to a reduction in hospital beds and closure of entire health care institutions.[24] Personnel shortages in a public health emergency could force existing providers to render care for conditions beyond their specific expertise, or to treat conditions for which they are not "up to date."[25] Large numbers of injured and sick patients could overwhelm already scarce resources and create concern among health care providers that their medical care was suboptimal and, rightly or wrongly, that they would be held liable if something were to go wrong.[26] Although the greatest concern would likely be liability for simple negligence, some providers might be concerned about more serious charges, in view of publicized accounts of health professionals accused of homicide while caring for patients during Hurricane Katrina.[27]

II. LEGAL IMMUNITY AS AN INCENTIVE TO SERVE

A. Traditional Protections for Volunteers Against Liability Claims

1. Federal Volunteer Protection Act of 1997

In 1997, Congress enacted the Volunteer Protection Act (VPA), declaring that "the willingness of volunteers to offer their services is deterred by the potential for liability actions against them."[28] This statute applies to properly licensed or otherwise authorized individuals "performing services for a nonprofit organization or government entity," not receiving compensation over $500 per year.[29] These volunteers would receive immunity for actions that cause harm as long as the actions were taken within the scope of their responsibilities to the organization or

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23. *See* Arthur L. Kellermann, *Crisis in the Emergency Department*, 355 NEW ENG. J. MED. 1300, 1301 (2006) (describing the effect of overcrowding in hospitals as a "rolling blackout").

24. *See* COMM'N ON HEALTH CARE FACILITIES IN THE 21ST CENTURY, A PLAN TO STABILIZE AND STRENGTHEN NEW YORK'S HEALTH CARE SYSTEM 4 (2006), *available at* http://www.nyhealthcarecommission.org/docs/final/commissionfinalreport.pdf (describing New York City's infrastructure as "fac[ing] . . . mounting costs, excess capacity, and unmet needs," leading to frequent bankruptcies and facility closures).

25. *See* Isaac Starr, *Influenza in 1918: Recollections of the Epidemic in Philadelphia*, 145 ANN. INTERNAL MED. 138, 139 (2006) (describing the phenomenon of volunteer, retired physicians providing suboptimal care during the 1918 influenza pandemic).

26. James G. Hodge Jr. et al., *Emergency Legal Preparedness for Hospitals and Health Care Personnel*, 3 DISASTER MED. & PUB. HEALTH PREPAREDNESS (SUPP. 1) S37, S37, S42 (2009) (enumerating legal risks to hospitals and providers, noting that "[d]isasters affecting the public health can greatly compromise the ability of ill-prepared health care providers to render critical care resulting in significant and avoidable morbidity and mortality").

27. *See* Affidavit for State of Louisiana, Louisiana v. Pou, No. 004039743 (July 2006), *available at* http://www.nola.com/katrina/pdf/072006_nolacharges.pdf; *infra* Part II.C.

28. 42 U.S.C. § 14501(a)(1) (2006).

29. *Id.* § 14505(6).

government entity.[30] Immunity generally applies to acts of ordinary negligence in specific circumstances delineated by statute, but not, in most cases, to acts of "willful or criminal misconduct, gross negligence, reckless misconduct, or a conscious, flagrant indifference to the rights and safety of the individual harmed . . . ."[31]

Nonprofit organizations and government entities do not generally rely on the VPA because of its limitations. For example, the VPA provides liability protection for volunteers but not for the nonprofit or government entity utilizing them.[32] Furthermore, although the VPA preempts state law that is inconsistent with its provisions, the statute does not preempt state law that provides additional liability protection,[33] and allows the states to opt out of federal coverage.[34] Also, states are permitted to impose certain conditions or limits in order for immunity to apply, such as requiring mandatory training of volunteers, or requiring the entity to provide a "financially secure source of recovery" for individuals harmed by the actions of a volunteer.[35] States have taken a variety of options permitted under the VPA.[36]

The VPA has seldom been tested in the courts, so there is little guidance on how this act should be applied in the health care setting. The VPA might not cover the extraordinary situation of a community wide disaster when nonaffiliated providers or other volunteers, including those from other states, might spontaneously arrive at a hospital hoping to help;[37] the VPA applies in limited situations to a "civil action in a state court . . . in which all parties are citizens of the State,"[38] so in states opting out of the VPA, liability protection coverage for out-of-state volunteers would need to come from another source.[39]

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30. *Id.* § 14503(a)(1).

31. *Id.* § 14503(a)(3).

32. *Id.* § 14503(c).

33. *Id.* § 14502(a).

34. *Id.* § 14502(b).

35. *Id.* § 14503(d)(1)–(4).

36. *See infra* Part II.A.2.

37. *See* Mimi Hall, *States Cutting Disaster Red Tape; Bills Seek Quick OK for Medical Help*, USA TODAY, Oct. 9, 2007, at A1, *available at* http://www.usatoday.com/news/nation/2007-10-08-disasterdoctors_N.htm (quoting a member of the National Conference of Commissioners on Uniform State Laws as suggesting that the infrastructure limitations resulting from disasters should not prohibit "allowing doctors to practice across state lines").

38. § 14502(b).

39. *See infra* Part II.B.

2. State Volunteer Liability Protection Statutes

State volunteer protection laws have long existed for the express purpose of encouraging volunteerism, including some with provisions similar to the VPA.[40] However, the nature of liability protection varies from state to state. For example, liability protection often provides indemnity rather than immunity;[41] thus, a claim could go forward but payment of damages would be covered by malpractice insurance purchased by the state or the organization, state funds available to claimants, or other mechanisms. The authority of states to impose conditions or limitations on volunteer immunity under the VPA[42] has led to broad variations in liability provisions. For example, in South Dakota the state's immunity provision cannot be used as an affirmative defense if a volunteer or the entity employing the volunteer participates in a risk-sharing pool or purchases liability insurance.[43] The broad range of traditional volunteer liability protections among the states has been reviewed in detail.[44]

3. Good Samaritan Statutes

Good Samaritan statutes cover actions taken by individuals who come upon an emergency by chance.[45] These statutes generally provide civil immunity from liability for ordinary negligence, and do not generally apply to clinicians with a pre-established duty of care to the patient or to those acting with the expectation of compensation.[46] States vary as to whether liability protection would apply in the

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40. UNIFORM EMERGENCY VOLUNTEER HEALTH PRACTITIONERS ACT ANN. 55 n.9 (Nat'l Conference of Comm'ns of Unif. State Laws, Proposed Draft 2007), *available at* http://www.uevhpa.org/Uploads/UEVHPA_Annotated_Nov07.pdf [hereinafter UEVHPA] (indicating that some states have adopted Volunteer Protection Acts, including Colorado, which has adopted COLO. REV. STAT. § 13-21-115.5(4)(a)(I), and Delaware, which has adopted DEL. CODE ANN. tit. 10, § 8133(b)).

41. Paul A. Hattis, *Overcoming Barriers to Physician Volunteerism: Summary of State Laws Providing Reduced Malpractice Liability Exposure for Clinician Volunteers*, 2004 U. ILL. L. REV. 167, 169 (noting that most states with liability protection laws either change the standard of care for negligence or indemnify volunteer health care providers).

42. 42 U.S.C. § 14503(d).

43. S.D. CODIFIED LAWS § 47-23-32 (2008).

44. *See generally* Hattis, *supra* note 41; James G. Hodge, Jr. et al., *The Legal Framework for Meeting Surge Capacity Through the Use of Volunteer Health Professionals During Public Health Emergencies and Other Disasters*, 22 J. CONTEMP. HEALTH L. & POL'Y 5 (2005).

45. *See* Hodge, *supra* note 44, at 36–37 ("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.").

46. *See, e.g.*, N.Y. EDUC. LAW § 6527(2) (McKinney 2006 & Supp. 2009) ("[A]ny licensed physician who voluntarily and without . . . compensation renders first aid or emergency treatment at the scene of an accident or other emergency . . . shall not be liable for damages . . . unless . . . caused by gross negligence . . . . [This] shall [not] be deemed or construed to relieve a licensed physician from liability for damages . . . caused by an act or omission . . . in the normal and ordinary course of his practice.").

context of a clinician's normal practice duties or locations.[47] Good Samaritan laws generally provide liability protection for health professionals explicitly,[48] but in many cases protect members of other professions, such as fire or police, or "any person" providing such assistance.[49]

B. Liability Protection for Volunteers Working During a Disaster

Since 2001, and despite new initiatives to address disasters, certain problems have remained. For example, although the need for health care professionals following Hurricane Katrina was great, large numbers of volunteers who came to assist from outside of New Orleans, often after traveling great distances, were reportedly not permitted into the city because of questions regarding credentialing and liability.[50] All states have adopted EMAC,[51] in which "officers or employees of a party state rendering aid in another state . . . [are] considered agents of the requesting state for tort liability and immunity purposes," and would not be held liable for acts rendered in "good faith," which would exclude "willful misconduct, gross negligence, or recklessness."[52] However, because EMAC provisions do not apply to volunteers from the private sector,[53] additional agreements or state statutory provisions would be needed to make such individuals temporary state employees under emergency circumstances.[54]

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47. *See, e.g.*, IDAHO CODE ANN. § 39-7703 (2006) (applying the protection to volunteer health care providers assisting at a free medical clinic); KAN. STAT. ANN. § 65-2891(c) (2005) (applying the protection to health care providers rendering such care within a hospital until the responsible physician or person is available).

48. *See, e.g.*, 745 ILL. COMP. STAT. ANN. 49/5–75 (West 2002 & Supp. 2008) (protecting specific licensed professionals, including dentists, physicians, nurses, and physician assistants, among others); *cf.* OKLA. STAT. ANN. tit. 59, § 518 (West 2000) (protecting only health practitioners).

49. *See, e.g.*, MONT. CODE ANN. § 27-1-714 (2008) (providing for limited liability for emergency care workers rendering care at the scene of an emergency); UTAH CODE ANN. § 78B-4-501 (2008) (applying Good Samaritan Act to a person who in general assists in defined emergency situations without receiving renumeration). *But see* UTAH CODE ANN. § 58-13-2 (2007 & Supp. 2008) (applying to a number of health care providers, but not specifically including other emergency personnel).

50. UNIF. EMERGENCY VOLUNTEER HEALTH PRACTITIONERS ACT prefatory note (Nat'l Conference of Comm'rs of Unif. State Laws, Proposed Draft 2007), *available at* http://www.law.upenn.edu/bll/archives/ulc/uiehsa/2007act_final.pdf [hereinafter UEVHPA prefatory note]; *see also* Hall, *supra* note 37.

51. UEVHPA prefatory note, *supra* note 50, at 3.

52. Emergency Management Assistance Compact, Pub. L. No. 104-321, § 1, 110 Stat. 3877, 3880 (1996).

53. *See id.* (specifically removing liability from a state, its "[o]fficers or employees . . . rendering aid in another state" consistent with the Compact).

54. Memorandum from James G. Hodge, Principal Investigator, & Lance A. Gable, Project Director, of the Ctr. for Law & Pub.'s Health at Georgetown & Johns Hopkins Univ. on Hurricane Katrina and Rita Responses—Legal Lessons (2005), *available at* http://www.publichealthlaw.net/Research/PDF/Katrina%20-%20Legal%20Lessons%20Learned.pdf.

Recognition of such gaps was followed by creation of the model Uniform Emergency Volunteer Health Practitioners Act (UEVHPA) in 2007.[55] In addition to establishing an organized system for the use of volunteer health practitioners under state direction,[56] a volunteer health practitioner providing services under the UEVHPA would not be "liable for damages for an act or omission of the practitioner in providing those services" except in the case of egregious or criminal conduct, claims by the host entity, and certain other circumstances.[57] In contrast to the VPA, UEVHPA would confer the added benefit and possible incentive of making workers' compensation available in case of death or injury of the volunteer.[58] Broad adoption of the Act, if uniformly applied and construed, would provide uniform standards among states regarding liability coverage and registration of volunteer health practitioners, and theoretically improve coordination of efforts involving interstate responses.[59] To date, six states have adopted this Act,[60] and it has been introduced in several others.[61]

The UEVHPA would provide liability protection to individual volunteers,[62] but would leave it to each state to determine whether such protection should apply to entities,[63] which are not protected under laws such as the federal VPA,[64] and would otherwise be vicariously liable for acts of their volunteers. A more recent Good Samaritan Entity Liability Protection Initiative promotes legislation at the state level to provide liability protection for good faith voluntary efforts by business and nonprofit entities in emergencies.[65]

The exclusions under existing immunity provisions for volunteers, including under the UEVHPA, would be minimized under law geared specifically to public health emergencies and other disasters. The Model State Emergency Health Powers

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55. UEVHPA prefatory note, *supra* note 50, at 6.

56. UEVHPA, *supra* note 40, § 3.

57. *Id.* § 11 Alternative A (a)–(d).

58. *Compare id.* § 12 (providing for workers' compensation in the case of injury or death under UEVHPA), *with* Volunteer Protection Act of 1997, 42 U.S.C. § 14503(c) (2000).

59. UEVHPA, *supra* note 40, § 13 cmt. (urging that states must consider the benefits of uniformity of law and that uniformity is a principle objective of the act).

