

The Home-Field Disadvantage: Tort Liability and  
Immunity for Paid Physicians During Disasters  
Within the Pacific Northwest Emergency Management  
Arrangement Member States

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## INTRODUCTION

In the years since the terrorist attacks of September 11, 2001, and Hurricane Katrina's destruction along the Gulf Coast in 2005, the United States has continued to modernize how it responds to disasters and emergencies.<sup>1</sup> One of the most important facets of any response to a disaster is protecting and preserving the health of the victims and the general public. To that end, the federal and state governments have developed a patchwork scheme of laws intended to grant various levels of authority and civil immunity to government actors and volunteer responders as a means of making emergency resource acquisition and distribution more efficient. These laws are also meant to encourage volunteers to provide their skills to those in need within the disaster-affected state.<sup>2</sup>

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1. INST. OF MED., GUIDANCE FOR ESTABLISHING CRISIS STANDARDS OF CARE FOR USE IN DISASTER SITUATIONS: A LETTER REPORT 10 (Bruce M. Altevogt et al. eds., 2009).

2. See Lainie Rutkow, Jon S. Vernick, Maxim Gakh, Jennifer Siegel, Carol B. Thompson & Daniel J. Barnett, *The Public Health Workforce and Willingness to Respond to Emergencies: A 50-State Analysis of Potentially Influential Laws*, 42 J.L. MED. & ETHICS 64, 65 (2014) (enumerating

As the large-scale response to the disaster begins to mount, front line hospitals and medical practitioners may receive material and personnel support from the federal government or other states. As additional medical practitioners from beyond the disaster-affected state respond, these practitioners are given immunity from civil liability under a mixture of federal and state laws developed to encourage and assist volunteers who provide medical assistance.<sup>3</sup> Conversely, local first-responding private physicians face the greatest risk of liability for the care they provide under such trying conditions. Unlike their out-of-state counterparts, private physicians practicing in the disaster-affected state are often not granted immunity from civil liability.<sup>4</sup>

Practicing medicine during a disaster can leave a local practitioner vulnerable to many potential causes of action, such as the following:

- (1) negligence, by the practitioner or the hospital under a theory of corporate negligence or *respondeat superior*;
- (2) constitutional claims, for lack of due process or equal protection;
- (3) criminal liability, for inadequate treatment or providing treatment beyond the scope of their usual practice;
- (4) Health Insurance Portability and Accountability Act (HIPAA) violations, for privacy breaches or sub-standard recordkeeping;
- (5) Americans with Disabilities Act (ADA) violations, for alleged discrimination in the triage criteria used for the providing of care;
- (6) Emergency Medical Treatment and Labor Act (EMTALA) violations, for failing to comply with the Act's requirement to provide a medical screening and render the patient medically stable upon arrival to the hospital.<sup>5</sup>

While practitioners might successfully defend themselves from liability, litigation is a less-than-optimal outcome. Defending against a claim places many burdens on a practitioner, including (1) taking time away from the practitioner's ability to see patients;<sup>6</sup> (2) taking an

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influential state laws on this topic); Christina Y. Chan, *Support for the First Line of Defense in Public Health Emergencies*, 105 NW. U. L. REV. 1347, 1352–63 (2011) (discussing federal laws protecting public and private health care entities and practitioners).

3. See Rutkow et al., *supra* note 2, at 65.

4. See Sharona Hoffman, Richard A. Goodman & Daniel D. Stier, *Law, Liability, and Public Health Emergencies*, 3 DISASTER MED. & PUB. HEALTH PREPAREDNESS 117, 122 (2009) [hereinafter Hoffman et al., *Law, Liability, and Pub. Health*] (discussing where patients will go after injury in a disaster and the general disparity in public actor versus private actor liability immunity); Sharona Hoffman, *Responders' Responsibility: Liability and Immunity in Public Health Emergencies*, 96 GEO. L.J. 1913, 1953–56 (2008) [hereinafter Hoffman, *Responders' Responsibility*] (discussing in detail the ways in which private actors are denied liability immunity).

5. Hoffman et al., *Law, Liability, and Pub. Health*, *supra* note 4, at 120.

6. Jonathan Thomas, *The Effect of Medical Malpractice*, 19 ANNALS OF HEALTH L. 306, 310 (2010).

emotional and psychological toll on the practitioner;<sup>7</sup> (3) negatively impacting his or her professional reputation by calling into question the practitioner's competency as a medical professional;<sup>8</sup> (4) increasing his or her medical malpractice insurance premiums;<sup>9</sup> and (5) potentially imperiling the practitioner's license to practice medicine in the state (or states) in which he or she possesses a medical license.<sup>10</sup> These burdens may generate a chilling effect that will dissuade private practitioners from providing medical care because disaster conditions negatively impact their ability to care for patients. Granting civil liability immunity to private practitioners during times of disaster will allow those private practitioners to avoid having to defend against a claim altogether, thus negating the chilling effect and will allow doctors to care for their patients to the full extent of their abilities, no matter how severely disaster conditions may impact the care being provided.

This Note identifies how the Pacific Northwest Emergency Management Arrangement member states of Alaska, Idaho, Oregon, and Washington<sup>11</sup> apply tort liability and immunity to medical professionals during times of disaster. This Note also identifies an example statutory scheme that, if enacted, will provide equal protection to all physicians who provide care to disaster victims, regardless of their local or out-of-state status.

## I. BACKGROUND

### A. *The Practice of Medicine*

When a disaster strikes, local hospitals and their associated physicians are often the first to respond, as these practitioners treat disaster victims who make their way to nearby hospitals.<sup>12</sup> These hospitals may receive a volume of patients that exceeds a hospital's "surge capacity."

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7. See S. Sandy Sanbar & Marvin H. Firestone, *Medical Malpractice Stress Syndrome*, in THE MEDICAL MALPRACTICE SURVIVAL HANDBOOK 9, 9–15 (2007).

