Special FOCUS

Emergency Legal Preparedness for Hospitals and Health Care Personnel

James G. Hodge Jr, JD, LLM, Andrea M. Garcia, JD, Evan D. Anderson, JD, and Torrey Kaufman

ABSTRACT

During the past decade, hospital emergency preparedness has become a focus of local, state, and federal governments seeking to address emergencies or disasters that affect the public health. Integral to hospital emergency preparedness are numerous legal challenges that hospitals and their health care personnel face during declared states of emergencies. In this article, we evaluate legal requirements for hospital emergency preparedness, key legal concerns that hospitals should consider in emergency preparedness activities, and how the changing legal landscape during emergencies necessitates real-time decision making. We then analyze legal issues including negligence, discrimination, and criminal culpability that may arise during or after medical triage. Finally, we examine the legal risks of evading preparedness, specifically asking how a hospital and its personnel may be held liable for failing to plan or prepare for an emergency. (*Disaster Med Public Health Preparedness.* 2009;3(Suppl 1):S37–S44)

The ability of hospitals and their health care personnel to anticipate and respond to disasters that affect the public health is a core component of national, state, and local emergency preparedness plans.[1] Since September 11, 2001, and particularly following hurricanes Katrina and Rita in 2005, an increasing number of hospitals have focused on emergency preparedness.[2] With the strong support of federal, state, and local governments, The Joint Commission, and others, many hospitals have developed sophisticated plans, executed memoranda of understanding (MOUs), and conducted significant training in coordination with public and private partners to address the foreseeable circumstances for which they can prepare and improve their emergency responses.[3] Other hospitals have marginalized the value of emergency planning and preparedness activities despite legal mandates that require their participation.[4] When thrust into an emergency environment that implicates the health of patients and populations, the degree to which hospitals have prepared in advance may positively correlate with their ability to effectively respond. This depends in part, however, on whether they have also adequately assessed their emergency legal preparedness.

Legal issues pervade emergency responses.[5] Laws at all levels of government define what constitutes a state of emergency, disaster, or public health emergency. They authorize emergency actions to improve individual and communal health. They guide hospitals, health care personnel, and others in how to alter practices during emergencies. Laws prohibit specific activities that may inhibit emergency responses. They help determine responsibility for harm to others resulting from acts or failures to act. Laws can provide structural and financial support during emergencies to facilitate response efforts. Conversely, laws may be interpreted or enforced in ways that impede hospitals and their personnel during emergencies. Concerns over liability, reimbursement, accreditation, licensing, and fines or other sanctions can thwart hospitals and their personnel from acting fully to protect patient and communal health.[6]

Preparing for legal issues is thus critical to hospital emergency preparedness. In this article, we discuss 3 core legal preparedness challenges for hospitals and their personnel. First, we assess the legal landscape during declared states of emergencies. Addressing legal issues during emergencies implicates an array of issues, all of which are affected by changing legal norms during actual emergencies. We discuss the legal requirements for hospital emergency preparedness, outline the major legal concerns that hospitals should consider in planning or executing MOUs (Table 1), and examine the changing legal landscape during emergencies.

Second, we explore specific legal issues arising from medical triage, a key component of many hospital emergency plans. Medical triage requires hospitals and their health care personnel to deviate from standard, nonemergency practices to quickly prioritize at-risk patients to determine who receives sustaining treatment and who does not. Complex legal issues in negligence, discrimination, and criminal culpability may arise whenever patients' access to treatment is implicated during medical triage.

Finally, we examine a countervailing legal issue underlying hospital emergency preparedness: When may a hospital be liable for a failure to plan? Hospital administrators may be overly concerned about their exposure to liability for positive actions taken during emergencies that harm patients or others. What about their potential liability for omissions, or failures, to act? We examine whether liability exposure may extend to hospitals and their personnel when they could have

https://doi.org/10.1097/DMP.0b013e3181949c7c Published online by Cambridge University Press