60. COLO. REV. STAT. ANN. §§ 12-29.3-101 to -113 (Supp. 2008); IND. CODE ANN §§ 10-14-3.5-1 to -22 (LexisNexis Supp. 2008); KY. REV. STAT. ANN. §§ 39A.350 to .366 (West Supp. 2008); N.M. STAT. ANN. §§ 12-12A-1 to -13 (LexisNexis Supp. 2008); TENN. CODE ANN. §§ 58-2-801 to -813 (Supp. 2008); UTAH CODE ANN. §§ 26-49-101 to -701 (2008); *see also* UEVHPA.org, Enactment Status Map, http://www.uevhpa.org/DesktopDefault.aspx?tabindex=2&tabid=67 (last visited Nov. 25, 2009).

61. UEVHPA.org, *supra* note 60.

62. UEVHPA, *supra* note 40, § 11 Alternative A.

63. *See id.* § 11 cmt. 2 (instructing that states make the final policy determination between Alternatives A and B). *Compare id.* § 11 Alternative A (protecting entities from vicarious liability), *with id.* § 11 Alternative B (subjecting entities to vicarious liability claims).

64. 42 U.S.C. § 14503(c) (2006).

65. North Carolina Institute for Public Health, Public/Private Legal Preparedness Initiative, http://nciph.sph.unc.edu/law/good_sam.htm (last visited Nov. 25, 2009).

Act (MSEHPA) would confer specific powers to the governor during a declared public health emergency, in order to protect the public in the face of "[n]ew and emerging dangers—including emergent and resurgent infectious diseases and incidents of civilian mass casualties . . . ."[66] Under MSEHPA, in-state health care providers acting within the scope of their responsibilities in a declared emergency would be immune from civil liability for the death or injury to a person, except in the case of gross negligence or willful misconduct.[67] In the case of out-of-state providers, this exception to immunity extends to "a reckless disregard for the consequences so as to affect the life or health of the patient."[68] By July 2006, twenty-three states had introduced or adopted provisions based on MSEHPA's § 804 immunity provision, thus augmenting and in some cases enhancing liability protections previously available under state law.[69] In one of these states, a health care provider is immune from criminal as well as civil liability during a catastrophic health emergency proclamation as long as he or she "acts in good faith."[70]

C. Would Immunity Provisions Have the Desired Effect?

Although immunity would lessen the disincentive to serve because of liability concerns, it could theoretically hamper the quality of care provided. One critic of MSEHPA has asserted there is no evidence from the recent past that health care providers are reluctant to assist, citing the high level of volunteerism in the wake of the September 11th and subsequent anthrax attacks.[71] Furthermore, immunity might mean that patients would not have recourse for any injury they might suffer, especially if treated by out-of-state providers, who would have immunity for "everything but manslaughter."[72] Lack of recourse for patients would be of particular concern if clinicians were called upon to provide treatment for which they lacked or no longer had skill.[73] In this case, a preferable alternative might be indemnity, in which a claim could go forward but damages would be paid by a variety of mechanisms.[74] For example, members of New York City's MRC are considered employees of the city when deployed, and receive protection in the form

66. MSEHPA, *supra* note 4, § 102(b).

67. *Id.* § 804(a)–(b).

68. *Id.* § 608(b)(3).

69. CTR. FOR LAW & THE PUB.'S HEALTH AT GEORGETOWN & JOHNS HOPKINS UNIVS., *supra* note 5, at 4.

70. MD. CODE. ANN., PUB. SAFETY § 14-3A-06 (LexisNexis Supp. 2008).

71. George J. Annas, *Bioterrorism, Public Health, and Civil Liberties*, 346 NEW ENG. J. MED. 1337, 1338–39 (2002).

72. *Id.* at 1341.

73. *See generally* Starr, *supra* note 25 (describing the author's recollection of his experience tending to unknown ailments as a student in his third-year of medical school).

74. *See supra* Part II.A.2.

of indemnification under state law,[75] whereas non-MRC volunteers in New York might receive immunity by statute under certain circumstances.[76]

A physician working under the extraordinary circumstances of a disaster might find indemnification insufficient, since identities of health care providers named in malpractice settlements or payments are reported by law to a national data bank.[77] The data bank has been criticized for being misleading and for not excluding "nuisance case[s] with no real merit," while at the same time having the potential to negatively impact physician licensure, staff privileges, and insurability.[78] However, even immunity might not ease liability concerns for physicians aware of the health professionals charged with homicide during Hurricane Katrina.[79] Available information regarding the case supports the charged physician's contention that her administration of sedating medications to respirator-dependent patients was consistent with accepted methods of palliative care, rather than an intentional overdose as the prosecution charged.[80] This case has been highly publicized in the news media,[81] and has received considerable attention in the medical literature as well.[82] Thus, even competent physicians practicing within their field of expertise could reasonably fear adverse consequences, including

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75. *See* N.Y. GEN. MUN. LAW § 50-k(1)(e), (3) (McKinney 2007) (providing indemnity to "volunteer[s] expressly authorized to participate in a city sponsored volunteer program").

76. *See* N.Y. UNCONSOL. LAW § 9193(1) (McKinney 2002 & Supp. 2008) ("[A] volunteer agency . . . performing civil defense services in this state . . . in good faith . . . shall not be liable for any injury or death to persons or damage to property as the result thereof.").

77. 42 U.S.C. § 11131(a)–(b) (2006).

78. Letter from Michael D. Maves, Executive Vice President and CEO, Am. Med. Ass'n, to Betsy Ranslow, Assoc. Adm'r, Bureau of Health Professions (May 22, 2006), *available at* http://www.ama-assn.org/ama1/pub/upload/mm/395/ama_comments_npdb.pdf; Am. Med. Ass'n, National Practitioner Data Bank, http://www.ama-assn.org/ama/pub/physician-resources/legal-topics/business-management-topics/national-practitioner-data-bank.shtml (last visited Nov. 25, 2009).

79. *See* Affidavit for State of Louisiana, *supra* note 27; Gwen Filosa & John Pope, *Grand Jury Refuses to Indict Dr. Anna Pou*, TIMES-PICAYUNE (New Orleans, La.), July 24, 2007, http://blog.nola.com/times-picayune/2007/07/grand_jury_refuses_to_indict_d.html (illustrating an instance when criminal charges were sought against a doctor in an emergency situation and two nurses who were later granted immunity to testify before a grand jury, which declined to indict the physician).

80. Susan Okie, *Dr. Pou and the Hurricane—Implications for Patient Care During Disasters*, 358 NEW ENG. J. MED. 1, 4–5 (2008).

81. Sheri Fink, *Strained by Katrina, a Hospital Faced Deadly Choices*, N.Y. TIMES MAG., Aug. 30, 2009, at 30–46, *available at* http://www.nytimes.com/2009/08/30/magazine/30doctors.html (reporting that civil wrongful death charges against the physician are still pending); James Varney, *Katrina Deaths at Hospital Spawn Lawsuits*, TIMES-PICAYUNE (New Orleans, La.), July 21, 2006, http://www.nola.com/news/t-p/frontpage/index.ssf?/base/news-6/1154325678123470.xml&coll=1.

82. *See, e.g.*, Fred Charatan, *New Orleans Doctor Is Charged with Giving Lethal Injections During Floods*, 333 BRIT. MED. J. 218, 218 (2006); Tyler J. Curiel, *Murder or Mercy? Hurricane Katrina and the Need for Disaster Training*, 355 NEW ENG. J. MED. 2067, 2067 (2006); Okie, *supra* note 80, at 1; Anna Maria Pou, *Hurricane Katrina and Disaster Preparedness*, 358 NEW ENG. J. MED. 1524, 1524 (2008).

criminal charges, and might not be mollified by the promise of immunity for "ordinary negligence" in the extraordinary circumstances of a disaster.

Finally, the oft-cited enthusiasm for health professionals to assist ill strangers likely emanates from experiences or emotions that have nothing to do with knowledge of liability protections.[83] For example, a group of commentators discussing ethical obligations of their profession in a disaster argues that emergency physicians as a group, like emergency medicine services personnel, "possess rescue personalities and are more likely to stay at their stations than others," and may be more likely to tolerate some risks because of "group camaraderie . . . a sense of loyalty and mutual regard when carrying out a difficult task together."[84] While it is unlikely that "rescue personalities" are confined to those practicing emergency medicine, it is most likely that personal characteristics, notably altruism, play a fundamental role in the willingness to serve.

III. DO PHYSICIANS HAVE A DUTY OF CARE DESPITE RISK TO THEMSELVES?

A. New and Emerging Dangers

A number of serious public health concerns have emerged in recent years, including the threat of terrorism. These include "Class A" bioterrorist agents, such as Clostridium botulinum toxin (botulism), anthrax, hemorrhagic fever viruses, such as Ebola, and Yersinia pestis, the bacterium causing pneumonic plague.[85] Class A agents are those that "pose a risk to national security because they can be easily disseminated or transmitted from person to person; result in high mortality rates and have the potential for major public health impact; might cause public panic and social disruption; and require special action for public health preparedness."[86] Other dangers of great concern include an intentional release of radiological material (i.e., a "dirty bomb"),[87] or a highly lethal chemical agent, such as sarin, which acts by paralyzing the nervous system.[88] Sarin was responsible for

83. *See* Lisa A. Eckenwiler, *Emergency Health Professionals and the Ethics of Crisis*, *in* IN THE WAKE OF TERROR: MEDICINE AND MORALITY IN A TIME OF CRISIS 111, 114–15 (Jonathan D. Moreno ed., 2003) (discussing potential reasons why health professionals commit to helping in emergencies).

84. Kenneth V. Iserson et al., *Fight or Flight: The Ethics of Emergency Physician Disaster Response*, 51 ANNALS EMERGENCY MED. 345, 349 (2008).

85. Ctrs. for Disease Control & Prevention, Bioterrorism Agents/Diseases (by Category), http://www.bt.cdc.gov/agent/agentlist-category.asp#adef (last visited Nov. 25, 2009).

86. *Id.*

87. Ctrs. for Disease Control & Prevention, Radiation Emergencies, http://www.bt.cdc.gov/radiation (last visited Nov. 25, 2009). For an explanation of dirty bombs, see U.S. NUCLEAR REGULATORY COMM'N, FACT SHEET: DIRTY BOMBS (Mar. 2003), *available at* http://www.nrc.gov/reading-rm/doc-collections/fact-sheets/dirty-bombs.pdf.

88. Ctrs. for Disease Control & Prevention, Chemical Emergencies Overview, http://www.bt.cdc.gov/chemical/overview.asp (last visited Nov. 25, 2009).

12 deaths and over 5000 injuries in the Tokyo subway system and resulted in secondary illness in many health care workers who treated the victims.[89]

Provider concerns for their own safety in a chemical or radiological attack would be enhanced by shortages of potentially protective resources. Decontamination facilities at hospital entrances have a limited ability to keep up with a large flow of patients, since the cumbersome process takes between five and twenty minutes for each patient brought in on a stretcher.[90] During decontamination, the hospital is in "lockdown," so no one enters, including physicians.[91] Protective clothing, if available in sufficient supply, can only be safely used by individuals trained in its use and vigorous enough to work while outfitted, as highly protective suits can be very confining and poorly tolerated, depending on the type and duration of work as well as factors such as environmental temperature.[92]

Most recently, pandemic influenza has emerged as an important public health concern. Although person-to-person transmission of novel Influenza A H5N1 (avian flu) virus has not been widely documented, the virus is affecting increasing numbers of people in Asia,[93] and has the potential for genetic modification to a more easily transmissible strain.[94] The actual pandemic of novel Influenza A H1N1 (swine flu) virus[95] is currently deemed to be moderate in severity but this may reflect relatively favorable socioeconomic conditions and health care access in

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89. H. Nozaki et al., *Secondary Exposure of Medical Staff to Sarin Vapor in the Emergency Room*, 21 INTENSIVE CARE MEDICINE 1032, 1033 (1995); Susan Kreiffels, *Japan Arrests Cult Leader*, USA TODAY, May 16, 1995, at 1A.

90. U.S. ARMY MEDICAL RESEARCH INSTITUTE OF CHEMICAL DEFENSE, MEDICAL MANAGEMENT OF CHEMICAL CASUALTIES HANDBOOK 201 (3d ed. 2000).

91. *See, e.g.*, *Hazmat Exposure Leaves 2 Dead, Prompts Lockdown of Hospitals*, FoxNews.com (Aug. 31, 2008), http://www.foxnews.com/story/0,2933,414041,00.html; Amanda O'Donnell, *2 ERs Placed on Lockdown After Chemical Scare*, CNN.com (Aug. 31, 2008), http://www.cnn.com/2008/US/08/30/hospital.lockdowns/index.html.

92. 29 C.F.R. § 1910.120 app. B (2008).

93. *See* U.S. DEP'T OF HEALTH & HUMAN SERVS., PANDEMIC PLANNING UPDATE VI 2-4 (2009), *available at* http://www.flu.gov/professional/pdf/panflureport6.pdf (documenting the growing number of countries affected with H5N1 virus in animals, the increasing number of confirmed human deaths as a result of the virus, and large number of cases in humans who have contracted the virus in Asia). *See generally* WORLD HEALTH ORG., H5N1 AVIAN INFLUENZA: TIMELINE OF MAJOR EVENTS (2008), *available at* http://www.who.int/csr/disease/avian_influenza/Timeline_08%2009%2023.pdf (cataloging the timeline of H5N1 avian influenza virus cases reported globally).