8. Thomas, *supra* note 6, at 310.

9. Morgan Lewis Jr., *Medical Malpractice Costs Continue to Climb*, MED. ECON. (Jan. 11, 2012), <http://medicaleconomics.modernmedicine.com/medical-economics/news/clinical/practice-management/medical-malpractice-costs-continue-climb> [<https://perma.cc/TA6G-G7K6>].

10. See generally WASH. REV. CODE § 18.130.180 (2015).

11. While the Canadian province of British Columbia and the Yukon Territory are also Arrangement members, they will be excluded from the scope of this note because of the systemic differences in health care delivery and management of medical liability in the United States and Canada.

12. See Hoffman et al., *Law, Liability, and Pub. Health*, *supra* note 4, at 122 (discussing where patients will go after injury in a disaster).

Surge capacity is the maximum limit of a hospital's available resources to treat patients.<sup>13</sup>

As resources become depleted, medical practitioners are forced to make difficult strategic and ethical choices regarding how to allocate the care and resources available. This decision-making process is known as triage. Various methods of triage exist, the most common of which is practiced in emergency rooms across the United States every day. The guiding principle of day-to-day triage in an emergency room is to rank incoming patients by the severity of their injuries, expediting the treatment of the most gravely injured patients, while having patients with less critical complaints wait.<sup>14</sup>

Alternatively, the guiding principle of disaster triage, which is applied when a hospital meets or exceeds its surge capacity, is to adjust the ranking criteria to place the focus on public care and saving the greatest number of people possible.<sup>15</sup> This new focus on saving the many at the cost of the few gravely injured, coupled with the strain on personnel and material resources, can give rise to questions regarding the applicable standards of care and the potential causes of action that may be brought against the hospital or medical practitioner responding to disasters.

The practice of medicine has two different and distinct standards of care that medical practitioners must abide by to avoid incurring liability: a medical standard of care and a legal standard of care.<sup>16</sup> The medical standard of care is "the type and level of medical care required by professional norms, professional requirements, and institutional objectives."<sup>17</sup> This medical standard of care is often institution-based and dependent on the circumstances under which the care was rendered.<sup>18</sup> The legal standard of care is "the care and skill that a healthcare practitioner must exercise in particular circumstances based on what a reasonable and prudent practitioner would do in similar circumstances."<sup>19</sup> Although the legal standard of care is defined on a state-by-state basis, the various definitions align with the general principle above because of medical malpractice's long common law history.<sup>20</sup>

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13. See Hoffman, *Responders' Responsibility*, *supra* note 4, at 1918.

14. Dawn Cushman, *When Disaster Hits, Where Does the Standard of Care Go?*, 31 J. HEALTHCARE RISK MGMT. 6, 11 (2011) (discussing the underlying goals of triage patient management).

15. *Id.*

16. INST. OF MED., *supra* note 1, at 45 (distinguishing the medical and legal standards of care in the medical profession).

17. *Id.* at 45 (defining the medical standard of care).

18. *Id.* (discussing the underlying factors considered in the medical standard of care).

19. *Id.* (defining the legal standard of care).

20. See Peter Moffett & Gregory Moore, *The Standard of Care: Legal History and Definitions: The Bad and Good News*, 12 W.J. EMERGENCY MED. 109 (2011).

*B. Declarations of Emergency, Disaster, or Public Health Emergency*

An invaluable tool for addressing any disaster is a “declaration of emergency” (a.k.a. an “emergency declaration”). An emergency declaration is often the event that triggers the granting of emergency powers to a governmental executive officer, agency, committee, or person or group tasked with managing the response to a disaster. The practice of granting extraordinary powers and immunity from liability extending from the use of those powers, has existed alongside the idea of democratic governance since the Roman era.<sup>21</sup>

The decision to make an emergency declaration balances the factors that support the existing legal authority structure (e.g., limits on executive authority, governmental borrowing and purchasing limitations, medical device testing standards, etc.) with the ability to effectively and efficiently respond to the conditions that created, or are the result of, the disaster.<sup>22</sup> When the existing bureaucratic processes impede the ability of the government to respond to a disaster, the executive officers of federal, state, and local governments may respond by declaring a state of emergency—if their respective legislative branches have granted them the authority to do so.

Granting extraordinary powers to the government and its agents during times of crisis also serves to create a divide between public medical practitioners and private medical practitioners. When a declaration of emergency, disaster, or public health emergency is made, medical practitioners who are a part of the governmental response to the disaster or emergency, or who are acting in a volunteer capacity, are given special immunities.<sup>23</sup> These immunities are granted in an effort to encourage volunteerism, but private practitioners—those who are “on call” or on-the-job and being paid during the disaster—are not given any special immunity.<sup>24</sup>

Because this Note looks specifically at the medical aspect of a disaster, the focus will be on declarations identifying the existence of a public health emergency. A public health emergency is a condition where

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21. Under normal circumstances, the executive branch of the Roman Republic consisted of two elected Consuls, who shared the duties of the executive branch. During exceptional circumstances—almost exclusively war—the Roman Senate passed legislation requesting the Consuls elect a Dictator. It was understood that “circumstances might arise in which it was of importance for the safety of the state that the government should be vested in the hands of a single person, who should possess for a season absolute power, and from whose decisions there should be no appeal to any other body.” WILLIAM SMITH, A DICTIONARY OF GREEK AND ROMAN ANTIQUITIES, 404–08 (John Murray ed., 1875).

22. INST. OF MED., *supra* note 1, at 46.

23. *See infra* Part I.C.

24. Ryan Bailey, *The Case of Dr. Anna Pou: Physician Liability in Emergency Situations*, 12 AM. MED. ASS’N J. ETHICS 726, 729 (2010).

“a health situation’s ‘scale, timing or unpredictability threatens to overwhelm routine capabilities.’”<sup>25</sup> Declarations of emergency can be made at the federal, state, and local levels of government.