TABLE 1

Selected Issues Concerning Hospital Emergency Legal Preparedness

Subject	Legal Question
Organizing personnel	How are employees, independent contractors, and volunteers legally distinguishable for the purpose of coordinating services and benefits during emergencies?
	Do existing labor contracts or union requirements affect the ability of the hospital and its personnel to respond to an emergency?
	Have appropriate contractual or other mechanisms been executed to facilitate the performance of services from employed personnel, secure worker safety, or ensure the availability of workers' compensation or other benefits during an emergency?
Access to treatment	Has the hospital assessed its strategy for conducting medical triage under legal requirements for treating existing and forthcoming patients?
	Is the hospital prepared to screen and potentially divert excess numbers of patients during an emergency consistent with EMTALA?
	Do health care personnel who are designated to treat existing and forthcoming patients pose any risks to these patients related to personnel exposure to infectious or other conditions?
Coordinating health services	Are health care personnel aware of the legal effect of changing standards of care and scope of practice during a declared emergency?
	Are adequate mechanisms in place to ensure compliance with surveillance, reporting, testing, screening, partner notification, quarantine, isolation, or other public health mandates during the emergency?
	Are legal issues concerning the use of volunteer health professionals during emergencies addressed through the hospital's emergency plan?
Patients' rights	Can patients with physical or mental disabilities be accommodated during the emergency consistent with disability protection laws?
	Barring waiver of national, state, or local privacy laws, are the hospital and its personnel prepared to respect patients' health information privacy rights during an emergency?
	Is the hospital prepared to evacuate at-risk patients in response to an emergency to avoid claims of patient abandonment?
Allocating resources	Is there a legitimate process for determining allocation of limited resources that is fair, reasonable, and nondiscriminatory?
	Can government "take" existing resources for communal purposes during an emergency?
	Is the plan for allocating scare resources based on credible justification centered on protecting the health of patients and the public?
Liability	When may the hospital and its personnel be liable for their actions to treat patients under changing standards of care during an emergency?
	What legal protections from liability for hospitals, their health care personnel, independent contractors, or volunteers (including insurance coverage) apply during an emergency?
	Do hospitals and their personnel face potential liability for failure to adequately plan or train for emergencies?
Reimbursement	Are there established reimbursement protocols for treating patients during emergencies?
	Are hospitals organized to seek federal reimbursement through CMS, FEMA, or other sources for care delivered in offsite facilities operated by the hospital?
	Have federal and/or state authorities accelerated, altered, or waived Medicare and/or Medicaid requirements for reimbursement during an emergency?
Interjurisdictional cooperation	Has the hospital executed MAAs or MOUs to facilitate interjurisdictional coordination of emergency health services?
	Are these MAAs or MOUs consistent with federal NIMS, CMS, HRSA, or other governmental requirements?
	Is the hospital's "all-hazards" emergency plan integrated with community-level emergency planning and objectives?

CMS, Centers for Medicare and Medicaid Services; EMTALA, Emergency Management Treatment and Labor Act; FEMA, Federal Emergency Management Agency; HRSA, Health Resources and Services Administration; MAA, mutual aid agreement; MOU, memoranda of understanding; NIMS, National Incident Management System.

avoided harms to patients through enhanced planning and preparedness.

LEGAL ISSUES ESSENTIAL TO HOSPITAL EMERGENCY PREPAREDNESS

Underlying hospitals' roles during emergencies are a slate of federal and state laws that require (or strongly encourage) effective preparedness and planning. Following September 11, 2001, the US Congress prioritized national emergency preparedness through multiple legislative bills.[7] In 2003, Homeland Security Presidential Directive 8 authorized state and local governments to enhance national emergency preparedness in collaboration with multiple federal agencies.[8] Pursuant to the Public Health Service Act,[9] the Health Resources Services Administration funneled nearly $500 million through state agencies to hospitals for protective equipment, education, and training to improve emergency preparedness.[10,11] The Department of Homeland Security devotes significant expertise and resources to support hospital emergency preparedness. Homeland Security's National Incident Management System requires hospitals receiving funds to adopt standards consistent with their emergency plans.[12]

The Pandemic and All-Hazards Preparedness Act of 2006,[13] which reorganized federal public health emergency responses,[14] authorizes the Department of Health and Human Services (DHHS) to withhold emergency preparedness funds from hospitals that do not meet certain benchmark requirements.[15,16] DHHS' Center for Medicare and Medicaid Services requires participating hospitals to develop and implement comprehensive emergency plans.[17] The Joint Commission requires hospitals to engage in emergency planning as a condition of accreditation.[18] Corresponding state laws and licensing standards similarly require, fund, or strongly encourage hospital emergency preparedness.[2,19]

Against this legal backdrop requiring emergency preparedness, hospital administrators, emergency planners, and their personnel confront diverse and profound legal issues.[6] Table 1 sets forth select legal emergency preparedness questions that hospitals face in several key areas including organizing personnel, access to treatment, coordinating health services, patients' rights, allocating resources, liability, reimbursement, and interjurisdictional cooperation.

Effective emergency preparedness planning requires hospitals and their personnel to address these (and likely other) legal issues before an emergency through tailored assessments based on jurisdiction-specific laws at the federal, state, and local levels. Emergency plans or MOUs may need to be altered depending on legal requirements based on these assessments. For example, a hospital emergency plan that anticipates the use of volunteer health professionals to meet patient surge capacity may require reexamination if state or local laws limit volunteer participation.[20] Examining the legal implications incident to planning efforts can facilitate the performance of preparedness activities during actual emergencies.

However, preemergency legal assessments are only part of emergency legal preparedness. In nonemergencies, statutory, regulatory, and judicial case laws offer reasonable predictability as to what constitutes lawful behavior or actions. During declared states of emergency, the legal environment changes extensively.[5] Emergency declarations instantly trigger a host of nontraditional powers that are designed to facilitate response efforts through public and private sectors. Emergency laws focus on the following:

- Providing government with sufficient flexibility
- Mobilizing central commands and infrastructures
- Encouraging response efforts by limiting liability
- Relaxing standards of care and licensure
- Shifting health personnel and resources
- Balancing communal and individual interests to protect the public health