94. *See* Writing Comm. of the Second World Health Org. Consultation on Clinical Aspects of Human Infection with Avian Influenza A (H5N1) Virus, *Update on Avian Influenza A (H5N1) Virus Infection in Humans*, 358 NEW ENG. J. MED. 261, 264 (2008) [hereinafter Writing Comm.] (noting that H5N1 mutations may have permitted human acquisition of avian influenza in some cases, but that "these mutations appear to be insufficient for efficient human-to-human transmission" so that "[c]hanges in multiple viral genes [would] probably [be] required to generate a potentially pandemic influenza A (H5N1) virus").

95. *See* Chan, World Health Org., *supra* note 2, at 1.

countries where most cases have been reported, and might poorly predict a future "bleaker picture" in countries that lack such advantages.[96]

During the epidemic of Severe Acute Respiratory Syndrome (SARS), a substantial number of deaths were reportedly among physicians, as well as other health care workers, suggesting that many if not most acquired infection during treatment of patients and not before.[97] Uncertainties about prevention[98] as well as treatment[99] of influenza would raise particular concerns in the event of a pandemic with a lethal strain. The reliability of N95 respirators, which are specialized masks designed to filter out 95% of viruses and other very small particles, has been questioned.[100] SARS Coronavirus, and probably influenza virus, as well as certain other infectious organisms, are usually carried on respiratory droplets, but are sometimes transmissible through air currents for distances of up to six feet, so transmission does not always require close patient contact.[101] These and other "airborne" organisms require enhanced protective equipment, such as individually fit-tested masks like N95 respirators or masks offering even higher protection, and special "airborne infection isolation rooms."[102] Sophisticated airborne protection equipment, in particular isolation rooms, are often in short supply in hospitals, even

96. *Id.* at 2.

97. Kent A. Sepkowitz & Leon Eisenberg, *Occupational Deaths Among Healthcare Workers*, 11 EMERGING INFECTIOUS DISEASES 1003, 1007 (2005), *available at* http://www.cdc.gov/ncidod/EID/vol11no07/pdfs/04-1038.pdf.

98. *See* Anna Balazy et al., *Do N95 Respirators Provide 95% Protection Level Against Airborne Viruses, and How Adequate Are Surgical Masks?*, 34 AM. J. INFECTION CONTROL 51, 52, 56 (2006) (studying whether "respirators and healthcare masks" adequately protect "against aerosolized viral particles" and concluding that, while "N95 respirators may fall below 95%" efficiency, "surgical masks [provide] much lower" protection); Writing Comm., *supra* note 94, at 271 (discussing the need for deliberation regarding vaccine use given the uncertainty with respect to timing and cause of an influenza pandemic as well as the lack of clarity surrounding adverse consequences of immunization).

99. *See* Writing Comm., *supra* note 94, at 268, 270 (noting reports of fatalities associated with antiviral drug resistance, and indicating that the ability of antivirals and other treatments to reduce overall mortality has yet to be determined).

100. Balazy et al., *supra* note 98, at 56.

101. *See* JANE D. SIEGEL ET AL., U.S. DEP'T OF HEALTH & HUMAN SERVS., 2007 GUIDELINE FOR ISOLATION PRECAUTIONS: PREVENTING TRANSMISSION OF INFECTIOUS AGENTS IN HEALTHCARE SETTINGS 19 (2007), *available at* http://www.cdc.gov/ncidod/dhqp/pdf/guidelines/Isolation2007.pdf (citing evidence that transmission of SARS Coronavirus, influenza virus, and noroviruses is primarily through respiratory droplets, and noting that, although not proven, demonstrations exist of "short distance transmission by small particle aerosols"); Francoise M. Blachere et al., *Measurement of Airborne Influenza Virus in a Hospital Emergency Department*, 48 CLINICAL INFECTIOUS DISEASES 438, 438 (2009) ("[I]nfluenza virus may . . . be transmitted by inhalation of small airborne particles" and "[o]bservational and epidemiological studies suggest that airborne influenza transmission occurs among people . . . .").

102. JANE D. SIEGEL ET AL., U.S. DEP'T OF HEALTH & HUMAN SERVS., *supra* note 101, at 27.

during non-epidemic circumstances, and are not found in offices, radiology suites, or most operating rooms.[103]

Finally, although infection with certain naturally occurring or putative bioterrorist agents may be preventable or manageable, such agents could be widespread before index cases were identified and public health measures were adopted.[104]

B. Duty of Care in Non-Disaster Situations: Application to a Disaster

1. Professional Codes of Ethics

The 1847 American Medical Association (AMA) Code of Ethics stated that "when pestilence prevails, it is [the] duty [of physicians] to face the danger, and continue their labors for the alleviation of suffering, even at the jeopardy of their own lives."[105] By 1977, the fear of epidemics had waned[106] and the duty of the older code was viewed as an "historical anachronism."[107] By that time, the AMA

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103. *See, e.g., id.* at 71 (offering alternative methods of preventing transmission of airborne infections "in settings where Airborne Precautions cannot be implemented due to limited engineering resources (e.g. physician offices)"); Amy H. Kaji & Roger J. Lewis, *Hospital Disaster Preparedness in Los Angeles County*, 13 ACADEMIC EMERGENCY MEDICINE 1198, 1202 (2006) (finding, among other shortages, potentially limiting hospital disaster preparedness that "more than half had fewer than ten designated isolation rooms"); *see also Preparing for Pandemic Flu: Hearing Before the S. Special Comm. on Aging*, 109th Cong. (2006) (statement of the Am. Hosp. Ass'n), *available at* http://www.ucop.edu/riskmgt/documents/aha_panflu_testimony.pdf (stating that, "in sustained disaster such as a pandemic," even by doubling the number of "negative pressure rooms available for patient isolation . . . [Washington D.C. Hospital Center] would be unable to effectively isolate the number of patients anticipated in a pandemic involving an unknown pandemic infectious agent or a known airborne infectious agent").

104. *See* Chan, World Health Org., *supra* note 2, at 1–2 (reporting in June 2009, in the absence of vaccine availability, "nearly 30,000 confirmed cases [of swine flu] . . . from 74 countries"); Donald A. Henderson et al., *Smallpox as a Biological Weapon: Medical and Public Health Management*, 281 JAMA 2127, 2136–37 (1999) (noting that a smallpox outbreak would be devastating "unless effective control measures can quickly be brought to bear" and that "[e]arly detection, isolation of infected individuals, surveillance of contacts, and a focused selective vaccination program are the essential items of a control program"); Thomas V. Inglesby et al., *Plague as a Biological Weapon: Medical and Public Health Management*, 283 JAMA 2281, 2289 (2000) ("Improving the medical and public health response to an outbreak of plague following the use of a biological weapon will require . . . improved rapid diagnostic and standard laboratory microbiology techniques" and "[a]n improved understanding of prophylactic and therapeutic antibiotic regimens . . . .").

105. AM. MED. ASS'N, CODE OF MEDICAL ETHICS OF THE AMERICAN MEDICAL ASSOCIATION app. E ch. III art. I § 1, at 105 (Chicago, American Medical Association Press 1847), *available at* http://www.ama-assn.org/ama/upload/mm/369/1847code.pdf.

106. *See* Leslie P. Francis et al., *How Infectious Diseases Got Left Out—And What this Omission Might Have Meant for Bioethics*, 19 BIOETHICS 307, 307 & n.1 (2005) (quoting United States Surgeon General William H. Stewart in a 1967 speech to the Association of State and Territorial Health Officers where he said "[i]t is time to close the book on infectious disease").

107. Samuel J. Huber & Matthew K. Wynia, *When Pestilence Prevails . . . Physician Responsibilities in Epidemics*, AM. J. BIOETHICS, Winter 2004, at W5, W7.

Code had accepted the concept that "free choice of physicians is the right of every individual," but that the concept of free choice also allows a physician to "decline to accept [an] individual as a patient."[108] While maintaining the physician's freedom to choose whom to serve, the AMA in 1986 affirmed that the physician is, nonetheless, ethically obliged not to discriminate on the basis of "race, color, religion, national origin, sexual orientation or any other basis that would constitute invidious discrimination."[109] Antidiscrimination policy was subsequently extended to HIV status.[110] Furthermore, the AMA Code has long declared that the physician's freedom "to choose whom to serve, with whom to associate, and the environment in which to provide medical care" does not extend to emergencies.[111] Despite these broad restrictions on freedom of choice, however, the AMA did not reinstitute a specific obligation for physicians to treat "at the jeopardy of their lives."[112]

Following the September 11th terrorist attacks, the AMA readdressed the issue of duty in the face of risk in a declaration that physicians should pledge to "[a]pply our knowledge and skills when needed, though doing so may put us at risk."[113] However, this portion of the declaration was explicitly directed to physicians in their roles as educators rather than clinicians, and did not represent a return to the original ethic or a revision of the Code of Ethics.[114] Subsequently, the AMA adopted an Opinion on the physician's role in disaster preparedness and response, which states that "individual physicians have an obligation to provide urgent medical care during disasters," an "ethical obligation [that] holds even in the face of greater than usual risks to their own safety, health or life."[115] Noting that the physician workforce is "not an unlimited resource," the Opinion states that the

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108. COUNCIL ON ETHICAL & JUDICIAL AFFAIRS, AM. MED. ASS'N, CODE OF MEDICAL ETHICS OF THE AMERICAN MEDICAL ASSOCIATION § 9.06, at 308–09 (2008–2009 ed. 2008) [hereinafter AMA CODE].

109. *Id.* § 9.12, at 325; *see also* Am. Osteopathic Ass'n, Code of Ethics § 3, http://www.osteopathic.org/index.cfm?PageID=aoa_ethics (last visited Nov. 25, 2009) (extending the antidiscrimination policy to handicapped individuals, but failing to include sexual orientation as a factor).

110. *See* AMA CODE, *supra* note 108, § 2.23, at 119, § 9.131, at 334 (issuing the guidelines, in 1992, that "[i]t is unethical to deny treatment to HIV-infected individuals because they are HIV seropositive or because they are unwilling to undergo HIV testing" and that "[p]ersons who are seropositive should not be subjected to discrimination based on fear or prejudice").

111. *Id.* at princs. VI, at xv; *see also* JUDICIAL COUNCIL, AM. MED. ASS'N, PRINCIPLES OF MEDICAL ETHICS § 5 (1958), *available at* http://www.ama-assn.org/ama/upload/mm/369/1957_principles.pdf ("A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability.").

112. *See* AM. MED. ASS'N, *supra* note 105, § 1, at 105.

113. AM. MED. ASS'N, REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS: A DECLARATION OF PROFESSIONAL RESPONSIBILITY 3 (2001), *available at* http://www.ama-assn.org/ama1/pub/upload/mm/369/ceja_5i01.pdf.

114. *Id.* at 2.

115. AMA CODE, *supra* note 108, § 9.067, at 313.

physician participating in disaster responses "should balance immediate benefits to individual patients with ability to care for patients in the future."[116] Thus, although physicians are admonished to balance risks to themselves against the duty to the patient, the AMA Code notes the balance is, in the end, for the sake of the patient.

The World Medical Association (WMA) Statement on Avian and Pandemic Influenza declares that "[p]hysicians have an ethical responsibility to provide services to the injured or ill,"[117] and "will have a strong public health duty in the time of a pandemic [when] his/her services will be critical at a time when surge capacity will be stressed."[118] At the same time, the WMA admonishes the physician to "take all measures necessary to protect their own health and the health of their staff,"[119] and "have resources in place in the event they and/or their own families become infected."[120]

With the exception of the AMA, physician codes of ethics in the United States are largely silent with regard to the issue of obligations in the face of personal risk. For example, the American College of Physicians, whose members number 126,000 physicians practicing internal medicine and its specialties,[121] proscribes as unethical "[t]he denial of appropriate care to a class of patients for any reason, including disease state . . . ."[122] This opinion was based on the organization's 1988 position statement regarding HIV-AIDS,[123] in response to fear on the part of many health professionals and reluctance to treat patients,[124] and therefore implicitly supports the obligation to treat despite personal risk. However, advances in HIV care and better understanding of prevention of HIV transmission to health care workers[125] have likely reduced the impact of any such implied obligation in the position statement.

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116. *Id.*

117. World Med. Ass'n, *WMA Statement on Avian and Pandemic Influenza*, 52 WORLD MED. J. 100, § 11(h), at 103, § 11(h)(i), at 103 (2006), *available at* http://www.wma.net/en/30publications/20journal/pdf/wmj12.pdf.

118. *Id.* § 11(h)(i), at 103.

119. *Id.* § 11(h)(ii), at 103.

120. *Id.* § 11(h), at 103.

121. Am. Coll. Physicians, Who We Are, http://www.acponline.org/about_acp/who_we_are/ (last visited Nov. 25, 2009).

122. Lois Snyder & Cathy Leffler, *Ethics Manual: Fifth Edition*, 142 ANNALS INTERNAL MED. 560, 565 (2005).

123. *See id.* (citing Theodore C. Eickhoff, *The Acquired Immunodeficiency Syndrome (AIDS) and Infection with the Human Immunodeficiency Virus (HIV)*, 108 ANNALS INTERNAL MED. 460, 462 (1988) ("The denial of appropriate care to patients for any reason is unethical.")).

124. *See* Eickhoff, *supra* note 123, at 463 ("The approach to patient care . . . should be based on knowledge of the actual risks of infection and not on speculation or unwarranted fears.").