At the federal level, several acts of Congress have granted the President the power to declare a general state of emergency. The two main acts are the Robert T. Stafford Disaster Relief and Emergency Assistance Act (Stafford Act) and the National Emergencies Act.<sup>26</sup> Under the Stafford Act, the President has the authority to declare a state of emergency and render aid to a state if the Governor of that state indicates that local and state resources have been overwhelmed and are in need of federal assistance.<sup>27</sup> Under the National Emergencies Act, there is no specific definition of what constitutes a disaster or emergency, thus providing the President much broader discretion to declare an emergency and utilize the powers granted by Congress.<sup>28</sup>

After the President has declared a general state of emergency, the Secretary of the United States Department of Health and Human Services (HHS) is also authorized to declare a public health emergency “in case of a disease, disorder, or bioterrorist attack that justifies such a declaration”<sup>29</sup> pursuant to the Public Health Service Act.<sup>30</sup> When the Secretary makes a determination that a public health emergency exists, the Secretary may, at that time or retroactively, grant waivers exempting hospitals and health care practitioners from regulatory requirements imposed upon them by Medicare, Medicaid, the Emergency Medical Treatment and Active Labor Act (EMTALA),<sup>31</sup> and the Health Insurance Portability and Accountability Act (HIPAA).<sup>32</sup>

At present, the only state in the Pacific Northwest Emergency Management Agreement that has granted its governor the authority to declare a public health emergency is Oregon.<sup>33</sup> The Oregon statute defines a public health emergency as existing when there is an act of biological terror, a new or previously eradicated source of infection that has the potential to be highly contagious, an epidemic, a natural disaster, a

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25. Rebecca Mansbach, *Altered Standards of Care: Needed Reform for When the Next Disaster Strikes*, 14 J. HEALTH CARE L. & POL’Y 209, 209 (2011).

26. 42 U.S.C. §§ 5121–5206 (2011); 50 U.S.C. § 1621 (2011).

27. 42 U.S.C. § 5191(a) (2011).

28. See 50 U.S.C. § 1621 (2011).

29. See Hoffman, *Responders’ Responsibility*, *supra* note 4, at 1922.

30. 42 U.S.C. § 247d(a) (2014).

31. EMTALA is a federal law that requires a hospital’s emergency room to stabilize and treat any patient who arrives there, regardless of his or her insurance status or ability to pay. See *EMTALA*, AM. C. OF EMERGENCY PHYSICIANS, <https://www.acep.org/News-Media-top-banner/EMTALA/> [<https://perma.cc/26X5-7KK7>].

32. 42 U.S.C. § 1320b–5 (2010).

33. OR. REV. STAT. § 433.441(1) (2014).

chemical spill, a chemical attack, a nuclear accident, or a nuclear attack, and such event poses a high probability of (1) a large number of deaths in the affected population; (2) the creation of a large number of serious or long-term disabilities in the affected population; or (3) widespread exposure to an infectious or toxic substance that may cause significant harm in the future.<sup>34</sup>

### C. Tort Immunity Statutes

The legislative purpose of statutes granting tort immunity is to encourage medical practitioners to provide medical care to those in a disaster area by lessening the medical practitioners' concerns about possible claims made against them resulting from the care they provide in the disaster area.<sup>35</sup> The medical practitioners who receive immunity under these laws are shielded from any liability, so long as the act was not criminal, willful misconduct, or grossly negligent.<sup>36</sup> These statutes have been enacted both federally and by the states.<sup>37</sup>

In this Note, the medical practitioners that are protected under these statutes will be classified into three categories: government actors, volunteer actors, and private actors. Government actors are individuals, agencies, or organizations acting to render aid within their capacity as a governmental entity, as an agent or employee of a governmental entity, or under the authority or direction of a governmental entity. The most common source of tort liability immunity for government actors is statutory sovereign immunity. Volunteer actors are individuals or organizations that are acting to render aid while receiving, or expecting to receive, little or no compensation. Alternatively, private actors are individuals or organizations acting to render aid while receiving, or expecting to receive, compensation.

#### 1. Federal Statutes

Several federal statutes granting tort liability immunity during public health emergencies exist. These statutes cover government, volunteer, and private actors.

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34. OR. REV. STAT. § 433.442 (2014).

35. Judith C. Ahronheim, *Service by Health Care Providers in a Public Health Emergency: The Physician's Duty and the Law*, 12 J. HEALTH CARE L. & POL'Y 195, 199 (2009).

36. Chan, *supra* note 2, at 1361.

37. See generally 42 U.S.C. § 300hh-11 (2013); 42 U.S.C. §247d(a) (2006); 42 U.S.C. §§ 14501-14505 (1997); ALASKA STAT. § 09.65.090 (2015); IDAHO CODE §§ 5-330, 46-1017, 39-1391c, 39-7703 (2015); OR. REV. STAT. §§ 30.800, 30.805, 676.340, 676.345 (2015); WASH. REV. CODE §§ 4.24.300, 38.56.080 (2015); Chan, *supra* note 2.

*a) Federal Statutes Granting Government Actor Immunity*

Medical practitioners who provide medical services as government actors receive statutory immunity derived from governmental sovereign immunity by means of precluding suits for their actions as government actors, agents, or deputies under the Federal Tort Claims Act.<sup>38</sup> There are three statutes that clearly illustrate the practice of a statute deputizing a medical practitioner as an agent of the government to qualify for government actor immunity.

The first statute created was the National Disaster Medical System (NDMS).<sup>39</sup> The NDMS consists of rapidly deployable groups of volunteer medical practitioners, with each group specializing in specific kinds of disaster response.<sup>40</sup> HHS, the Federal Emergency Management Agency, the Department of Defense, and the Department of Veterans Affairs jointly administer the NDMS program.<sup>41</sup> The authority to activate and deploy the NDMS groups is granted to the Secretary of HHS by the Public Health Security and Bioterrorism Preparedness and Response Act of 2002.<sup>42</sup>

The second of these statutes is the Public Readiness and Emergency Preparedness (PREP) Act.<sup>43</sup> The PREP Act focuses on the tools and materials, such as “drugs, devices, and biological products”<sup>44</sup> categorized as “covered countermeasures,”<sup>45</sup> that a medical practitioner may require to provide treatment during a public health emergency and the liability that may result from the use of those covered countermeasures.<sup>46</sup> Under the PREP Act, the Secretary of HHS has the authority to make a determination that “a disease[,] . . . health condition[,] or other threat to health constitutes a public health emergency, or that there is a credible risk that the disease, condition, or threat may in the future constitute such an emergency.”<sup>47</sup> The Secretary also has the authority to specify “the manufacture, testing,

38. See Hoffman, *Responders' Responsibility*, *supra* note 4, at 1938.

39. 42 U.S.C. § 300hh-11 (2013).