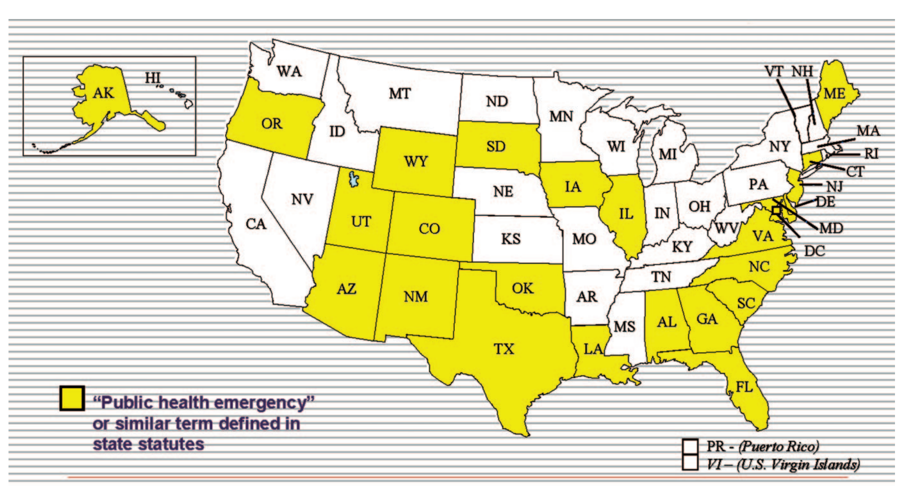
The extent of legal changes, however, depends on the type of emergency declared. The federal government, every state, many territories, and some local governments may declare either general states of emergency or disaster in response to crises that affect the public's health.[5] Such declarations largely authorize emergency management agencies and others to coordinate responses in addressing exigencies. The federal DHHS and more than half of the states may also declare formal states of "public health emergency" (Figure 1),[21] based in part on the Model State Emergency Health Powers Act (MSEHPA) drafted in 2001 by the Centers for Law and the Public's Health.[22]

Unlike states of emergency or disaster, MSEHPA authorizes public health authorities to coordinate response efforts under a high threshold of what constitutes a "public health emergency," defined as[23]:

An occurrence or imminent threat of an illness or health condition that is (1) believed to be caused by bioterrorism, the appearance of a novel or

FIGURE 1

States that statutorily define "public health emergency"



https://doi.org/10.1097/DMP.0b013e31819d977c Published online by Cambridge University Press

previously controlled or eradicated infectious agent or biological toxin; and (2) poses a high probability of a large number of deaths in the affected population, a large number of serious or long-term disabilities in the affected population; or widespread exposure to an infectious or toxic agent that poses a significant risk of substantial future harm to a large number of people in the affected population.[24]

Some jurisdictions, such as the federal government and multiple states, may jointly declare states of "emergency or disaster" and "public health emergency," which can lead to confusion as divergent governmental powers and entities are unleashed to address the common goal of ameliorating the impact of emergencies.[5]

Enveloped in these varying emergency schemes are a host of powers and protections that can further (or hamper) hospital preparedness activities depending on legal interpretations made in real time. Hospital administrators, emergency planners, and their legal counsel may not understand or be able to assess how the legal environment has changed during emergencies. Facing legal uncertainty, some health care personnel may act without knowledge of legal ramifications; others may not act at all because of legal concerns. Neither of these consequences is acceptable if they impede hospital emergency response efforts.[25]

Through a concept we call *legal triage*, hospital administrators, emergency planners, and their legal counsel must prioritize legal issues and solutions to facilitate legitimate public health responses during declared states of emergencies.[25] This requires them to do the following:

- Understand how legal changes pursuant to the declaration of a public health emergency temporarily alter, suspend, or obviate typical legal interventions
- Continuously monitor changing legal norms during emergencies
- Identify legal issues that may facilitate or impede preparedness activities in advance or as they arise
- Develop and explain innovative legal solutions that are motivated toward protecting patients, promoting the public's health, and respecting individual and group interests
- Revisit the utility and efficacy of legal interpretations to improve health outcomes during emergencies

Practicing legal triage is not easy. Amidst increased morbidity and mortality and changing societal expectations during public health emergencies, public and private sectors may have competing needs and goals.[26] Hospitals may be focused on their immediate patient's needs while public health authorities attend to the larger community's needs. Government demands for available resources, personnel, or facilities may directly affect hospitals' emergency plans and abilities.[25] For example, hospital planners may have purchased adequate medical supplies in advance of an emergency. However, their supplies may be depleted by governmental authorities who can legally take them (with compensation) for communal distribution under the MSEHPA and many existing emergency laws.[27] To enhance preparedness, hospitals may need to plan ahead by obtaining additional resources from other regional hospitals through MOUs or from other suppliers through advance contracts. Being prepared for these and other legal uncertainties during actual emergencies entails advance legal maneuvers, identification of issues, competency building, and legal training during nonemergencies.