125. *Compare id.* at 460 (noting the various means of transmission, yet failing to explicitly list occupational transmission), *with* Elise M. Beltrami et al., U.S. Dep't Health & Human Servs., *Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HBV, HCV, and HIV and Recommendations for Postexposure Prophylaxis*, MORBIDITY & MORTALITY WKLY. REP.,

Perhaps surprisingly, even the Code of Ethics of the American College of Emergency Physicians is silent regarding a need to tolerate personal risk.[126] However, not only are emergency physicians obliged to serve "as health care providers of last resort for many patients who have no other feasible access to care,"[127] but the Code states that "access to quality emergency care is a fundamental individual right and should be available to all who seek it," regardless of "race, religion, gender, ethnic background, social status, type of illness or injury, or ability to pay."[128]

Finally, the AMA's Council on Ethical and Judicial Affairs has recently emphasized that the requirement to treat in an emergency is a "fundamental exception" to the physician's freedom to choose whom to treat.[129] At least on this issue, there is a virtual consensus among medical organizations, including the American Osteopathic Association,[130] the American College of Emergency Physicians,[131] the American College of Physicians,[132] and the World Medical Association,[133] of which the AMA is the National Member Association representing the U.S.[134] In short, despite limited mention of personal risk, codes of

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Jun. 29, 2001, at 7–8, *available at* http://www.cdc.gov/mmwr/PDF/rr/rr5011.pdf (discussing in detail the risk of occupational transmission of HIV).

126. *But see* Am. Coll. Emergency Physicians, Code of Ethics for Emergency Physicians § II(A)(3), *in* 52 ANNALS EMERGENCY MED. 581, 584 (2008), *available at* http://www.acep.org/practres.aspx?id=29144 (defining courage—one of the virtues in emergency medicine—as "the ability to carry out one's obligations despite personal risk or danger"); Iserson et al., *supra* note 84, at 347 (describing the "emergency physician's responsibility to put patient welfare first" as the most important of emergency physician's ethical principles).

127. Am. Coll. Emergency Physicians, *supra* note 126, § II(A)(2), at 583.

128. *See id.* § II(D)(3)(a), at 588.

129. AM. MED. ASS'N, REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS: PHYSICIANS OBJECTION TO TREATMENT AND INDIVIDUAL PATIENT DISCRIMINATION 1 (2007), *available at* http://www.ama-assn.org/ama1/pub/upload/mm/369/ceja_6a07.pdf.

130. Am. Osteopathic Ass'n, *supra* note 109, § 3 ("In emergencies, a physician should make his/her services available.").

131. *See* Am. Coll. Emergency Physicians, *supra* note 126, § I(2), at 582, § II(A)(2), at 583, § II(D)(3)(d), at 589 (finding that, in addition to a duty to "[r]espond promptly and expertly, without prejudice or partiality, to the need for emergency medical care," an ethical duty exists beyond the hospital to offer assistance as a special resource in the community and "to respond to prehospital emergencies and disasters").

132. *See* Snyder & Leffler, *supra* note 122, at 562 (noting the duty "to provide care to an individual person . . . when emergency treatment is required").

133. *See* World Med. Ass'n, *World Medical Association International Code of Medical Ethics*, 52 WORLD MED. J. 87, 87 (2006), *available at* http://www.wma.net/en/30publications/20journal/pdf/wmj12.pdf ("A physician shall give emergency care as a humanitarian duty unless he/she is assured that others are willing and able to give such care.").

134. World Med. Ass'n, *WMA Directory of National Member Medical Associations Officers and Council*, 52 WORLD MED. J., Dec. 2006, at i, iii, *available at* http://www.wma.net/en/30publications/20journal/pdf/wmj12.pdf.

ethics governing physician behavior would be misread if they were interpreted as condoning that doctors flee the area in the event of an epidemic.

2. Codes of Ethics and the Law

Although professional codes do not themselves constitute binding law,[135] the codes find their way into the law implicitly and explicitly. Medical Boards have statutory authority to develop standards for the medical profession, including codes of conduct, and may impose sanctions for violation of professional ethical standards, including loss of licensure.[136]

A model act developed by the Federation of State Medical Boards provides guidance to states in promulgating medical practice acts, and defines "unprofessional or dishonorable conduct" to include "violation of any provision of a national code of ethics acknowledged by the Board."[137] In Texas, the provider is required to "adhere to established professional codes of ethics," as these codes "define the professional context within which the provider works."[138] Some states have codified specific medical codes of ethics in their regulations. In Nevada, the State Board of Medical Examiners is authorized to initiate disciplinary action or deny licensure to a physician whose conduct "violates any provision of a code of ethics adopted by the Board by regulation based on a national code of ethics."[139] In New Mexico, the Board has specifically adopted the AMA Code of Ethics for this purpose.[140] The Rhode Island State Medical Board "relies upon the AMA [C]ode of [E]thics as the legal standard" in determining professional conduct, according to the state's Department of Health website.[141] In Utah, medical records must be maintained to "be consistent with" the AMA Code of Ethics,[142] in accordance with the state's Medical Practice Act, which requires that "[m]edical records maintained by a licensee shall meet the standards and ethics of the profession . . . ."[143] The Kentucky statute specifically authorizes its Medical Board to use the Codes of Ethics of the AMA and the American Osteopathic Association in its finding of "dishonorable, unethical or unprofessional conduct,"[144] and specifies that failure to

135. Zita Lazzarini, *An Analysis of Ethical Issues in Prescribing and Dispensing Syringes to Injection Drug Users*, 11 HEALTH MATRIX 85, 90 (2001).

136. ESSENTIALS OF A MODERN MED. PRACTICE ACT §§ III(B)(3), IX(A)(1) (Fed'n of State Med. Bd. of the U.S. 2006).

137. *Id.* § IX(D), § IX(D)(37).

138. 25 TEX. ADMIN. CODE § 448.216 (2009).

139. NEV. REV. STAT. ANN. § 630.301(9) (LexisNexis 2008).

140. N.M. CODE R. § 16.10.8.9 (Weil 2009).

141. R.I. Dep't Health, Board of Medical Licensure and Discipline, http://www.health.ri.gov/hsr/bmld/ (last visited Nov. 25, 2009).

142. UTAH ADMIN. CODE r.156-67-602(2) (2009).

143. UTAH CODE ANN. § 58-67-803(1)(a) (2007).

144. KY. REV. STAT. ANN. § 311.597(4) (West 2006).

conform to the principles of the code can lead to license suspension even if actual injury to a patient is not established.[145]

Finally, courts have often relied on medical codes of ethics to provide guidance in reaching certain decisions. In a Vermont case, the state's highest court agreed "as a general matter, with those courts that accept professional ethics codes as potential sources of public policy," with the conditions that the ethical provisions relied upon be "sufficiently concrete" and those being applied be "primarily for the benefit of the public as opposed to the interests of the profession alone."[146] In a Maryland case involving a forensic psychiatrist, the court noted that the Maryland State Board of Physicians recognizes the AMA Code in general, and in this particular case, relied also on specific guidelines of the American Academy of Psychiatry and the Law, as well as the American Psychiatric Society annotations of the AMA Code that are applicable to psychiatry.[147] Finally, in upholding a Washington state law banning assisted suicide, the U.S. Supreme Court cited the AMA Code of Ethics' disapproval of physician-assisted suicide, in support of the legitimate government interest in maintaining the integrity and ethics of the medical profession.[148]

Courts do not uniformly find that ethics codes can serve as a source of public policy, and when they do, it is with provisos. For example, in a New Jersey case, a physician who refused to perform research could not prevail in her claim of wrongful discharge by simply stating the research violated her interpretation of the Hippocratic oath;[149] rather, an employee must show how the disputed issue involved a clear mandate of public policy, expressions of which could be found not only in legislation, administrative rules, and judicial decisions, but also, under some circumstances, in professional codes.[150] In a Vermont decision involving a physician who claimed wrongful termination of employment for refusing to refer cases to physicians whom he felt provided inadequate medical care, the Court found that professional codes, like the AMA Principles of Medical Ethics, can serve as potential sources of public policy, as long as the proponent of the code can prove that the code articulates a "clear and compelling public policy."[151] In

145. *See id.* § 311.595(9).

146. LoPresti v. Rutland Reg'l Health Servs., 865 A.2d 1102, 1112 (Vt. 2004) (citing Rocky Mountain Hosp. and Med. Serv. v. Mariani, 916 P.2d 519, 525 (Colo. 1996)); *see also* Pierce v. Ortho Pharm. Corp., 417 A.2d 505, 512 (N.J. 1980) (holding, in a case of a physician who refused to perform research in violation of her professional code of ethics, "that an employee has a cause of action for wrongful discharge when the discharge is contrary to a clear mandate of public policy," which could be expressed in a "professional code of ethics").

147. Salerian v. Md. State Bd. of Physicians, 932 A.2d 1225, 1235–36 (Md. Ct. Spec. App. 2007).

148. Washington v. Glucksberg, 521 U.S. 702, 731 (1997) (citing AMA Code of Ethics' disapproval of physician-assisted suicide as "fundamentally incompatible with physician's role as healer").

149. *Pierce*, 417 A.2d at 507, 513, 518.

150. *Id.* at 512.

151. *LoPresti*, 865 A.2d at 1112, 1114.

contrast, an Illinois decision seemed to foreclose the possibility that the AMA Code could provide an expression of public policy. In a ruling involving the objection to physician covenants not-to-compete, the Illinois Supreme Court noted that an AMA Opinion was "not the equivalent of a . . . statute or rule of professional conduct and, [therefore] . . . does not provide a clear expression of the public policy of this state."[152] The Court did, however, find the AMA's position discouraging such covenants to be commensurate with Illinois common law requirements that "restrictive covenants be reasonable and not adverse to the public welfare."[153]

In short, although physician codes of ethics do not constitute binding law, at a minimum, they serve as persuasive authority, and in some jurisdictions, physician adherence to a code of ethics may be a legal requirement. Although several courts have found that physicians' codes of ethics may serve, in some circumstances, as expressions of public policy, the question remains whether courts would be persuaded by the AMA obligation that physicians confront "risks to their own safety, health or life" in order to benefit the public in a disaster.[154]

3. The Established Physician-Patient Relationship and Abandonment

As a matter of common law, once a relationship has been established between a patient and physician, the physician has an ongoing obligation to care for the patient.[155] In the case of a generalist, this obligation would be broad,[156] whereas in the case of a specialist the obligation might be limited to the conditions the specialist has agreed to treat.[157] In either case, this obligation derives from the express or implied contract between patient and physician that is established once the physician has agreed to see the patient.[158] The patient as well as the physician may discontinue the relationship at any time,[159] but if the physician unilaterally wishes to discontinue, he or she must provide the patient with "reasonable notice" to permit the patient to seek (though not necessarily succeed in finding) an

152. Mohanty v. St. John Heart Clinic, 866 N.E.2d 85, 94 (Ill. 2006).

153. *Id.* (citing Idbeis v. Wichita Surgical Specialists, 112 P.3d 81 (Kan. 2005)).

154. AMA CODE, *supra* note 108, § 9.067, at 313.

155. *See, e.g.*, Ricks v. Budge, 64 P.2d 208, 211 (Utah 1937) ("[T]he law is well settled that a physician or surgeon, upon undertaking an operation or other case, is under the duty . . . of continuing his attention . . . so long as the case requires attention.").

156. STEDMAN'S MEDICAL DICTIONARY 798 (28th ed. 2006) (defining a generalist as "[a]n internist, family physician, or pediatrician who performs general medicine; one who treats most diseases that do not require surgery, sometimes including those related to obstetrics").

157. *Id.* at 1796 (characterizing a specialist as "[o]ne who has developed professional expertise in a particular specialty or subject area").

158. *See, e.g.*, Childs v. Weis, 440 S.W.2d 104, 107 (Tex. Civ. App. 1969) ("[I]t is unquestionably the law that the relationship of physician and patient is dependent upon contract, either express or implied . . . .").

159. *Ricks*, 64 P.2d. at 211.

alternative care provider.[160] If the situation is such that the patient is in need of further attention, this notice should be "sufficient . . . so the patient can procure other medical attention if . . . desire[d]."[161] Not to do so would constitute abandonment.[162] If the abandonment is found to be the proximate cause of injury to the patient, the physician can be held liable for damages.[163]

In some states, abandonment is explicitly forbidden by statute. In New York, abandonment is considered unprofessional conduct[164] and is subject to sanctions, including possible loss of license.[165] Idaho's Medical Practice Act specifically authorizes the Board of Medicine to discipline a physician on grounds of "abandonment of a patient."[166] In New Mexico, abandonment of patients is grounds for license revocation on the basis of "unprofessional or dishonorable conduct."[167]

In contrast, Virginia and Texas statutory provisions specifically delineate procedures under which physicians may unilaterally sever a relationship. In Virginia, a physician is not required to render treatment that he "determines to be medically or ethically inappropriate;"[168] if this determination conflicts with the patient's advance directive or request by the patient's designated surrogate, he must attempt to transfer the patient to an agreeing physician and provide life-sustaining treatment if needed, but is not required to continue treatment after fourteen days.[169] In Texas, a "medical futility" provision[170] protects a physician from civil and criminal liability as well as professional disciplinary action for refusing to honor an advance directive "or a health care or treatment decision made by or on behalf of a patient," upon following certain procedures.[171] If the physician is refusing a request for life-sustaining treatment, he need only provide such treatment for ten days after informing the patient or surrogate of a committee's concurrence that the

160. *Id.* at 211–12.