40. Chan, *supra* note 2, at 1354.

41. *Id.*

42. *Id.* (citing 42 U.S.C. § 300hh-11 (2013)).

43. Public Readiness and Emergency Preparedness (PREP) Act, 42 U.S.C. § 247-6d to 247d-6e (Supp. 2007).

44. Hoffman et al., *Law, Liability, and Pub. Health*, *supra* note 4, at 121.

45. A “covered countermeasure” is a broad statutory definition that encompasses any drug, biological product, or device that is authorized by the Secretary of HHS for use in responding to an emergency. See 42 U.S.C. § 247d-6d(i)(1)(c) (2006). When the covered countermeasure is used to combat the natural spread of disease, it is referred to as a “qualified pandemic or epidemic product.” See 42 U.S.C. § 247d-6d(i)(7)(c) (2006). When the covered countermeasure is used to combat “any biological, chemical, radiological, or nuclear agent” it is referred to as a “security countermeasure.” See 42 U.S.C. § 247d-6b(c)(1)(B).

46. Targeted Liability Protections for Pandemic and Epidemic Products and Security Countermeasures, 42 U.S.C. § 247d-6d (2005).

47. 42 U.S.C. § 247d-6d(b)(1) (2006).

development, distribution, administration, or use of one or more covered countermeasures.”<sup>48</sup> Under the PREP Act, “a covered person”<sup>49</sup> shall be immune from suit and liability under Federal and State law with respect to all [tort] claims for loss . . . resulting from the administration to or the use by an individual of a covered countermeasure . . . .”<sup>50</sup> Immunity is only waived for a “death or serious physical injury” resulting from “willful misconduct.”<sup>51</sup> An entity or person is engaging in willful misconduct when they knowingly and intentionally, with no legal or factual justification, act or fail to act with the purpose of accomplishing a wrongful goal, disregarding known or obvious risks that are so great that it is highly probable the potential harm will outweigh the potential benefit.<sup>52</sup>

The third statute is the Federal Tort Claims Act (FTCA).<sup>53</sup> Under normal circumstances, a government agency and its agents may be subject to a civil suit for damages when their actions cause injury, or otherwise incur liability under the FTCA.<sup>54</sup> However, during a state of emergency, the agency and its actors may not be subject to a claim under the FTCA’s discretionary function exemption.<sup>55</sup> This exemption bars claims against actions of a federal employee for decisions made based on consideration of public policy that involved the exercise of the employee’s discretion or judgment, unless the decision intrudes upon the constitutional rights of an individual.<sup>56</sup> The United States is also immune from claims brought under the FTCA if the injury underlying the claim was caused by exercise of governmental discretion, “whether or not that discretion is exercised negligently or wrongfully, whether or not it is exercised at all, and whether or not it is abused.”<sup>57</sup>

This discretionary exemption grants broad immunity to governmental agencies and their “on-the-job” employees during a state of emergency to enable them to make the best possible judgment calls on matters of public policy. Hypothetically, this government immunity could apply to medical practitioners employed by or acting under the direction of a government agency. In short, when a state of emergency exists, the

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48. *Id.*

49. A “covered person” is the United States, or a person or entity who is: the manufacturer; distributor; program planner; the qualified individual prescribing, administering, or dispensing the covered countermeasure; and any of the agents, employees, or officials of the persons or entities described above. *See* 42 U.S.C. § 247d-6d(i)(2) (2006).

50. 42 U.S.C. § 247d-6d(a)(1) (2006).

51. 42 U.S.C. § 247d-6d(d)(1) (2006).

52. 42 U.S.C. § 247d-6d(c)(1)(A) (2016).

53. 28 U.S.C. § 2680 (2014).

54. Federal Tort Claims Act, 28 U.S.C. §§ 2671–72 (2006).

55. 28 U.S.C. § 2680(a) (2014).

56. AMERICAN JURISPRUDENCE PROOF OF FACTS 241 (3d ed. 2009).

57. *Lane v. United States*, 918 F. Supp. 864, 867 (E.D. Pa. 1996).

controlling emergency statutes under which governmental agencies act and governmental agents exercise their powers provide those government actors with immunity under the FTCA through the discretionary function exemption.

*b) Federal Statutes Granting Volunteer Actor Immunity*

Another route that medical practitioners may take to secure tort immunity while practicing medicine during a disaster is to practice medicine as a volunteer. Rather than becoming a de facto or de jure government employee and securing government actor immunity, it may be more practical for most medical practitioners to provide volunteer medical services to receive federal statutory immunity. The Volunteer Protection Act of 1997 (VPA) grants properly licensed volunteers rendering aid on behalf of government entities and nonprofit organizations limited immunity for harm that results from any act or omission performed within the scope of their responsibilities, provided that act or omission does not amount to “willful or criminal misconduct, gross negligence, reckless misconduct, or a conscious, flagrant indifference to the rights or safety of the individual harmed.”<sup>58</sup> The VPA also establishes a minimum level of protection for volunteer aid workers, including volunteer medical practitioners, by preempting any state law that fails to offer equal protections, but not those laws that offer greater protections.<sup>59</sup>

A limiting factor of this immunity is that medical practitioners will only receive volunteer immunity if they are providing services for less than \$500 per year or on an uncompensated volunteer basis.<sup>60</sup> This compensation limitation prevents paid medical practitioners from utilizing volunteer immunity during disasters. The purpose of this type of legislation is to counter the deterrent effect potential volunteers might feel as a result of possible liability against them.<sup>61</sup>

*c) Federal Statutes Granting Private Actor Immunity*

Medical practitioners who provide medical services as private actors and charge for their services are often left ducking for cover when seeking liability protections under federal statutes designed to protect medical practitioners and other emergency personnel responding to disasters.<sup>62</sup> The

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58. 42 U.S.C. § 14503(a) (2014).