LEGAL ISSUES IN MEDICAL TRIAGE

Emergencies or disasters that have a significant impact on the public health require affected hospitals and their personnel to meet surge capacity by providing health services to a large number of patients despite limited resources. During a mass casualty event this may require hospitals and personnel to shift largely from individual patient care to population-based care via well-planned medical triage.[28] DHHS specifically recommends, for example, that hospitals include triage, clinical evaluation, and admissions criteria in their plans for pandemic influenza.[29]

Multiple medical triage protocols exist and may apply, depending on the type of disaster event (eg, trauma, critical care, chemical, biological, radiological, nuclear). The goal of each of these protocols is to save as many lives as possible with limited resources. Although ethical principles may guide how to allocate resources in disaster situations, no medical triage protocol is 100% effective toward limiting morbidity and mortality among affected populations. One historic study found that the triage officers in 2 large mass casualty incidents were unable to identify as many as half of the victims who sustained life-threatening injuries.[28] Unpredictable outcomes of medical triage raise potential civil and criminal penalties that hospitals and health care personnel may face from their decisions about who should receive life-sustaining treatment. Principal among potential legal claims are actions in negligence, vicarious liability, wrongful death, and discrimination.

These and other legal claims resulting from medical triage may arise in multiple ways. During declared emergencies, as hospitals shift to meet surge capacity, patients may go through multiple triage processes: in the prehospital environment, via the emergency department, within the hospital, and upon a change in clinical status.[30] Tertiary triage in hospital settings involves sorting patients in terms of those who require care and those who have a high risk of death. Those who meet the inclusion criteria for tertiary care are prioritized and offered life-sustaining treatment.[30] Others are excluded from treatment but should be provided palliative care. Many hospitals designate triage officers to decide ultimately who receives care at each stage of triage and provide little or no process for patients to appeal decisions.[30]

Inevitable mistakes by personnel conducting triage may leave personnel or triage officers open to claims of liability based in negligence. Hospitals may be secondarily liable under claims

of vicarious liability for the negligent acts of their personnel who are within their scope of employment.[31,32] Although the threat of liability may increase during emergencies, protections from liability may also surface. Immunity provisions triggered by the declaration of an emergency protect some health personnel from civil liability, but the impact of these laws varies depending on the status of responders as a public or private employee or volunteers, the method of deployment, and other factors.[33] Such legal protections for individuals, however, are rarely extended to entities such as hospitals,[31] although this is changing due to state legislative reforms.[34] Hospitals should take a proactive approach to limit their liability by developing plans and protocols, practicing their plans, having a transparent triage process, and adequately documenting triage decisions.[30]

Even so, the aftermath of Hurricane Katrina in 2005 demonstrated that requiring hospitals to implement a medical triage plan is not always sufficient. Following Katrina, medical triage decisions were made in a state of chaos unlike anything that health care providers had previously faced. Accounts suggest that hospitals in New Orleans triaged patients under different standards.[35] At Tulane University Medical Center the sickest patients were treated first. Doctors at Lindy Boggs Medical Center designated the most seriously ill to be evacuated first, whereas firefighters insisted the sickest patients be evacuated last.[35] At Memorial Medical Center, Dr Anna Pou recounted that the staff was under military orders to implement "reverse triage," meaning the healthiest patients were evacuated first.[36] These differing standards led to fundamental injustices because patients' chances of survival depended on their condition and the hospital where they were located.

As a consequence of the sickest patients remaining at Memorial Medical Center during what have been described as miserable conditions, Dr Pou later faced second-degree murder charges for allegedly providing 4 patients with a lethal "cocktail" of medications to hasten their death. She stated that the health care providers "did everything in [their] power to give the best treatment that [they] could to the patients in the hospital to make them comfortable."[37] An Orleans Parish grand jury ultimately refused to indict her on criminal charges, but civil wrongful death charges are still pending.[38] Louisiana has since enacted several disaster reform laws including Senate Bill 301, which "provides immunity for simple and gross negligence by doctors and nurses, thereby protecting them from civil damage to patients as a result of evacuation or treatment (or failed evacuation or treatment) at the direction of the military or government in accordance with 'disaster medicine' protocols," including reverse triage.[38]

Recommendations on who should receive treatment via medical triage during a disaster implicate federal and state laws prohibiting age and disability discrimination.[39] The federal Age Discrimination Act prohibits discrimination on the basis of age in programs or activities receiving federal financial assistance (including most hospitals that receive federal reimbursements through Medicare and Medicaid programs).[40] Research indicates that approximately 50% of those who died in Louisiana as a result of Katrina were 75 years old or older.[41] Although it is unknown how many of these people died related to decisions made during medical triage, antidiscrimination laws seemingly prohibit age from being considered as the sole factor for exclusion from treatment. Even so, recent panel recommendations on critical care triage offer 2 major exclusion criteria, namely a patient's Sequential Organ Failure Assessment score and severity of chronic illness (which is defined to include being older than 85 years).[30] Age was not initially included in the exclusion criteria because it "may not be a strong predictor of critical care outcomes in general."[30] Only later was age included as a result of consistent feedback from experts and other stakeholders. The panel admitted that this is an area that requires more research and input from the community.[30] Making triage decisions solely or even largely based on age while ignoring potential life expectancy would be inconsistent with these recommendations. Future decisions to not treat patients based solely on age and not health status may subject hospital and triage officers to claims for age discrimination.