161. *Id.* at 212.

162. N.Y. COMP. CODES R. & REGS. tit. 8, § 29.2(a)(1) (2009); *see also* Hill v. Medlantic Health Care Group, 933 A2d. 314, 328 (D.C. 2007) (citing Miller v. Greater Se. Comm. Hosp., 508 A.2d 927, 929 (D.C. 1986)); MARK A. HALL ET AL., HEALTH CARE LAW AND ETHICS 170 (Aspen Publishers 2007) (1955) (describing abandonment liability).

163. O'Neill v. Montefiore Hosp., 202 N.Y.S.2d 436, 440 (N.Y. App. Div. 1960) (citing Meiselman v. Crown Heights Hosp., 34 N.E.2d 367 (N.Y. 1941)).

164. N.Y. COMP. CODES R. & REGS. tit. 8, § 29.2(a)(1) (2009).

165. N.Y. EDUC. LAW § 6511 (McKinney 2008).

166. IDAHO CODE ANN. § 54-1814(15) (2008). The Board is also empowered to control physician licensure. *Id.* § 54-1806(7).

167. N.M. STAT. ANN. § 61-6-15(D)(24) (LexisNexis 2008).

168. VA. CODE ANN. § 54.1-2990(A) (2005).

169. *Id.*

170. Robert L. Fine & Thomas Wm. Mayo, *Resolution of Futility by Due Process: Early Experience with the Texas Advance Directives Act*, 138 ANNALS INTERNAL MED. 743, 743 (2003); Robert D. Truog, *Tackling Medical Futility in Texas*, 357 NEW ENG. J. MED. 1, 2 (2007).

171. TEX. HEALTH & SAFETY CODE ANN. § 166.046(a) (2006 & Supp. 2008).

intervention is inappropriate.[172] These time-limited obligations to patients, however, emanate from long-standing concerns about surrogate demands that could harm dying patients, as well as misuse of resources, rather than concerns about physician failure to fulfill the duty of care.[173]

Despite a contractual obligation to the patient, and the possibility of an abandonment claim, a physician might understandably be reluctant to attend to a patient if doing so could harm the physician—for example, if the patient were infected with a highly contagious, potentially lethal virus. Although an abandonment claim would fail if the physician had provided "reasonable notice" for the patient to seek an alternate, qualified physician to take over care,[174] the notion of reasonable notice in the extraordinary circumstance of a public health crisis would not apply as a practical matter if the patient were seriously ill, and physicians were in short supply or available physicians declined to take over the patient's care.

Courts have not addressed "personal risk" as a defense to an abandonment claim, but it is questionable whether such a defense would survive. In contract law, a "health danger" might be a defense for failure to perform, as long as the danger was not caused by the nonperforming party, and was unforeseen when the parties entered into the contract.[175] However, any physician whose services involve direct patient contact would be exposed to health dangers and would enter virtually any agreement to treat patients with that knowledge. Certain, specialty-specific risks are common and obviously foreseeable. For example, surgeons, internists, and others who perform invasive procedures face the possibility of developing serious blood-borne illnesses such as HIV or Hepatitis B or C.[176] However, other risks ought to be anticipated and protective measures taken. In the U.S., transmission of tuberculosis to health care workers is currently most common when the patient has unsuspected or undiagnosed disease;[177] thus, for example, a radiologist whose most common

172. *Id.* § 166.046(e).

173. *See, e.g.*, Council on Ethical & Judicial Affairs, Am. Med. Ass'n, *Medical Futility in End-of-Life Care*, 281 JAMA 937 (1999); Ethics Comm. of the Soc'y of Critical Care Med., *Consensus Statement of the Society of Critical Care Medicine's Ethics Committee Regarding Futile and Other Possibly Inadvisable Treatments*, 25 CRITICAL CARE MED. 887 (1997); Marshall B. Kapp, *Futile Medical Treatment: A Review of the Ethical Arguments and Legal Holdings*, 9 J. GENERAL INTERNAL MED. 170 (1994); Robert D. Truog et al., *The Problem with Futility*, 326 NEW ENG. J. MED. 1560 (1992).

174. *See* Ricks v. Budge, 64 P.2d. 208, 211 (Utah 1937) (requiring "reasonable notice" to avoid a claim of abandonment).

175. Handicapped Children's Educ. Bd. of Sheboygan County v. Lukaszewski, 332 N.W.2d 774, 777 (Wis. 1983) (citing Jennings v. Lyons, 39 Wis. 553, 557–58 (1876)).

176. Donald E. Fry, *Occupational Risks of Blood Exposure in the Operating Room*, 73 AM. SURGEON 637, 637 (2007).

177. Paul A. Jenson et al., *Guidelines for Preventing the Transmission* of Mycobacterium Tuberculosis *in Health-Care Settings, 2005*, MORBIDITY & MORTALITY WKLY REP., Dec. 30, 2005, 1, 2, *available at* http://www.cdc.gov/mmwr/pdf/rr/rr5417.pdf.

foreseeable risk is x-ray exposure might nonetheless have contact with such a patient and would need to anticipate such occurrences.

Clinicians are exposed to other dangers in the health care setting and are expected to handle them. For example, nursing home residents may be discharged from the facility involuntarily if they endanger the health or safety of individuals in the facility,[178] but such actions "must be the last resort" used only after the facility has "exhaust[ed] the options available to it . . . ."[179] Options could be selected from an array of pharmacologic or behavioral interventions available to the medical profession and its various specialties.[180] Although the federal Nursing Home Reform Act strongly supports nursing home residents' rights, including the right to refuse treatments[181] and to be free of "physical or chemical restraint,"[182] the Act specifically permits their use "to treat a specific condition as diagnosed and documented in the clinical record . . . ."[183] Likewise, physicians are permitted to administer antipsychotic medications to mentally ill or mentally retarded patients over their objections if "the patient presents a danger to himself or other members of society or engages in dangerous or potentially destructive conduct within the institution . . . ."[184] In New York State, facilities treating the mentally disabled may give treatment "at any time to all patients, despite objection in a case where the treatment appears necessary to avoid serious harm to life or limb of the patients themselves or others."[185]

Legal and regulatory protections are available for infectious disease and other work-related hazards in the health care environment. The Joint Commission requires facilities to maintain and furnish personal protective equipment (PPE) when needed, and to train health care workers in its use.[186] The Occupational Health and Safety Act[187] and laws in at least twenty-six states[188] impose similar

178. 42 C.F.R. § 483.12(a)(2)(iii)–(iv) (2008).

179. *In re* Involuntary Discharge or Transfer of J.S. by Hall, 512 N.W.2d 604, 612 (Minn. Ct. App. 1994).

180. *Id.*

181. 42 C.F.R. § 483.10(b)(4).

182. *Id.* § 483.13(a).

183. *Id.* § 483.25(l)(2)(i).

184. Rivers v. Katz, 495 N.E.2d 337, 343 (N.Y. 1986).

185. N.Y. COMP. CODES R. & REGS. tit. 14, § 27.8(b)(1) (2009).

186. JOINT COMM'N, *supra* note 3, at 3, 8–10.

187. 29 U.S.C. § 652(5) (2006) (applying to employers "engaged in a business affecting commerce who has employees, but does not include the United States (not including the United States Postal Service) or any State or political subdivision of a State").

188. U.S. Dep't of Labor, *State Occupational Safety and Health Plans*, http://www.osha.gov/dcsp/osp/index.html (last visited Nov. 27, 2009) (listing twenty-six states with OSHA-approved job safety and health programs fulfilling requirements that they be "'at least as effective as' comparable federal standards"). Twenty-two of these programs also apply to employers at government facilities. *Id. See, e.g.*, N.Y. LAB. LAW § 27-a(4) (McKinney 2002 & Supp. 2009) (relying on OSHA for coverage of private institutions); VA. CODE ANN. § 40.1-1 (2002).

requirements on certain health care facilities. Most basic PPE used in hospitals, such as masks, gowns, and gloves, are intended for use by anyone, including non-employees, who might be in contact with a patient infected by or vulnerable to infection with a transmissible infectious agent.[189]

Thus, in certain circumstances, the physician's obligation to care for a patient for whom he has a contractual obligation may persist despite the possibility that the patient's condition or actions could harm the physician. In fact, physicians have many tools available to minimize risk when treating patients, and are expected by the law to exhaust the options in the care of the patient.[190] Tools available to physicians are not without limit, however. For example, methods exist to prevent transmission of certain infectious agents between patient and physician, but prevention of transmission of highly infectious agents, such as influenza virus, and protection from agents of bioterror are less easily accomplished.[191]

4. Duty to Care for People with Disabilities: The Americans with Disabilities Act, the Rehabilitation Act, and the "Direct Threat" Exception

As a general rule, a physician is under no legal obligation to enter into the physician-patient contract, even in an emergency.[192] However, federal law explicitly forbids discrimination on the basis of race, color, and national origin in programs receiving federal funds,[193] and discrimination on the basis of disability is explicitly forbidden under federal law and in many states.[194]

189. CTRS. FOR DISEASE CONTROL & PREVENTION, U.S. DEP'T HEALTH & HUMAN SERVS., GUIDELINES FOR ENVIRONMENTAL INFECTION CONTROL IN HEALTH-CARE FACILITIES: RECOMMENDATIONS OF CDC AND THE HEALTHCARE INFECTION CONTROL PRACTICES ADVISORY COMMITTEE (HICPAC) 26, 36–37 (2003), *available at* http://www.cdc.gov/ncidod/dhqp/pdf/guidelines/Enviro_guide_03.pdf (mentioning individual recommendations generally as applying to "health-care workers and visitors").

190. *See In re* Involuntary Discharge or Transfer of J.S. by Hall, 512 N.W.2d 604, 612 (Minn. Ct. App. 1994) ("A facility must first exhaust the options available to it within the level of care it is authorized to provide.").

191. *See supra* Part III.A.

192. Hiser v. Randolph, 617 P.2d 774, 776 (Ariz. Ct. App. 1980) (citing Hurley v. Eddingfield, 59 N.E. 1058, 1058 (Ind. 1901)); Childs v. Weis, 440 S.W.2d 104, 106 (Tex. Civ. App. 1969)) (finding the physician's contract with the hospital did not create a physician-patient relationship despite the patient's presence in the hospital and emergency medical condition).

193. 45 C.F.R. § 80.3(a) (2007) (applying to programs administered by the Department of Health and Human Services); *see also, e.g.*, N.Y. EDUC. LAW § 6509(6) (McKinney 2001 & Supp. 2009) ("Refusing to provide professional service to a person because of such person's race, creed, color, or national origin" is prohibited and constitutes grounds for discipline under the state's medical licensure statute).

194. 42 U.S.C. § 12132 (2006).

The federal Rehabilitation Act provides that a recipient of federal funds[195] "may not, on the basis of handicap deny a qualified person . . . benefits or services," or provide benefits or services that are not as effective as or equal to those provided to others.[196] A handicapped person is defined as "any person who has a physical or mental impairment which substantially limits one or more major life activities, has a record of such an impairment, or is regarded as having such an impairment."[197] The definition of "physical or mental impairment" includes "any physiological disorder or condition . . . affecting one or more of the body systems," including neurological, musculoskeletal, respiratory, cardiovascular, and many others.[198] The same prohibitions hold under the American with Disabilities Act (ADA) of 1990, and apply to discrimination regarding benefits and services of a public entity[199] or "by any person who owns, leases (or leases to) or operates a place of public accommodation,"[200] which would include, among others, hospitals, clinics, and physicians offices,[201] as well as private entities, such as the professional office of a health care provider, hospital, or other service establishments if "operations of such entities affect commerce."[202] The ADA definition of "disability"[203] is equivalent to the Rehabilitation Act definition of "handicap."[204] Regulatory standards of the ADA and Rehabilitation Act are to be applied similarly by the courts.[205]

Thus, the ADA and Rehabilitation Act apply to a broad group of physicians and institutions. A physician employed by or having a contractual arrangement with a public facility, or who accepts Medicare or Medicaid payment in his or her office, would not be excluded from the requirement to provide care for a person disabled under the Act. That is, the general right to choose whom to treat would not apply under these circumstances.

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195. Lesley v. Chie, 81 F. Supp. 2d 217, 222 (D. Mass. 2000) (citing Glanz v. Vernick, 756 F. Supp. 632, 636 (D. Mass. 1991) (finding that receipt of Medicare or Medicaid funds is considered "federal financial assistance" under the Rehabilitation Act, 20 U.S.C § 794).

196. 45 C.F.R. § 84.52(a)(1)–(3) (2008).

197. *Id.* § 84.3(j)(1)(i)–(iii).

198. *Id.* § 84.3(j)(2)(i).

199. 42 U.S.C. § 12132.

200. *Id.* § 12182(a).

201. Bass v. County of Butte, 458 F.3d 978, 980 (9th Cir. 2006) (stating that Disabled Persons Act, CAL. CIV. CODE § 54(a), expressly provides disabled persons the right to utilize various types of medical facilities).

202. 42 U.S.C. § 12181(7)(F).

203. *Id.* § 12102(2).

204. 45 C.F.R. § 84.3 (j)(l)(i)–(iii).

205. Bragdon v. Abbott, 524 U.S. 624, 631–32 (1998) (citing 42 U.S.C. § 12201(a) (providing the authority to promulgate the regulations of the Rehabilitation Act)) (requiring the court to construe the ADA to grant at least as much protection as provided by the regulations implementing the Rehabilitation Act).