59. 42 U.S.C. § 14502 (2014).

60. The Volunteer Protection Act defines a “volunteer” as “an individual performing services for a nonprofit organization or a governmental entity who does not receive . . . compensation (other than reasonable reimbursement or allowance for expenses actually incurred)[ ] or any other thing of value in lieu of compensation, in excess of \$500 per year . . . .” 42 U.S.C. §§ 14501–05 (1997).

61. Ahronheim, *supra* note 35, at 199 (citing 42 U.S.C. § 14501(a)(1) (2006)).

62. Hoffman et al., *Law, Liability, and Pub. Health*, *supra* note 4, at 122.

greatest likelihood of a private physician receiving immunity under federal public health emergency laws is through the PREP Act; however, this immunity is limited to harms related to the use of a covered countermeasure approved under the Act.<sup>63</sup> Hypothetically, a paid medical practitioner could use a covered countermeasure in the course of treating a patient;<sup>64</sup> however, if the use of the covered countermeasure were to cause harm to the patient, the limitation on liability would only extend to the use of the controlled countermeasure.<sup>65</sup>

## 2. Interstate Mutual Aid Agreements

A mutual aid agreement is a cooperative agreement entered into by states, territories, provinces, tribes, and other governmental entities for the purpose of sharing strategic resources such as personnel, volunteers, and information when responding to a public health emergency.<sup>66</sup> This type of cooperative response to emergencies originated as a solution to the ineffective utilization of volunteer medical practitioners during the Hurricane Katrina disaster, where questions regarding licensing impeded volunteers.<sup>67</sup> There is one national-scale interstate mutual aid agreement that includes all fifty states, known as the Interstate Emergency Management Assistance Compact (EMAC),<sup>68</sup> and several smaller regional-scale agreements, which may include multiple states and some governmental entities from neighboring Canadian and Mexican territories and provinces.<sup>69</sup>

### *a) Interstate Emergency Management Assistance Compact (EMAC)*

Originally approved by Congress in 1996 with thirteen member states,<sup>70</sup> the Emergency Management Assistance Compact (EMAC) is a national-scale mutual aid agreement administered by the National Emergency Management Association. To request aid under EMAC, the

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63. Chan, *supra* note 2, at 1361; Hoffman et al., *Law, Liability, and Pub. Health*, *supra* note 4, at 122.

64. 42 U.S.C. § 247d-6d(d)(1).

65. *Id.*; Chan, *supra* note 2, at 1361.

66. DANIEL D. STIER & MELISA L. THOMBLEY, CTR. FOR DISEASE CONTROL & PREVENTION, PUBLIC HEALTH MUTUAL AID AGREEMENTS: A MENU OF SUGGESTED PROVISIONS 1 (2007), [http://www.cdc.gov/phlp/docs/Mutual\\_Aid\\_Provisions.pdf](http://www.cdc.gov/phlp/docs/Mutual_Aid_Provisions.pdf) [<https://perma.cc/96MM-UWT3>].

67. Ahronheim, *supra* note 35, at 202.

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

69. See generally *An Updated Overview of the Great Lakes Border Health Initiative*, MICH. DEP'T OF HEALTH & HUM. SERVS., [http://www.michigan.gov/mdch/0,4612,7-132-54783\\_54875-170665--,00.html](http://www.michigan.gov/mdch/0,4612,7-132-54783_54875-170665--,00.html) [<https://perma.cc/3JFE-MSB3>]; OR. PUB. HEALTH DIV., UPDATE REPORT ON PUBLIC HEALTH EMERGENCY PREPAREDNESS IN OREGON 11 (2008), <https://public.health.oregon.gov/Preparedness/mediacenter/Documents/phep0708.pdf> [<https://perma.cc/329H-2TTR>].

70. Emergency Management Assistance Compact §1.

governor of a state must declare a state of emergency, assess the needs of the state, determine the amount by which the state's local resources will fall short, and place a request with the National Emergency Management Association.<sup>71</sup> Under EMAC, when a licensed medical practitioner is sent to a state requesting aid, the requesting state must recognize the medical practitioner as licensed to practice medicine.<sup>72</sup> However, EMAC's liability protection only extends to "[o]fficers and employees of a party state rendering aid" by treating them as if they were agents of the requesting state for purposes of liability and immunity.<sup>73</sup> This immunity extends to any good faith act or omission occurring during the rendering of aid, so long as the act or omission does not amount to "willful misconduct, gross negligence, or recklessness."<sup>74</sup>

Unfortunately, EMAC fails to provide immunity from liability to volunteers.<sup>75</sup> Some states address this shortcoming directly with legislation extending the immunity to responders who are not state employees.<sup>76</sup> However, EMAC does not expressly define what an "officer," "employee," or "agent" is.<sup>77</sup> This ambiguity thus allows the possibility of arguing that individuals deputized by the state, or otherwise acting under the orders of the state or a state employee, can be considered an "officer," "employee," or "agent" of the state and, therefore, qualify for immunity under EMAC.<sup>78</sup>

*b) Pacific Northwest Emergency Management Arrangement (PNEMA)*

The Pacific Northwest Emergency Management Arrangement (PNEMA)<sup>79</sup> is an intergovernmental regional mutual aid agreement between the states of Alaska, Idaho, Oregon, and Washington, as well as the Canadian provinces of British Columbia and the Yukon Territory.<sup>80</sup> The agreement allows any member to request aid from other member states in the event of a "natural or technological emergency or disaster" or

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71. Emergency Management Assistance Compact, Pub. L. No. 104-321, 110 Stat. 3877 (1996); see *Emergency Management Assistance Compact*, NAT'L EMERGENCY MGMT. ASS'N, [http://www.emacweb.org/index.php?option=com\\_content&view=article&id=99&Itemid=339](http://www.emacweb.org/index.php?option=com_content&view=article&id=99&Itemid=339) [<https://perma.cc/53YB-R6RU>].

72. Emergency Management Assistance Compact, art. V.

73. *Id.* at art. VI.