Discrimination claims may also arise from medical triage decisions that affect other vulnerable populations, including people with disabilities and minorities. After a class action lawsuit (which ended in a settlement agreement) was filed against the Federal Emergency Management Agency challenging its ability to provide accessible housing to people with disabilities during emergencies,[42] President George W. Bush issued an Executive Order in July 2004 to prioritize people with disabilities in all aspects of emergency preparedness, response, and recovery.[43] Similarly, DHHS and the Office of Minority Health developed a consensus statement on disaster preparedness for minority communities.[44] The Department of Homeland Security Appropriations Act of 2006 requires the Federal Emergency Management Agency to address the needs of populations with limited English proficiency during a disaster.[45] These and other legal requirements suggest that hospitals and health care providers that fail to treat vulnerable populations equally could face claims of discrimination under state and federal civil rights laws.

LEGAL RISKS IN FAILING TO PLAN FOR EMERGENCIES

The common perception is that liability most often arises in emergencies or disasters through actions or omissions that occur during the throes of exigency. However, hospitals and health care personnel are also subject to civil liability, loss of accreditation, and other sanctions for failing to meaningfully plan for reasonably foreseeable disasters. In addition, hospital administrators and emergency planners can be held individually liable for failing to facilitate adequate disaster preparedness. Potential liability for "failing to plan" is underappreciated and seldom fully understood. For the purposes of this section, civil liability refers to the responsibility that a person

https://doi.org/10.1097/DMP.0b013e31819d977c Published online by Cambridge University Press

or entity owes to another for causing harm due to a failure to fulfill certain established duties,[46] either through actions or omissions.[47] Criminal liability may arise in instances where one's actions fail to satisfy certain general or statutory duties so as to constitute a morally reprehensible act against society (with or without harm to any particular person).[48] Determining the existence and defining the contours of such duties are threshold questions in "failure to plan" cases. Once duties are established, fact-finders (eg, juries, judges, accreditation committees) determine whether the acts or omissions of the at-fault party deviate from those duties. Hospitals and health care personnel may thus be liable for a failure to plan for emergencies if it is determined that they had a duty to plan, the duty was breached, and the breach was the proximate cause of harm to patients.

As to the first element, hospitals and health care entities clearly owe various duties to patients, including a duty to take reasonable steps to ensure a safe environment. This is the same general duty shared by all entities that serve the public. For example, restaurants and movie theaters have general duties to prevent foreseeable harm from foreseeable dangers such as liquid spills[49] and fires.[50] These legal duties have been explained and refined through litigation and subsequent formulation of safety laws and professional best practices. Accordingly, restaurants are legally obligated to frequently inspect their premises for slippery surfaces and movie theaters must install lighted exits to facilitate rapid evacuations during fires. Failures to inspect premises or install safety lights may lead to liability when people are injured or killed. As facilities of public accommodation, hospitals have similar duties to take reasonable measures to avoid foreseeable harms in various circumstances (eg, fires, electrical outages).

Hospitals also have additional, specific duties to plan that exceed providing a safe and secure environment. As providers of professional services, they are required to provide medical care to patients that is consistent with accepted standards. This includes ensuring that treating physicians are appropriately qualified[51] and that medical resources comply with reasonable standards of quality and maintenance.[51] In addition, based on the unique "trust relationship" between patients and health care providers, hospitals and health care professionals also have a general duty to act in the best interests of individuals that they accept as patients.[52] As a result, once a patient–physician relationship is initiated, the physician and hospital are obligated to provide services until the patient consents to ending the relationship.[53,54] The potential for civil liability to stem from this duty is reinforced by a number of federal[55] and state[56] laws that clarify facets of the patient–physician relationship.

Hospitals' duties to provide a safe environment, high-quality medical care, and patient sustenance do not end during disasters. They may, however, be altered. The contours of these duties are informed by prevailing standards of care with which hospitals must adhere to maintain the operational ability of the facility. To quantify the appropriate standard of care, hospitals must consider the potential harm from a particular incident, the likelihood of the incident, and the burden of avoiding the harms related to the incident.[57] Disasters 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. If these harms to patients can be tied to improper, insufficient, or outright failures to plan, then liability may follow for 3 principal reasons: the value of proper planning on minimizing the harms to patients during disasters is incontrovertible; basic planning is rarely cost prohibitive (or, as noted above, sometimes directly funded by government)[12]; and a wide array of laws and standards requires hospitals and health care providers to plan for disasters. These include the following:

- State licensing statutes[58] and regulations[59] for hospitals, and nursing facilities,[60] which require, for example, the ability to shelter-in-place for certain periods of time[58]
- State emergency preparedness statutes that require evacuation plans[61]
- Safety standards promulgated by the Occupational Safety and Health Administration relating to disaster planning and preparedness[62]
- Standards of accreditation by The Joint Commission regarding emergency management requirements[63]
- Medicaid and Medicare accreditation requirements including provisions requiring evacuation and general disaster plans[64,65]
- Preparedness requirements under the National Incident Management System and the Hospital Incident Management System that require hospitals and other institutions to have disaster plans and command structures to respond to emergencies[12]

These (and other) requirements strongly support a hospital's general duty to engage in emergency planning and preparedness activities. The question is whether this sort of general duty to plan may trigger civil liability in specific cases.[66]