Contagious diseases are not excluded from the Rehabilitation Act's definition of handicapped,[206] and a person disabled by the infectious disease cannot be denied health care on the basis of the disability unless the individual poses a "direct threat" to others.[207] In *Bragdon v. Abbott*, a seminal case initiated at the height of the AIDS epidemic, a dentist's refusal to treat a woman infected with HIV was found to be in violation of the ADA.[208] Abbott's HIV infection was found to be a disability under the Act on the basis that it interfered with her ability to procreate, a major life activity.[209] The Court found that the dentist could have refused to treat her under the statute's "direct threat" exception, if, in this case, the infectious condition posed "a direct threat to the health or safety of others . . . that [could] not be eliminated by a modification of policies, practices, or procedures . . . ."[210]

Because risk to the physician could serve as a defense to a disabilities claim, it is logical to ask whether the ADA and Rehabilitation Act would apply to people who have been exposed to a highly contagious, lethal respiratory virus. The same question would apply to other exposures such as radiological, chemical, or even nuclear agents. The possibility of discriminatory acts by clinicians would be great, and might include refusing to treat, or providing unequal treatment—for example ordering or administering treatment less frequently than needed in order to minimize exposure to the patient.

The courts have interpreted the ADA definition of "disability" very stringently.[211] In *Toyota v. Williams*,[212] the Supreme Court considered a case of a woman who claimed her employer refused to accommodate her manual disability; the Court held that "to be substantially limited in performing manual tasks," the impact of her impairment, among other things, "must be permanent or long term."[213] Using this standard, a previously healthy person who developed acute illness and became temporarily disabled in the common sense of the word, would not be legally disabled unless, and perhaps not until, he or she developed long-term

206. *See* Sch. Bd. of Nassau County, Fla. v. Arline, 480 U.S. 273, 284 (1987) (regarding employment of a teacher with recurrent tuberculosis).

207. 42 U.S.C. § 12182(b)(3).

208. *Bragdon*, 524 U.S. at 628–29.

209. *See id.* at 641–42 (affirming lower court's acceptance of Abbott's unchallenged testimony as to her reasons for not having children on the basis of HIV infection).

210. *See id.* at 648–49 (citing 42 U.S.C. § 12182(b)(3)); *see also* Abbott v. Bragdon, 163 F.3d 87, 90 (1st Cir. 1998) (finding on remand that appropriate practices were found to exist, and the dentist could not be excused from treating the patient).

211. *See, e.g.*, Toyota Motor Mfg., Ky. v. Williams, 534 U.S. 184, 187 (2002) (finding that the proper standard in classifying a disabled individual is to consider whether the individual's afflictions inhibited one's general performance in carrying out important daily tasks); Sutton v. United Air Lines, 527 U.S. 471, 475 (1999) (holding that mitigating considerations should have been taken into account in evaluating whether an individual is categorically disabled under the ADA).

212. 534 U.S. 184 (2002).

213. *Id.* at 198.

disability from the illness. In the case of pandemic influenza, disabling long term complications might include chronic pulmonary disease or neuromuscular derangements,[214] although these complications could not be predicted in the acute phase of the illness.[215]

However, in the recently enacted ADA Amendments Act (ADAAA), Congress rejected a series of high court analyses, including that in *Toyota*, as creating a standard of disability "higher than Congress intended,"[216] and directed the courts to construe the definition of disability "in favor of broad coverage . . . ."[217] The ADAAA's rejection of the *Toyota* standard did not refer to the Court's requirement that the impairment's impact must be "permanent or long term,"[218] stipulating only that such a requirement would be imposed on persons falling under the "third prong" of the definition of handicapped, namely on individuals "regarded as" having an impairment whether or not such an impairment exists.[219] Furthermore, whether a condition constitutes a disability under the law has to be determined on a case-by-case basis—i.e., whether the condition interferes with a major life activity.[220] In the case of a communicable disease, the courts, including *Toyota*,[221] have largely held to individualized assessments of whether different persons with the same infectious disease satisfied the definition of

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214. Simon N. Fletcher et al., *Persistent Neuromuscular and Neurophysiologic Abnormalities in Long-Term Survivors of Prolonged Critical Illness*, 31 CRITICAL CARE MEDICINE 1012, 1014 (2003) (reporting long term outcomes in one series of patients with a syndrome of persistent weakness and neurological deficits commonly seen after prolonged intensive care unit stays); *see also* Margaret S. Herridge et al., *One-Year Outcomes in Survivors of the Acute Respiratory Distress Syndrome*, 348 NEW ENG. J. MED. 683, 688–89 (2003) (finding that "patients who survived the acute respiratory distress syndrome have persistent functional limitation one year after their discharge from the [intensive care unit], largely as a result of muscle wasting and weakness" and that fewer than half had resumed working).

215. William D. Schweickert & Jesse Hall, *ICU-acquired Weakness*, 131 CHEST 1541, 1544–45 (2007) (reviewing the literature on syndrome of "ICU-acquired weakness" and noting wide variation in clinical occurrence of ICU-acquired weakness in patients who survived prolonged treatment in the ICU setting). *See generally* Herridge et al., *supra* note 214, at 691–92 (finding among SARS survivors patient characteristics and treatments associated with higher risk of developing worse long-term functional outcomes, although no factor is a precise predictor of outcome).

216. ADA Amendments Act of 2008, Pub. L. No. 110-325, § 2(b)(4), 122 Stat. 3553, 3554 (2008). Through enactment of the ADA Amendments Act of 2008, Congress rejected the *Toyota* standard that "to be substantially limited in performing a major life activity under the ADA" the impairment must be one that "prevents or severely restricts the individual from doing activities that are of central importance to most people's daily lives." *Id.* (citing Toyota Motor Mfg., Ky. v. Williams, 534 U.S. 184, 198 (2002)).

217. *Id.* § 4(a), 122 Stat. at 3555.

218. *Toyota*, 534 U.S. at 198.

219. ADA Amendments Act § 4(a), 122 Stat. at 3555 (noting that the standards governing such individuals would not apply to impairments that are minor and having "an actual or expected duration of [six] months or less").

220. Sutton v. United Air Lines, Inc., 527 U.S. 471, 483 (1999) (citing 42 U.S.C. § 12102(2)).

221. *Toyota*, 534 U.S. at 198 (citing Bragdon v. Abbott, 524 U.S. 624, 641–42 (1998)).

disability.[222] However, whether the courts would rule that pandemic influenza or other disaster-related diseases satisfied broadened definitions of disability remains to be seen.

Certain state antidiscrimination laws define disability more broadly than does federal law. In California, for example, conditions such as high blood pressure, which "may handicap in the future but have no present disabling effect," cannot be excluded as a protected physical handicap within the meaning of the state's Fair Employment & Housing Act.[223] This definition of disability is also applied in California's Disabilities Act.[224] The definition of disability that encompasses conditions that may handicap in the future has been applied in Maryland, with regard to high blood pressure,[225] and in New York, in the case of severe obesity.[226]

It remains to be seen whether a person surviving acutely disabling influenza but now permanently impaired because of inadequate treatment could claim discrimination in the health care setting under disabilities law. Under an ADA claim, a clinician could invoke the "direct threat" exception, citing historical data about occupationally acquired disease and death during other epidemics,[227] or more timely data regarding infection and morbidity among health care workers during the epidemic at issue. Unlike the well-informed guidelines on prevention of HIV and Hepatitis B and C viruses,[228] uncertainties about prevention and treatment of highly contagious respiratory viruses, such as influenza,[229] would raise particular concerns in the event of a pandemic with a lethal strain. Serious questions regarding use and availability of personal protective equipment for other agents[230] would make it doubtful that the threat could be eliminated by "a modification of

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222. *See, e.g.*, Gowesky v. Singing River Hosp. Sys., 321 F.3d 503, 508 (5th Cir. 2003) (finding physician with Hepatitis C not disabled for purposes of employment discrimination claim because the disease did not interfere with her ability to perform alternate work); Furnish v. SVI Sys., 270 F.3d 445, 449 (7th Cir. 2001) (finding Hepatitis B not a disability as the court disagreed with the claimant's representation of liver function as major life activity). *But see* Quick v. Tripp, Scott, Conklin, & Smith, P.A., 43 F. Supp. 2d 1357, 1367–68 (S.D. Fla. 1999) (finding Hepatitis C a disability as interfering with procreation in an otherwise qualified employee able to perform her job).

223. Am. Nat'l Ins. Co. v. Fair Employment & Hous. Comm'n, 651 P.2d 1151, 1155 (Cal. 1982).

224. CAL. CIV. CODE § 54(a)–(b)(1) (West 2007 & Supp. 2008).

225. Mass Transit Admin. v. Md. Comm'n on Human Relations, 515 A.2d 781, 784 (Md. 1986) (agreeing with *American National Insurance Co.* that high blood pressure is potentially handicapping and therefore the Human Rights Commission could hear the case of man claiming violation of MD. CODE ANN., art. 49B § 16(a)(1) (1979)).

226. State Div. of Human Rights v. Xerox Corp., 480 N.E.2d 695, 696 (N.Y. 1985) (citing N.Y. EXEC. LAW § 296(1)(a)).

227. See Huber & Wynia, *supra* note 107, at W5–W6.

228. *See generally* Beltrami et al., *supra* note 125.

229. SIEGEL ET AL., U.S. DEP'T OF HEALTH & HUMAN SERVS., *supra* note 101, at 20; *see also* Balazy et al., *supra* note 98, at 56; Writing Comm., *supra* note 94, at 264.

230. *See supra* Part III.A.

policies, practices, or procedures . . . ."[231] In determining whether a patient might be a direct threat to a treating physician, courts might give "special weight and authority" to guidelines promulgated by public health authorities,[232] but the opinion of an individual physician is "entitled to deference" even if it deviates from the general consensus, so long as it rests on a "credible scientific basis . . . ."[233] A clinician, furthermore, need only demonstrate a risk—as opposed to a certainty—of becoming infected, and could invoke the severity of the risk in bolstering his argument as well.[234]

In the employment context, conditions that last "for only a few days or weeks and have no permanent or long-term effects on an individual's health" do not rise to the level of disability.[235] Chronic infections, such as HIV, have been the subject of disability discrimination claims regarding access to health care[236] as well as in the employment context.[237] However, neither federal nor state courts have been faced with the question of whether an acutely ill person in the health care setting, who might or might not recover, is disabled under the law and is protected from discrimination on the basis of that illness. While it is probable that discrimination would occur in the case of serious pandemic influenza, it is less probable that an aggrieved patient could find protection under the ADA, in which case the direct threat exception would be moot. Moreover, legal options would exist for patients harmed by inadequate care, as the legal duty of care is broad and would extend to most if not all venues where seriously ill patients would seek diagnosis and treatment.[238] However, the possibility would remain that fearful providers could find other pretexts to avoid exposure, such as claiming lack of skill in treating a particular condition,[239] or, if turning up for work, other rationale.[240]

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231. 42 U.S.C. § 12182(b)(3) (2006).

232. Bragdon v. Abbott, 524 U.S. 624, 650 (1998).

233. Lesley v. Chie, 250 F.3d 47, 56–57 (1st Cir. 2001) (citing *Bragdon*, 524 U.S. at 650).

234. *Bragdon*, 524 U.S. at 664 (citing Sch. Bd. of Nassau County, Fla. v. Arline, 480 U.S. 273, 288 (1987)).

235. U.S. Equal Employment Opportunity Comm'n, Section 902 Definition of the Term Disability, http://www.eeoc.gov/policy/docs/902cm.html (last visited Nov. 27, 2009) (mentioning influenza, along with the common cold, as examples of temporary conditions that do not constitute a disability).

236. *Bragdon*, 524 U.S. at 628–29; *Lesley*, 250 F.3d at 49; Howe v. Hull, 874 F. Supp. 779, 782 (N.D. Ohio 1994).

237. *See, e.g.*, *Lesley*, 250 F.3d at 222; Estate of Mauro v. Borgess Medical Ctr., 137 F.3d 398, 400 (6th Cir. 1998); *Sch. Bd. of Nassau County*, 480 U.S. at 276.

238. *See supra* Part III.B.3; *infra* Part III.B.5.

239. *Lesley*, 250 F.3d at 49, 58.

240. *See, e.g.*, Sharon E. Straus et al., *Severe Acute Respiratory Syndrome and Its Impact on Professionalism: Qualitative Study of Physicians' Behavior During an Emerging Healthcare Crisis*, 329 BMJ 83, 83 (2004), *available at* http://www.bmj.com/cgi/reprint/329/7457/83.pdf (while caring for hospitalized patients during SARS epidemic, physicians described occasional "strained professional behavior" of colleagues consisting of refusal to assist, making comments such as "I didn't sign up for this" or "they don't pay me enough to take this kind of risk").