74. *Id.*

75. *Id.* at art. VI (restricting immunity from liability to "officers and employees of a party state").

76. See IND. CODE § 10-14-3-19(d) (2013); IOWA CODE § 135.143.2 (2011); ME. REV. STAT. tit. 37-B, § 784-A (2013); Hoffman, *Responders' Responsibility*, *supra* note 4, at 1942.

77. See generally, Emergency Management Assistance Compact, §1.

78. See Hoffman, *Responders' Responsibility*, *supra* note 4, at 1942.

79. Pacific Northwest Emergency Management Arrangement, Pub. L. No. 105-381, 112 Stat. 3402 (1998); OR. REV. STAT. § 402.250 (2015).

80. Pacific Northwest Emergency Management Arrangement, Pub. L. No. 105-381, 112 Stat. 3402 (1998).

“enemy attack.”<sup>81</sup> For a member state to request aid, the authorized representative may make a request to the authorized representative of any other member state, either verbally<sup>82</sup> or in writing, with a description of the emergency service required, the amount and type of assistance required, and a time, place, and point of contact for responding forces.<sup>83</sup>

The licensed medical practitioner receives the same licensing recognition under the PNEMA as they would under the EMAC. However, unlike EMAC, PNEMA offers liability protection to any person or entity of a member state by treating them as if they were agents of the requesting state for purposes of liability and immunity.<sup>84</sup> Under PNEMA, all government actors and volunteers are extended liability immunity for their acts or omissions in rendering aid, or while maintaining or operating any equipment associated with rendering aid, unless that act, omission, maintenance, or operation amounts to “willful misconduct, gross negligence, or recklessness.”<sup>85</sup>

### 3. State Statutes

States have also enacted statutes to address the issue of responder liability during disasters.<sup>86</sup> States have implemented a variety of approaches to deal with the issue of responder liability, and the approach implemented can vary drastically from state to state. This note will focus on the four states that are members of the Pacific Northwest Emergency Management Arrangement.<sup>87</sup> This section explores the various approaches adopted by the four states and highlight the lack of immunity available to paid medical practitioners during disasters.

#### *a) Alaska*

##### *i. Alaska State Statutes Granting Government Actor Immunity*

According to the Alaska Code, a deputized medical practitioner or one made an agent of the State to provide medical services on behalf of the State can receive government actor immunity in the same manner that a deputized medical practitioner or one made an agent of the federal

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81. *Id.*

82. A verbal request for aid must be accompanied by a written confirmation within fifteen days of the initial request. Pacific Northwest Emergency Management Arrangement, Annex B, art. III(2) (2005).

83. *Id.* art. III(2)(A)–(C).

84. *Id.* art. VI.

85. *Id.*

86. *See infra* Part I.C.3(a)–(d)

87. Pacific Northwest Emergency Management Arrangement, Pub. L. No. 105-381, 112 Stat. 3402 (1998); OR. REV. STAT. § 402.250 (2015).

government can receive government actor immunity.<sup>88</sup> During a state of emergency, “the state, a district of the state, an employee, agent, or representative of the state or a district, or a volunteer or auxiliary civilian defense worker or member of an agency”<sup>89</sup> an “officer or employee of another state,”<sup>90</sup> or “a volunteer authorized by the state, a municipality or other political subdivision of the state, or a federal agency to engage in a civil defense activity”<sup>91</sup> is not liable for damage to property or injury or death to a person if the harm occurred while in the process of performing a civil defense activity<sup>92</sup> or obeying a civil defense order or regulation.<sup>93</sup> Additionally, out-of-state volunteers rendering aid under the EMAC and PNEMA mutual aid agreements are afforded the same liability as a condition of Alaska’s membership in those agreements.<sup>94</sup>

#### ii. Alaska State Statutes Granting Volunteer Actor Immunity

Under Alaska’s version of a Good Samaritan law, an individual who encounters an “injured, ill, or emotionally distraught person”<sup>95</sup> who “reasonably appears . . . to be in immediate need of emergency aid in order to avoid serious harm or death . . .”<sup>96</sup> at a “hospital or any other location”<sup>97</sup> and “renders emergency care . . . or counseling . . . is not liable for civil damages [from] an act or omission in rendering emergency aid.”<sup>98</sup>

Additionally,

[a] member of an organization that exists for the purpose of providing emergency services is not liable for civil damages for injury to a person that results from an act or omission in providing first aid, search, rescue, or other emergency services to the person, regardless of whether the member is under a preexisting duty to render assistance, if the member provided the service while acting as a volunteer member of the organization.<sup>99</sup>

Under this statute, a volunteer is defined as an individual who is paid less than \$10 per day for a total of less than \$500 a year, exempting any

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88. *See supra* Part I.C.1(a).

89. ALASKA STAT. § 26.20.140(d)(1) (2015).

90. *Id.* § 26.20.140(d)(5).

91. *Id.* § 26.20.140(d)(6).

92. In Alaska, civil defense activities include medical service, vaccination, and other actions to protect public health. *Id.* § 26.20.200(2).

93. *Id.* § 26.20.140(b).

94. *See* Emergency Management Assistance Compact, Pub. L. No. 104-321, 110 Stat. 3877 (1996); Pacific Northwest Emergency Management Arrangement, Annex B, art. VI (2005).