In recent cases, courts and juries have tended to commiserate with health care providers, even in the face of planning failures that contributed to shockingly tragic deaths. During Hurricane Katrina, the failure of a Louisiana nursing facility to carefully formulate and implement an emergency evacuation plan led to the drowning deaths of 34 elderly and incapacitated patients, many of whom floated out of the broken windows of the facility.[65] Although 45 civil suits are pending,[67] a grand jury acquitted the owners of the nursing facility of all criminal negligence charges, despite significant evidence that additional preparation would have saved lives.[65] The grand jury and segments of the population apparently viewed those failures to satisfy formulated planning requirements as unpersuasive evidence that the nursing facility acted unreasonably as stewards of their patients.[68]

The continued expansion of emergency preparedness requirements for hospitals may diminish the likelihood that juries will look sympathetically on negligent conduct. Moreover, in some states, violations of legal planning requirements (eg, a hospital's failure to plan for emergencies when federal, state, and local laws require such plans) may establish an automatic presumption of negligence.[69,70] In other states, such violations could be viewed by courts as irrefutably establishing negligence under what is often called negligence per se.[71,72] Although applied differently among the states,[73–75] legal proof of negligence per se generally requires evidence that the

1. Victim was a member of the class of persons intended to be protected by the legal requirement (eg, a patient who died because the hospital failed plan for evacuations during a declared emergency)
2. Risk was intended to be resolved by the legal requirement (eg, the risk of harm would have been mitigated if an adequate evacuation plan was in place)
3. Breach of the legal requirement caused harm (the failure to plan for an emergency proximately caused patients' deaths)[74]

Recent legislative efforts by states have significantly enhanced liability protection for the actions of volunteers and entities employing volunteers during emergencies through formal MOUs.[34] These protections are unlikely to apply to the actions or omissions of hospitals taken in advance of a disaster. Given the proliferation and increased legal support for hospital preparedness and planning standards, whether based on general negligence theories or theories of negligence per se, potential civil liability for failure to plan is a risk that hospitals cannot afford to take.

Conclusions

Legal preparedness is critical to hospital emergency preparedness and response for emergencies or disasters that affect the public's health. Yet, there are significant challenges underlying emergency legal preparedness. The legal environment during declared emergencies changes drastically, requiring advance planning in multiple areas and the ability to make legal decisions in real time. Risks of liability, discrimination, and other claims stemming from the provision of medical triage necessitate transparency, accountability, and fairness in making triage decisions. Preparing for emergencies through advance legal assessments, processes, and training designed to facilitate hospital emergency responses is worth the investment of time and resources. Hospitals and health care personnel that fail to plan for emergencies not only place their patients at risk but they may also ultimately find themselves facing legal claims in civil and criminal negligence without any laudable defense.

About the Authors

Mr Hodge is Executive Director, Centers for Law and the Public's Health: A Collaborative at Johns Hopkins and Georgetown Universities; Ms Garcia is a policy analyst, Center for Public Health Preparedness and Disaster Response, American Medical Association; and Mr Anderson is a senior fellow and Ms Kaufman is a research assistant at the Centers for Law and the Public's Health.

Address correspondence and reprint requests to James G. Hodge Jr, Johns Hopkins Bloomberg School of Public Health, Hampton House, Room 513, 624 N Broadway, Baltimore, MD 21205-1996 (e-mail: jhodge@jhsph.edu).

Authors' Disclosures

The authors report no conflicts of interest.

Acknowledgment

The authors gratefully acknowledge the contributions of James Tsai, JD, and P.J. Wakefield for their editing and formatting assistance.

ISSN: 1935-7893 © 2009 by the American Medical Association and Lippincott Williams & Wilkins.

DOI: 10.1097/DMP.0b013e31819d977c

REFERENCES

1. Michael O. Leavitt, Secretary, US Department of Health and Human Services, Statement on HHS Bioterrorism and Public Health Emergency Preparedness Before the Committee on Health, Education, Labor and Pensions United States Senate, Thursday, March 16, 2006. *http://www.hhs.gov/asl/testify/t060316.html*. Accessed September 28, 2008.
2. Lister SA. Public Health and Medical Preparedness and Response: Issues in the 110th Congress. CRS Report RS22602. *http://www.cnie.org/NLE/CRSreports/07March/RS22602.pdf*. Accessed February 16, 2009.
3. Davis LM, Ringel JS, Cotton SK, et al. Public Health Preparedness: Integrating Public Health and Hospital Preparedness Programs. RAND/TR-317-DHHS, 2006. *http://www.rand.org/pubs/technical_reports/2006/RAND_TR317.pdf*. Accessed October 3, 2008.
4. Kaji L. Hospital disaster preparedness in Los Angeles County. *Acad Emerg Med*. 2006;13:1198–1203.
5. Hodge JG. Legal triage during public health emergencies and disasters. *Admin Law Rev*. 2006;58:627–644.
6. Rickard L, Fehn A. Unresolved issues in disaster planning for hospital clients. *Health Lawyer*. 2007;6:10–13.
7. Redhead CS, Vogt DU, Tiemann ME. Bioterrorism: Legislation to Improve Public Health Preparedness and Response Capacity. CRS Report RL32173. *http://www.law.umaryland.edu/marshall/crsreports/crsdocuments/RL31263a.pdf*. Accessed February 16, 2009.
8. Homeland Security Presidential Directive-8 (HSPD-8). The White House, December 17, 2003. *http://www.whitehouse.gov/news/releases/2003/12/20031217-6.html*. Accessed September 23, 2008.
9. Public Health Service Act, 42 USC §247d-6d (1946).
10. Bioterrorism Hospital Preparedness Program: HRSA Work Plan Priority Area 1: Administration. *http://www.health.state.mn.us/oep/healthcare/04cooperativeagree.pdf*. Accessed February 16, 2009.
11. Remarks to the 2004 National Bioterrorism Hospital Preparedness Meeting by HRSA Administrator Elizabeth M. Duke, December 7, 2004. *http://newsroom.hrsa.gov/speeches/2004speeches/bioterrorism-dec7.htm*. Accessed February 16, 2009.
12. FEMA Frequently Asked Questions re: NIMS. *http://www.fema.gov/emergency/nims/faq/compliance.shtm*. Accessed September 23, 2008.
13. Pub L No. 109–417.
14. Hodge JG, Gostin LO, Vernick JS. The pandemic and all-hazards preparedness act: improving public health emergency response. *JAMA*. 2007;297:1708–1711.
15. PAHPA, 42 USC § 300hh–10.
16. 73 Fed Reg 30, 401 (2008).
17. Agwunobi JO. Hospital Disaster Preparedness: Past, Present, and Future. Testimony before the Subcommittee on Oversight and Investigations, Committee on Energy and Commerce, US House of Representatives, January 26, 2008. *http://www.hhs.gov/asl/testify/t060126.html*. Accessed February 16, 2009.