5. Duty of Care in Emergencies

Although physicians may have an ethical obligation to treat patients in emergencies,[241] the law is considerably narrower. It has long been held that a physician is under no obligation to enter into the physician-patient contract, even in an emergency.[242] "Good Samaritan" laws[243] in two states contain an affirmative duty to assist in an emergency, with fines for violation."[244] These requirements are not imposed specifically on physicians, however, and one requirement to give "reasonable assistance may include obtaining or attempting to obtain aid from law enforcement or medical personnel."[245]

A broader obligation for health professionals is contained in the Emergency Medical Treatment and Active Labor Act (EMTALA).[246] Under EMTALA, a hospital that accepts Medicare payments and has an emergency department must screen all persons coming to the emergency department to determine if they have an emergency medical condition, and if one exists, must either stabilize the medical condition or transfer the patient to a facility that is willing and able to provide appropriate treatment.[247] The intent of EMTALA was to prevent hospital emergency rooms from refusing to accept or treat patients with emergency medical conditions when they are uninsured or unable to pay,[248] a practice sometimes referred to as *patient dumping*.[249] EMTALA subjects the physician as well as the hospital to a civil penalty of up to $50,000 per violation.[250] Further, in the case of a physician, "if the violation is gross and flagrant or is repeated," the penalty may consist of exclusion from participation in the Medicare and Medicaid programs.[251]

In state "anti-dumping" laws, requirements may be broader and penalties more stringent than under EMTALA, which does not preempt state and local requirements unless they directly conflict.[252] In Texas, "reckless violation" of the nondiscrimination requirement in the provision of emergency services could lead to

241. AMA CODE, *supra* note 108, at princs. VI, at xv.

242. Hiser v. Randolph, 617 P.2d 774, 776 (Ariz. Ct. App. 1980) (citing Hurley v. Eddingfield, 59 N.E. 1058, 1058 (Ind. 1901)); Childs v. Weis, 440 S.W.2d 104, 106–07 (Tex. Civ. App. 1969).

243. *See supra* Part II.A.3.

244. VT. STAT. ANN. tit. 12, § 519 (2002) (imposing a fine of up to $100 for willful violation if aware that another is "exposed to grave physical harm"); MINN. STAT. ANN. §§ 604A.01, 609.02.4a (West 2000 & Supp. 2008) (stating that a person violating the requirement to assist at the scene of an emergency is guilty of a "petty misdemeanor" and thus subject to a fine of up to $300).

245. MINN. STAT. ANN. § 604A.01.1 (West 2000 & Supp. 2008).

246. 42 U.S.C. § 1395dd (2008).

247. *Id.*

248. H.R. REP. No. 99-241, at 27 (1985).

249. Karen I. Treiger, Note, *Preventing Patient Dumping: Sharpening the COBRA's Fangs*, 61 N.Y.U. L. REV. 1186, 1186–88 (1986).

250. 42 U.S.C. § 1395dd(d)(1)(A).

251. *Id.* § 1395dd(d)(1)(B)(ii).

252. *Id.* § 1395dd(f).

fines or imprisonment, or both,[253] and intentional infraction resulting in a patient's death could lead to imprisonment of up to 10 years.[254] In New York City, the state's mandate to treat in emergencies may extend to general hospitals without emergency departments; failure to provide emergency medical care to anyone needing it, who arrives at the entrance of the hospital, constitutes a misdemeanor.[255] A physician who refuses to treat such a patient is subject to a fine and imprisonment of up to one year.[256] This statute and its sanctions were upheld in the case of a physician who refused to treat a woman in labor coming to the hospital where he was on duty.[257] Notably, the lower court stated that strict liability statutes are often "found valid in the areas of public health, safety, and welfare," where:

> . . . the public policy of achieving social betterment through the exercise of the police power "may require that in the prohibition or punishment of particular acts it may be provided that he who shall do them shall do them at his peril and will not be heard to plead in defense good faith or ignorance."[258]

Although some states impose fines for similar infractions,[259] for the most part, penalties in state anti-dumping statutes are unusual, and most do not specify a cause of action or penalties.[260]

Under EMTALA, an "emergency medical condition" is one that manifests itself by "acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected" to jeopardize the patient's health, function, or bodily integrity.[261] A large number of people, including the "worried well," are likely to present to hospital emergency rooms during a public health crisis or other disaster, as hospitals are often

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253. TEX. HEALTH & SAFETY CODE ANN. § 311.022(a), (e) (Vernon 2001); TEX. PENAL CODE ANN. §§ 12.21–.22 (Vernon 2003).

254. TEX. HEALTH & SAFETY CODE ANN. § 311.022(a), (e) (Vernon 2001); TEX. PENAL CODE ANN. §§ 12.21–.22 (Vernon 2003); TEX. PENAL CODE ANN. § 12.34.

255. N.Y. PUB. HEALTH LAW § 2805-b(2)(a) (McKinney 2007 & Supp. 2009) (stipulating that certain highly specialized hospitals could be exempted from this requirement by the Health Commissioner).

256. *Id.* § 2805-b(2)(b).

257. People v. Anyakora, 656 N.Y.S.2d 253, 253 (N.Y. App. Div. 1997).

258. People v. Anyakora, 616 N.Y.S.2d 149, 152 (N.Y. Sup. Ct. 1993) (quoting Shevlin-Carpenter Co. v. Minnesota, 218 U.S. 57, 70 (1910)) (emphasizing also that the statute applies broadly to "any licensed medical practitioner," to private as well as public hospitals, and regardless of where at the hospital the person arrives).

259. *See, e.g.*, 210 ILL. COMP. STAT. ANN. 80/1 to /2 (West 2004) (imposing a fine of $10,000 on a hospital or person failing to render necessary emergency services).

260. MD. CODE ANN., HEALTH–GEN. § 19-307.1 (LexisNexis 2005); WASH. REV. CODE ANN. § 36.62.100 (West 2003); Thomas A. Gionis et al., *The Intentional Tort of Patient Dumping: A New State Cause of Action to Address the Shortcomings of the Federal Emergency Medical Treatment and Active Labor Act (EMTALA)*, 52 AM. U. L. REV. 173, 187–90 (2002) (arguing that minimal remedies in certain states contribute to the continued problem of patient dumping).

261. 42 U.S.C. § 1395dd(e)(1) (2008).

perceived as safe havens by the public.[262] Not only would many arrivees satisfy the EMTALA definition of "emergency medical condition," requiring stabilization by emergency department staff, but the remainder would at a minimum have to be given an appropriate screening examination, which would require direct contact between patient and one or more clinicians, and potential risk exposure. Not to render care in this circumstance would expose the hospital and responsible staff to penalties under the law.

Although in-state nonaffiliated clinicians, such as physician volunteers, would only be required to work if their state had adopted special provisions for public health emergencies,[263] health professionals volunteering to work at the hospital would presumably be willing to take the risk of a harmful exposure. The EMTALA mandate, however, extends to any physician with a contractual relationship with the hospital, including a physician on call[264] and expected to respond. A physician who was credentialed by the hospital but not on call would not be required to come to the hospital under EMTALA,[265] but if he later refused to attend to a patient for whom he had responsibility he might nonetheless risk liability for abandonment, loss of hospital credentials, or even sanctions by the state board of medicine for unprofessional conduct.[266]

Under EMTALA, a hospital is required to provide care "within the capability of the hospital's emergency department . . . ."[267] In non-disaster situations, hospital emergency departments that have reached the limit of their ability to care for patients frequently "go on diversion,"[268] instructing emergency medical services to transport the patient to a hospital that still has capacity and resources. Emergency medical services are not under any legal requirement to comply with such requests and might still take the patient to a hospital on diversion if they think it is

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262. *See, e.g.*, Madison Park, CNNhealth.com, *"Walking Well" Flood Hospitals with—or Without—Flu Symptoms* (May 2 2009), http://www.cnn.com/2009/HEALTH/05/02/worried.well.hospitals/index.html (noting early in swine flu outbreak that "record numbers" of patients, including the "worried well," went to emergency rooms, some of which were forced to close down when they could not accommodate the large numbers).

263. *See infra* Part II.B.

264. 42 U.S.C. § 1395dd(d)(1)(B).

265. *See* KEITH CONOVER, DEP'T OF EMERGENCY MED., MERCY HOSP. OF PITTSBURGH, FEDERAL LAW AND THE PHYSICIAN 7–8, 21–27 (2003), *available at* http://www.pitt.edu/~kconover/ftp/emtala-draft.pdf.

266. *See infra* Parts III.B.2–.3.

267. § 1395dd(a).

268. Catherine W. Burt et al., *Analysis of Ambulance Transports and Diversions Among US Emergency Departments*, 47 ANNALS EMERGENCY MED. 317, 317 (2006); Catherine W. Burt & Linda F. McCraig, Ctrs. for Disease Control & Prevention, *Staffing, Capacity, and Ambulance Diversion in Emergency Departments: United States, 2003–04*, ADVANCE DATA, Sept. 27, 2006, at 1, 6, *available at* http://www.cdc.gov/nchs/data/ad/ad376.pdf.

necessary—for example, if they believe the patient's condition to be unstable.[269] Taking an unstable patient to a hospital unable to treat the patient promptly might well place the arriving patient at risk. However, in a declared and activated emergency, the law specifically provides that hospitals "with dedicated emergency departments in the emergency area will not, during the emergency period, be subject to EMTALA sanctions for . . . [r]edirecting individuals seeking [a medical screening examination] . . . or [for] [i]nappropriate transfers arising out of the circumstances of the emergency."[270] An inappropriate transfer would include failure to "minimize the risks to the individual's health . . . ."[271]

In 2006, there were 118.4 million emergency department visits among 4587 community hospitals in the United States,[272] and virtually all of these would have been covered under EMTALA rules.[273] The EMTALA mandate would therefore appear to have a broad reach. Furthermore, there is no exception to the physician's duty of care under EMTALA in the case of a patient whose condition poses a risk to the physician's health.[274] Thus, under EMTALA and related state laws, physicians in hospital emergency departments—and in at least one jurisdiction, even hospitals without emergency departments—might be obliged to provide care to patients despite risk to themselves. This risk would be greatly augmented and far more prevalent during a public health emergency or other disaster.

Once a patient is admitted to the hospital, EMTALA rules no longer apply,[275] but the possibility of recurring or new emergencies in the hospital wards would

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269. *See, e.g.*, People v. Anyakora, 616 N.Y.S.2d 149, 151 n.1 (N.Y. Sup. Ct. 1993) (noting, in a case of a physician refusing to treat a woman in labor because the hospital was on diversion, that ambulances do not have to honor diversion); Policy Statement, N.Y State Dep't of Health Bureau of Emergency Med. Servs., No. 06-01: Emergency Patient Destinations and Hospital Diversion (Jan. 11, 2006), *available at* http://www.health.state.ny.us/nysdoh/ems/pdf/06-01.pdf.

270. Thomas E. Hamilton, Director, Survey & Certification Group, Ctr. for Medicare & Medicaid Servs., Waiver of Emergency Medical Treatment and Labor Act (EMTALA) Sanctions in Hospitals Located in Areas Covered by a Public Health Emergency Declaration (2007), *available at* http://www.cms.hhs.gov/SurveyCertificationGenInfo/downloads/SCLetter08-05.pdf (citing 42 C.F.R. § 489.24(a)(2) (2006)).

271. 42 U.S.C. § 1395dd(c)(2)(A) (2006).

272. AM. HOSP. ASS'N, TREND WATCH CHARTBOOK 2008: TRENDS AFFECTING HOSPITALS AND HEALTH SYSTEMS app. 3, at A-28 tbl.3.3 (2008), *available at* http://www.aha.org/aha/trendwatch/chartbook/2008/08appendix3.pdf.

273. 42 U.S.C. § 1395dd(e)(2) (A "participating hospital" is one "that has entered into a [Medicare] provider agreement under [42 U.S.C. § 1395cc]"); Lauren A. Dame, *The Emergency Medical Treatment and Active Labor Act: The Anomalous Right to Health Care*, 8 HEALTH MATRIX 1, 10 (1998) ("While [EMTALA] applies only to hospitals that participate in Medicare . . . [,] the protections of the law include any person who comes to the emergency room, not merely Medicare beneficiaries. In addition, since almost all of the nation's hospitals are certified to receive Medicare funds, the law's reach is very broad.").

274. Ariel R. Schwartz, Note, *Doubtful Duty: Physicians' Legal Obligation to Treat During an Epidemic*, 60 STAN. L. REV. 657, 679 (2007).

275. Bryant v. Adventist Health Sys., 289 F.3d 1162, 1168 (9th Cir. 2002) ("EMTALA's stabilization requirement ends when an individual is admitted for inpatient care.").

continue. At that time, the obligation to the patient would apply to virtually any physician in charge of the care of inpatients, including a private attending physician who had a previous relationship with the patient, a hospitalist[276] or other physician with inpatient contractual obligations under a managed care plan, a licensed house officer in training, and in the case of an unlicensed house officer (and most likely even a licensed one), the supervising attending physician of record.[277]

C. Duty of Care in a Declared Emergency

1. Mandate to Serve: MSEHPA § 608(a)

The Model State Emergency Health Powers Act (MSEHPA) would confer a number of extraordinary powers to the governor during a declared public health emergency.[278] Under § 608 of MSEHPA, the public health authority would have the power "[t]o require in-state health care providers to assist in the performance of vaccination, treatment, examination, or testing of any individual as a condition of licensure, authorization, or the ability to continue to function as a health care provider in th[e] State."[279]

At least thirteen states have adopted provisions based on all or part of § 608,[280] but they vary in key points. South Carolina has adopted all the requirement and sanctions of § 608.[281] In New Jersey, providers would face similar sanctions but only for failures to assist under a specific vaccination program.[282] Maryland has adopted MSEHPA's § 608 provisions, with additional sanctions including monetary penalties or imprisonment, or both.[283] Although New York did

276. STEDMAN'S MEDICAL DICTIONARY 904 (28th ed. 2006) (defining a hospitalist as "[a] primary care physician (not a house officer) who assumes responsibility for the observation and treatment of hospitalized patients and returns them to the care of their private physicians when they are discharged from the hospital"); *see also* Yong-Fang Kuo et al., *Growth in the Care of Older Patients by Hospitalists in the United States*, 360 NEW ENG. J. MED. 1102, 1102–03 (2009) (defining hospitalists as "physicians in general internal medicine who has at least five evalution-and-management billings in a given year and generated at least 90% of their total evaluation-and-management billings in the year from services to hospital inpatients" and identifying 120,226 physicians as of 2006 who could be identified as hospitalists).