95. ALASKA STAT. § 09.65.090(a) (2015).

96. *Id.*

97. *Id.*

98. *Id.*

99. *Id.* § 09.65.090(b).

costs incurred while providing the emergency service.<sup>100</sup> However, this immunity will not apply if (1) the person rendering care is a physician who has a preexisting duty to render emergency care,<sup>101</sup> or (2) the actions or omissions that occurred while rendering aid amount to gross negligence, recklessness, or intentional misconduct.<sup>102</sup>

### iii. Alaska Statutes Granting Private Actor Immunity

Under Alaska's Good Samaritan statute, as originally passed by the legislature, a private medical practitioner working in a hospital would have qualified for immunity.<sup>103</sup> However, the Supreme Court of Alaska held that physicians and other individuals who had taken on a preexisting duty to render care were ineligible to receive liability immunity under the Good Samaritan statute.<sup>104</sup>

In *Deal v. Kearney*, the Supreme Court of Alaska held that the legislative purpose of including physicians under the Good Samaritan statute was to encourage physicians to render emergency medical services to people who were not their patients and not to exempt physicians from any preexisting duties owed to patients the physician had before the emergency started.<sup>105</sup> Under Alaska's statutes, private medical practitioners who are being paid for their work lack immunity for emergency services rendered during a condition of disaster emergency.<sup>106</sup>

## b) Idaho

### i. Idaho Statutes Granting Volunteer Actor Immunity

Idaho has two statutes granting immunity to volunteer actors: a Good Samaritan statute<sup>107</sup> and a statute granting immunity to health care professionals providing charity care.<sup>108</sup> Under Idaho's Good Samaritan statute, any person or group offering or rendering first aid or medical care

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100. *See id.*

101. *Deal v. Kearney*, 851 P.2d 1353 (Alaska 1993) (holding that physicians do not receive immunity from the Good Samaritan statute if they have a preexisting duty to render emergency care); *see also* *Bunting v. United States*, 662 F. Supp. 971 (D. Alaska 1987) (holding Alaska's "Good Samaritan" statute provides partial immunity only to persons who had no preexisting duty to render aid).

102. *See* ALASKA STAT. § 09.65.090(d) (2015).

103. ALASKA STAT. § 09.65.090 (2016).

104. *See Kearney*, 851 P.2d at 1353 (holding that physicians do not receive immunity from the Good Samaritan statute if they have a preexisting duty to render emergency care).

105. *Kearney*, 851 P.2d at 1356–57.

106. ALASKA STAT. § 09.65.090(b) (2016).

107. IDAHO CODE § 5-330 (2015).

108. *Id.* § 39-7703.

in good faith by stopping at an accident is given immunity.<sup>109</sup> The immunity will exist until the person receiving aid is delivered to a hospital, placed in the care of an ambulance attendant, or delivered to the office of any person who treats ill or injured persons.<sup>110</sup> This immunity prevents any civil claim for damages.<sup>111</sup> However, the immunity will not apply if it can be proven that the volunteer actor rendering care provided care or otherwise treated the person in a grossly negligent manner.<sup>112</sup>

The strict conditions imposed in Idaho's Good Samaritan statute significantly limit the immunity it could provide to medical professionals responding to a disaster. The statute limits the scope of immunity in two ways. First, the statute restricts immunity physically by requiring the rendering of aid be initiated at an accident site.<sup>113</sup> Second, the statute terminates the immunity when the aid recipient is delivered to a hospital, clinic, or other emergent care facility.<sup>114</sup> This restriction, while protecting medical first responders, does not cover the medical professionals who are receiving the patient at a hospital, clinic, or office. The second Idaho statute providing protection to volunteer actors offers immunity for any civil action as a result of the actor providing charity care if the patient has signed a waiver explaining that the care is to be rendered with no expectation of payment and that the medical practitioner will be granted immunity.<sup>115</sup>

The preauthorization requirement makes this statute unsuitable for offering immunity to medical practitioners under most disaster response conditions. Several factors may impede the ability of medical practitioners providing charity care during a disaster to secure a signed waiver of payment from a patient: (1) the physical location and condition of the site where the medical practitioner is rendering care may be unsuitable for the creation, retrieval, or filing of waivers (e.g., imminent danger necessitating rapid treatment and evacuation, loss of power, flooding, rendering care in a field hospital, destruction of hardcopy files, destruction of computers or loss of computer networks, lack of administrative personnel, etc.); (2) the response to a mass casualty event may be too frantic and chaotic to successfully locate and duplicate forms; (3) medical practitioners may prioritize triaging patients and providing emergency medical care over securing waivers.

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109. *See id.* § 5-330.

110. *See id.*

111. *See id.*

112. *See id.*

113. *Id.*

114. *Id.*

115. *See id.* § 39-7703.

## ii. Idaho Statutes Granting Private Actor Immunity

In an effort to encourage doctors of any specialty or training to provide emergency care, Idaho presumes that any licensed physician<sup>116</sup> is “qualified to undertake . . . any emergency or surgical care.”<sup>117</sup> This presumption requires that the treatment provided by the medical practitioner is the result of a good faith judgment that the care is required based on the condition and best interest of the patient, and that the care is rendered in a manner that is not grossly negligent under the circumstances.<sup>118</sup> Under the statute, any physician or hospital that performs emergency care will be granted immunity from any civil action resulting from that care.<sup>119</sup>

*Eby By & Through Eby v. Newcombe* is the controlling case law for this statute.<sup>120</sup> In *Eby*, the Supreme Court of Idaho found that, while this statute was intended to encourage a physician of any specialty to render emergency care or first aid, it was not intended “to affect or change the standard of care or liability of physicians in the ordinary doctor/patient relationship.”<sup>121</sup> The Supreme Court of Idaho opined that when an ordinary doctor–patient relationship exists, the attending medical practitioner does not qualify for immunity under the statute when rendering emergency care.<sup>122</sup>

## c) Oregon

### i. Oregon State Statutes Granting Government Actor Immunity

When either a state of emergency or a public health emergency is declared, medical practitioners who are registered on the “emergency healthcare provider registry,”<sup>123</sup> or those who volunteer to render medical services, are considered agents of the state for tort liability and immunity purposes.<sup>124</sup> Additionally, those locations designated as “emergency health centers” by the Oregon Health Authority and “persons operating emergency health care centers designated [by the Health Authority] are agents of the state . . . for the purposes of any claims arising out of services that are provided . . . without regard to whether the . . . person is

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116. *Id.* § 39-1391(c) (2015).

117. *Id.*

118. *See id.*

119. *Id.* § 39-1391(c) (2016).

120. *Eby By & Through Eby v. Newcombe*, 780 P.2d 589 (1989).

121. *Id.* at 591.

122. *See id.* at 592.

123. *Id.* § 401.654 (2015).