18. The Joint Commission, Surge Hospitals: Providing Safe Care in Emergencies, December 2005. *http://www.jointcommission.org/NR/rdonlyres/802E9DA4-AE80-4584-A205-48989C5BD684/0/surge_hospital.pdf*. Accessed February 16, 2009.
19. Maldin B, Lam C, Franco C, et al. Regional approaches to hospital preparedness. *Biosecur Bioterror*. 2007;5:43–53.
20. Hodge JG, Anderson ED, Teret SP, et al. *Blueprint Outline of Model Memorandum of Understanding Between Hospitals During Declared Emergencies*. (Draft as of October 1, 2008, on file with author.)
21. Hodge JG, Anderson E. Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP): Legal and Regulatory Issues, Department of Health and Human Services (DHHS). 2008. *http://www.publichealthlaw.net/Projects/ESAR-VHP.php*. Accessed February 16, 2009.
22. Centers for Law and the Public's Health: A Collaborative at Johns Hopkins and Georgetown Universities. The Model State Emergency Health Powers Act (2001). *http://www.publichealthlaw.net/ModelLaws/MSEHPA.php*. Accessed October 3, 2008.
23. Centers for Law and the Public's Health: A Collaborative at Johns Hopkins and Georgetown Universities. MSEHPA State Legislative Activity Table, July 15, 2006. *http://www.publichealthlaw.net/MSEHPA/MSEHPA%20Leg%20Activity.pdf*. Accessed October 3, 2008.
24. MSEHPA § 104(m).
25. Hodge JG, Anderson ED. Principles and practice of legal triage during public health emergencies. *Annu Surv Am Law*. 2008;98:231–237.
26. Buehler JW, Whitney EA, Berkelman RL. Business and public health collaboration for emergency preparedness in Georgia: a case study. *BMC Public Health*. 2006;6:285.
27. Gostin LO, Sapsin J, Teret SP, et al. The Model State Emergency Health Powers Act: planning and response to bioterrorism and naturally occurring infectious diseases. *JAMA*. 2002;288:622–688.
28. Zimmerman JM. Mass casualty management. In: Ballinger WF, Rutherford WF, Zudeima OD, eds, *The Management of Trauma*. Philadelphia: WB Saunders; 1968: pp. 778–782.
29. Department of Health and Human Services, HHS Pandemic Influenza Plan: Supplement 3 Healthcare Planning. *http://www.hhs.gov/pandemicflu/plan/sup3.html*. Accessed September 28, 2008.
30. Devereaux AV, Dichter JR, Christian MD et al. Definitive care for the critically ill during a disaster: a framework for allocation of scarce resources in mass critical care: from a Task Force for Mass Critical Care Summit Meeting, January 26–27, 2007, Chicago, IL. *Chest*. 2008;133:51–66.
31. Hodge JG, Calves S, Gable LA, et al. Risk management in the wake of hurricanes and other disasters: hospital civil liability arising from the use of volunteer health professionals during emergencies. *J Med Law*. 2006;10:57–86.
32. *Thompson v Nason Hospital*, 591 A. 2d 703 (Pa. 1991).
33. Hodge JG, Gable LA, Calves S. The legal framework for meeting surge capacity through the use of volunteer health professionals during public health emergencies and other disasters. *J Contemp Health Law Policy*. 2006;22:5–71.
34. Matthews G. Expanding Emergency Liability Protection within Existing State Laws: The Work Around Approach. *http://nciph.sph.unc.edu/law/tampa_report2.pdf*. Accessed October 1, 2008.
35. Davis R. Three major needs emerge from Katrina. January 23, 2006. *http://www.usatoday.com/news/nation/2006-01-23-katrina-lessons_x.htm*. Accessed September 25, 2008.
36. Foster M. Doctor cleared in patient deaths recounts Katrina scene. July 20, 2008. *http://www.usatoday.com/weather/hurricane/2008-07-20-Katrina-hospital-horror_N.htm*. Accessed September 28, 2008.
37. Griffin D, Johnson K. Katrina investigation focuses on more than one person. *http://www.cnn.com/2005/US/12/21/katrina.hospital/index.html*. Accessed September 13, 2008.