277. *See, e.g.*, RHODE ISLAND HOSPITAL: HOUSE OFFICER'S CONTRACT, *available at* http://www.brown.edu/Departments/Pediatrics/Residency/Homepage/redesign/contract.pdf (last visited Nov. 27, 2009); UNIV. OF CAL. SAN DIEGO MED. CTR., HOUSE OFFICER POLICY AND PROCEDURE DOCUMENT 2 (2009), *available at* http://meded.ucsd.edu/assets/6/File/housestaff/HOPPD.pdf.

278. MSEHPA, *supra* note 4, pmbl., §§ 401, 405(a), 803(a), 808; *see also supra* Part II.B.

279. MSEHPA, *supra* note 4, § 608(a).

280. *See* CTR. FOR LAW & PUB.'S HEALTH AT GEORGETOWN & JOHNS HOPKINS UNIVS., *supra* note 5, at 4 (identifying the states that have adopted aspects of § 608).

281. S.C. CODE ANN. § 44-4-570 (Supp. 2008).

282. N.J. STAT. ANN. § 26:13-23 (West 2007).

283. MD. CODE ANN., PUB. SAFETY §§ 14-3A-03, 14-3A-08 (LexisNexis Supp. 2008).

not adopt MSEHPA provisions,[284] the state's 1951 Defense Emergency Act provides for very broad powers on the part of the governor and officers of state agencies,[285] as well as criminal penalties for violations.[286] The law applies to broadly defined work related to radiological, chemical, bacteriological, or other biological attack,[287] and its provisions would apply to medical personnel.[288] Contemporary cases have reaffirmed the statute's broad application in civil defense.[289] Thus, the possibility of compelling physicians to render care in disasters is not new, and a legal duty of care could be created under circumstances of great risk in some jurisdictions.

2. Critique of the Mandate to Serve

Critics of MSEHPA assert that health care providers would be conscripted "to perform duties that might well violate their Oath to serve patients according to the best of their own judgment and ability."[290] Others have pointed out that health care providers represent only one of many categories of workers who would be needed during a public health crisis such as an infectious disease outbreak, and should not be singled out by the law for "drastic penalties like license revocations or imprisonment" when others with equally vital roles may refuse to work without such penalties.[291]

Competing obligations, such as the need to care for a child or elderly family member, might be justified exemptions to the mandate, as would exceptions for health care providers at enhanced risk, such as pregnant women,[292] but MSEHPA

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284. CTR. FOR LAW & PUB.'S HEALTH AT GEORGETOWN & JOHNS HOPKINS UNIVS., *supra* note 5, at 4 (showing that as of July, 15, 2006, MSEHPA § 608 had not been adopted by New York state).

285. N.Y. UNCONSOL. LAW §§ 9101–9202 (McKinney 2002).

286. *Id.* § 9181; N.Y. PENAL LAW § 55.10 (McKinney 2004).

287. N.Y. UNCONSOL. LAW § 9103. In comparison, the New York State Natural and Man Made Disaster Act applies to other situations, such as floods, epidemics, radiological accidents, and others, and provides for broad government powers, including coordination of peacetime emergency response functions and the civil defense. N.Y. EXEC. LAW §§ 20 to 29-g (McKinney 2002).

288. N.Y. UNCONSOL. LAW § 9103.

289. *See, e.g.*, Daly v. Port Auth. of N.Y. & N.J., 793 N.Y.S.2d 712, 717–19 (N.Y. Sup. Ct. 2005) (deciding a case of first impression involving demolition work at the World Trade Center site; holding that 1951 Defense Emergency Act applies more broadly than nuclear disaster); *In re* World Trade Ctr. Disaster Site Litig., 456 F. Supp. 2d 520, 548–49 (S.D.N.Y. 2006) (reaffirming contemporary, broad application of the Act).

290. Jane M. Orient, Ass'n of Am. Physicians & Surgeons, AAPS Analysis: Revised Draft of Model State Emergency Health Powers Act (Dec. 21) Still a Prescription for Tyranny (Jan. 9, 2002), http://www.aapsonline.org/testimony/emerpower2.htm.

291. Carl H. Coleman & Andreas Reis, *Potential Penalties for Health Care Professionals Who Refuse to Work During a Pandemic*, 299 JAMA 1471, 1473 (2008).

292. Denise J. Jamieson et al., *Emerging Infections and Pregnancy: West Nile Virus, Monkeypox, Severe Acute Respiratory Syndrome, and Bioterrorism*, 32 CLINICS IN PERINATOLOGY 765, 766, 773 (2005); Victor R. Suarez & Gary D. V. Hankins, *Smallpox and Pregnancy: From Eradicated Disease to Bioterrorist Threat*, 100 OBSTETRICS & GYNECOLOGY 87, 91–92 (2002); WORLD HEALTH ORG.,

does not provide for such exemptions.[293] A health professional who refuses to cooperate is not entitled, under MSEHPA, to dispute "conscription" through prospective due process procedures, such as a hearing or the taking of evidence for purposes of determining if specific circumstances would legitimately prevent him or her from serving.[294] One could argue that such procedures would be impractical in the exigencies of a disaster, although MSEHPA does provide for notice and hearing for individuals subject to isolation and quarantine,[295] and those subject to temporary isolation and quarantine without notice may be released unless the public health authority petitions the court and shows by a preponderance of the evidence that such confinement is "reasonably necessary to prevent or limit the transmission of a contagious . . . disease to others."[296]

Despite these concerns, mandating health care providers to respond would seem justified if it is needed to protect the public's health. In one view, health professionals have an obligation to confront risk because of their specific ability to provide care and because they freely chose a profession—with all of its attendant risk—devoted to care of the ill.[297] Although due process procedures for clinicians might be impractical to apply prospectively in a public health emergency, established mechanisms for licensed clinicians facing sanctions exist in all jurisdictions.[298]

ETHICAL CONSIDERATIONS IN DEVELOPING A PUBLIC HEALTH RESPONSE TO PANDEMIC INFLUENZA 13 (2007), *available at* http://www.who.int/csr/resources/publications/WHO_CDS_EPR_GIP_2007_2c.pdf.

293. Some clinicians might, however, be covered by the federal Family and Medical Leave Act, which requires employers with at least fifty employees on the job for at least twelve months to grant leave for up to "[twelve] work weeks" for purposes of caring for a son, daughter, spouse, or parent with a "serious health condition." 29 U.S.C. §§ 2611(4)(A)(i), 2612(a)(1)(C) (2006 & Supp. 2009). Similar provisions exist in many states. *See, e.g.*, N.J. STAT. ANN. §§ 34:11B-3(e), 34:11B-4 (West 2000).

294. *See* Schwartz, *supra* note 274, at 687, 690.

295. MSEHPA, *supra* note 4, § 605(b)(3)–(4).

296. *Id.* § 605(b)(5).

297. *See* Chalmers C. Clark, *In Harm's Way: AMA Physicians and the Duty to Treat*, 30 J. MED. & PHILOSOPHY 65, 80 (2005) (discussing the opposing views on physicians' rights and obligations; summarizing one view that believes that "by freely joining a profession designed to combat disease, one consents to some standard of risk"); Carl H. Coleman, *Beyond the Call of Duty: Compelling Health Care Professionals to Work During an Influenza Pandemic*, 94 IOWA L. REV. 1, 25, 33 (2008) (discussing the various arguments, including one that suggests "health care professionals have an inherent obligation to work during infectious-disease outbreaks because they 'assume the risk' of exposure . . . when they voluntarily commit themselves to the healing profession" and one that espouses an obligation "grounded in the fact that health care professionals have knowledge and special skills" beyond that of the average individual).

298. ESSENTIALS OF A MODERN MED. PRACTICE ACT § X (Fed'n State Med. Bd. of the U.S. 2006); Schwartz, *supra* note 274, at 691, 693; *see, e.g.*, N.J. STAT. ANN § 45:9-19.9 (West 2004 & Supp. 2008); N.Y. PUB. HEALTH LAW § 230 (McKinney 2002 & Supp. 2009).

Emergency department physicians are those most often subject to EMTALA requirements,[299] and would perhaps be the most likely among the medical specialties to confront risk during an infectious disease outbreak. However, any clinician who has patient contact could confront such a risk, and many, if not most, would have a legal obligation to do so, at least in certain circumstances. Such obligations exist wherever the physician has promised to serve the patient if able—in the hospital, the office, the radiology suite, the nursing home, or at home. To unilaterally withdraw from the care of a patient to whom a physician has particular or general obligation would require fulfillment of a duty that might well be unrealistic in a public health emergency—providing the patient with "reasonable time" to seek an alternative care provider.

IV. CONCLUSION

A physician's duty of care, within his capabilities, is broad. A physician, whether a generalist or specialist, may not abandon a patient with whom he has an established relationship, whether the relationship was established in an outpatient setting or upon the patient's admission to the hospital.[300] He may not refuse contact with a patient who comes to his hospital's emergency room.[301] Such duties would extend to most if not all venues where patients seriously ill with pandemic influenza would seek diagnosis and treatment.[302]

Exceptions to these distinct duties of care exist, but cannot be realistically applied in a public health crisis. There would be insufficient time to seek an alternative care provider for an established patient who was sick and required care, or merely needed evaluation. Shortages are great even under ordinary circumstances,[303] and the concept of diversion of patients to other hospital emergency rooms would be meaningless when the number of patients in urgent need of evaluation overwhelmed all hospitals in the community.

Mandates similar to MSEHPA would close any remaining gaps in existing law, by requiring professionals to serve patients without exception for personal risk. Most physicians have formally pledged to put the patient's welfare first.[304] For

299. 42 U.S.C. § 1395dd (2006); *see generally* Laura Brockway, *EMTALA: Requirements for On-call Physicians*, THE REPORTER, Nov.-Dec. 2008, at 1; Emtala.com, FAQ on EMTALA, http://emtala.com/faq.htm (last visited Nov. 27, 2009).

300. *See supra* Part III.B.3.

301. *See supra* Part III.B.5.

302. *See* WORLD HEALTH ORG., *supra* note 292, at 13.

303. CTR. FOR WORKFORCE STUDIES, ASS'N OF AM. MED. COLLEGES, RECENT STUDIES AND REPORTS ON PHYSICIAN SHORTAGES IN THE U.S. 1 (2009), *available at* http://www.aamc.org/workforce/recentworkforcestudies.pdf.

304. Audiey C. Kao & Kayhan P. Parsi, *Content Analyses of Oaths Administered at U.S. Medical Schools in 2000*, 79 ACAD. MED. 882, 882–84, 884 tbl.2 (2004) (surveying content of oaths administered at accredited medical schools and finding that 81% of oaths contain language such as "the health and life of my patient will be my first consideration").

those who have not made such an oath, and perhaps even for those who have,[305] mandates to serve might impose a requirement to take on a role they never affirmatively assumed; this in turn would invoke concerns about infringements of human rights for health professionals as an entire group.[306] If infringement of one's rights can be justified on the basis of ensuring the survival of the community, then public policy should also dictate that these mandates be balanced by increased rights for health care professionals at risk. These rights should include guaranteed health care for those required to serve, guaranteed due process, even if retrospective, for failure to serve, and enhanced protections against criminal charges in the extraordinary circumstances of a community-wide disaster. In addition, any state prepared to require service and impose serious penalties for failure to comply has a reciprocal obligation to notify any potential conscripts in advance of a crisis; to provide them with adequate preparedness training, including education about recognition and treatment of putative agents and effectiveness and use of various protective methods; and to guarantee access to sufficient protection should they be called up.[307]

In reality, the magnitude of any crisis, coupled with society's preparation for it, will determine the outcome. Although a physician's special knowledge and skill might impose a greater duty of care,[308] the survival of the community may demand that this responsibility be shared with others. The legal duty to serve should be consistent with national accreditation standards for health care institutions, which recognize the limited ability of hospitals to provide sufficient resources in all cases.[309] The Joint Commission Emergency Management Standards require hospitals to make plans to function in a catastrophe, while delineating response procedures that could include curtailing services, closing the hospital to new patients, or even total evacuation, if such a need arose.[310] This approach thus includes shifting responsibility from the hospital to the population at large.[311] Similarly, the community at large should call upon its members who are willing and able to serve and prepare them in advance for the shared responsibility of their own survival.

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305. Coleman, *supra* note 297, at 29 ("An individual who makes . . . commitments [in an oath] would have no reason to believe that she was agreeing to treat patients during an infectious-disease outbreak even if her job does not require it.").

306. *See* WORLD HEALTH ORG., *supra* note 292, at 13.

307. *Id.* at 14–15.

308. Coleman, *supra* note 297, at 33.

309. JOINT COMM'N, *supra* note 3, at 8.

310. *Id.* at 4.

311. *Id.* at 2, 4.