38. The Committee for Disaster Medicine Reform, Louisiana Governor's Signature Enacts America's Most Comprehensive Disaster Medicine Reform. *http://www.cdmr.org*. Accessed September 25, 2008.
39. Docs List Who Would Be Allowed to Die in a Catastrophe. *http://www.cnn.com/2008/HEALTH/05/05/pandemic.rationing.ap/index.html*. Accessed September 15, 2008.
40. Nondiscrimination on the Basis of Age in Programs or Activities Receiving Federal Financial Assistance. 34 CFR 110.
41. Brunkard J, Namulanda G, Ratard R. Hurricane Katrina deaths, Louisiana, 2005. *Disaster Med Public Health Preparedness* . 2008;2:215–223.
42. *Brou v FEMA*, No. 06-838 (E.D. La.). *http://www.fema.gov/pdf/library/brou_fema.pdf*. Accessed September 30, 2008.
43. Wilkinson WA. Department of Health and Human Services, Office of Civil Rights, Emergency Preparedness Planning: HIPAA Privacy and Special Needs Populations Considerations. December 4, 2006. *http://www.hhs.gov/ocr/wilkinson061204.html*. Accessed September 30, 2008.
44. Drexel University School of Public Health. New Consensus Statement Offers First Blueprint for Disaster Preparedness in Minority Communities. *http://www.diversitypreparedness.org/Topic/Subtopic/Record-Detail/18/search__consensus+statement/resourceId__16947*. Accessed September 30, 2008.
45. S 689(e). Department of Homeland Security Appropriations Act of 2006.
46. 74 Am Jur 2d Torts § 7.
47. 74 Am Jur 2d Torts § 9.
48. 21 Am Jur 2d Criminal Law § 2.
49. *Martoccio v Western Restaurants, Inc*, 269 Ill App 3d 1075 (App. Ct Ill 1997).
50. *Garrett v Holiday Inns, Inc*, 58 NY 2d 253, 447 NE 2d 717 (NY, 1983).
51. *Thompson v Nason Hospital*, 527 Pa 330, 591 A 2d 703, 59 USLW 2734 (Pa, 1991) (PA Sup Ct).
52. *Moore v Webb*, 345 SW 2d 239 (KC Ct App 1961).
53. 61 Am. Jur. 2d Physicians, Surgeons, and Other Healers. § 216 (1981).
54. 61 Am Jur 2d, Physicians, Surgeons, and Other Healers. § 234 (1981).
55. Emergency Medical Treatment and Active Labor Act, 42 USC § 1395dd.
56. McKinney's Consolidated Laws of New York, Public Health Law § 2803-c (e).
57. *US v Carroll Towing Co*, 159 F 2d 169 (2d Cir 1947).
58. Fl Rev Stat § 395.1055.(b) (2007).
59. NJ Admin Code tit. 8, § 43G-5.16.
60. NJ Admin Code tit. 8, § 43-12.2.
61. West's FSA § 252.356 (2000).
62. US Government Accountability Office. Report to Congressional Committee. Better Planning Would Improve OSHA's Efforts to Protect Worker's Safety During Disasters. March 2007. *http://www.gao.gov/new.items/d07193.pdf*. Accessed September 30, 2008.
63. Joint Commission Standards EC 4.10.
64. Requirements for Long-Term Care Facilities. 42 CFR § 483.75.(b) (m) (1) (2005).
65. Mead RA. St. Rita's and lost causes: improving nursing home emergency preparedness. *Marq Elder's Advisor*. 2006;6:153–169.
66. *Sawyer v Food Lion, Inc*. 144 NC App 398, 401, 549 SE 2d 867, 869 (2001).
67. In re Katrina Canal Breaches, Slip Copy, 2007 WL 1438739 (ED La).
68. Katrina Nursing Home Owners Acquitted: Owners of Nursing Home Where 35 Patients Drowned in Hurricane's Flood Waters Found Not Guilty. September 7, 2007. *http://www.cbsnews.com/stories/2007/09/07/national/main3243854.shtml*. Accessed September 23, 2008.
69. *Gradle v Doppelmayr USA, Inc*, 9 Cal. Rptr 3d 889 (Ct App 2004).
70. *Kalata v Anheuser-Busch Co., Inc*, 581 NE 2d 656 (Ill 1991).
71. Kozlowski T. Dams and levees are not enough: the case for recognizing a cause of action against non-complying NFIP communities. *William Mary Environ Law Policy Rev*. 2007;32: 263–264.
72. *Zeni v Anderson, 243 NW 2d 270* (Mich 1976).
73. *Restatement (Third) of Torts §14*.
74. *Paramount Dev. Corp. v Hunter, 238 A 2d 869* (Md 1968).
75. *Waugh v Traxler, 412 SE 2d 756* (W Va 1991).