124. *Id.* § 401.667 (2016).

compensated for the services.”<sup>125</sup> However, this immunity will only extend to those emergency health centers that have “credentialing plans that govern the use of emergency health care providers registered under [the emergency health care provider registry] and other health care providers who volunteer to perform health care services.”<sup>126</sup>

#### ii. Oregon State Statutes Granting Volunteer Actor Immunity

Oregon’s Good Samaritan statute is unique among the PNEMA states, as it restricts the class of people covered to professional medical practitioners.<sup>127</sup> However, the statute maintains the usual requirements that the care be voluntarily rendered without expectation of compensation and to a person who, based on the circumstances, is in need of emergency medical or dental care as the final means to prevent death or serious harm.<sup>128</sup> Further, it grants immunity from any action for damages that result from an act or omission while rendering aid, so long as the aid rendered was not grossly negligent.<sup>129</sup> However, Oregon’s statute imposes location-specific conditions on the availability of statutory immunity. Specifically, the statute only provides immunity for “[m]edical or dental care not provided in a place where [such care] is regularly available, including . . . a hospital . . . first aid station [or] office of a physician, physician assistant, or dentist.”<sup>130</sup>

#### iii. Oregon State Statutes Granting Private Actor Immunity

The State of Oregon currently lacks a statutory scheme to grant immunity to medical practitioners who are paid during a state of emergency.

### *d) Washington*

#### i. Washington State Statutes Granting Government Actor Immunity

During a state of emergency, no “covered volunteer emergency worker” can be held liable for any act or omission committed while performing “covered activities”<sup>131</sup> rendered during the course of responding to the disaster,<sup>132</sup> unless those acts or omissions amount to

125. *See id.* § 401.667(2) (2015).

126. *See* OR. REV. STAT. § 401.667(4) (2015).

127. *See id.* § 30.800; *see also* ALASKA STAT. § 09.65.090(a) (2015), IDAHO CODE § 5-330 (2015), WASH. REV. CODE § 4.24.300(1) (2015).

128. *See* OR. REV. STAT. § 30.800 (2015).

129. *See id.* § 30.800(2).

130. *Id.* § 30.800(1)(a).

131. WASH. REV. CODE § 38.52.180(3)(a) (2015).

132. *Id.* § 38.52.180(2).

“gross negligence or willful or wanton misconduct.”<sup>133</sup> A “[c]overed volunteer emergency worker” is an emergency worker who is not receiving, nor expecting to receive, compensation from the state as an emergency worker and who is not a state or local employee, unless that employee is on unpaid leave at the time.<sup>134</sup> Under the statute, an emergency worker is a “person who is registered with a local emergency management organization . . . and holds an identification card issued by the local emergency management director . . . or is an employee of the state of Washington or any political subdivision thereof who is called upon to perform emergency management activities.”<sup>135</sup> The covered activities that invoke liability protections are as follow:

Providing assistance . . . authorized by the department during an emergency or disaster or search and rescue . . . whether such assistance . . . is provided at the scene of the emergency or disaster or search and rescue, at an alternative care site, at a hospital, or while in route to or from such sites or between sites . . . .<sup>136</sup>

#### ii. Washington State Statutes Granting Volunteer Actor Immunity

Washington’s Good Samaritan statute covers any person who provides “emergency care at the scene of an emergency [or] transportat[ion from the scene] for emergency medical treatment ” without an expectation of compensation.<sup>137</sup> The Washington Good Samaritan statute will provide that person with immunity from any action for civil damages caused by an act or omission in rendering the emergency care if the manner in which the emergency care was provided does not amount to “gross negligence or willful or wanton misconduct.”<sup>138</sup> The controlling case law relating to the Good Samaritan statute is *Maynard v. Ferno-Washington, Inc.*<sup>139</sup> In *Maynard*, the court found that the purpose of the Good Samaritan statute is to “protect volunteer emergency workers coming to the aid of an injured person from liability for simple negligence that caused further injury to the injured person.”<sup>140</sup>

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133. *Id.* § 38.52.180(4)(c).

134. *See id.* § 38.52.180(5)(a).

135. *Id.* § 38.52.010(7).

136. *Id.* § 38.52.180(5)(b).

137. *Id.* § 4.24.300(1).

138. *See id.* § 4.24.300(1).

139. *Maynard v. Ferno-Washington, Inc.*, 22 F. Supp. 2d 1171, 1174 (E.D. Wash. 1998).

140. *Id.* at 1174.

## iii. Washington State Statutes Granting Private Actor Immunity

The State of Washington currently lacks a statutory scheme to grant immunity to medical practitioners who are paid during a state of emergency.

## II. ISSUES WITH THE CURRENT STATUTORY SCHEMES

As they stand, the laws offering immunity to medical practitioners during times of declared emergencies or disasters fail to provide legal protection to the front line practitioners who are often the first to reach surge capacity, as victims of a disaster seek care and are admitted to private hospital facilities.<sup>141</sup> Further, these laws are fractured and difficult to navigate, lack standardization, and fail to provide uniform protections to all disaster responders.<sup>142</sup> In every PNEMA member state, the doctors staffing emergency rooms and trauma centers do not currently enjoy the same liability protections that are extended to federal or state government actors or Good Samaritan volunteers.<sup>143</sup>

Hypothetically, the current legal landscape could allow for two surgeons of equal skill and care, operating on the same patient, under the same conditions, and with the same resources, to have the same civil action brought against them and yet experience different degrees of liability. The first surgeon could be held liable if he or she was either on call or working at the time of the disaster. However, the second surgeon could be held not liable due to the immunity that the surgeon receives under government actor immunity, volunteer actor immunity, or mutual aid agreement statute immunity.<sup>144</sup> All of these factors contribute to a general unwillingness of paid medical practitioners to respond to a disaster and provide care.<sup>145</sup> Fear of this “immunity gap” may lead to a decrease in doctors who are willing to respond to hospital staffing requests during disasters.<sup>146</sup>

Currently, the law offers excellent immunity protections to government actors, as well as to those medical practitioners who are considered government actors by means of employment, agency, or deputation.<sup>147</sup> This expansion of “government actor” status may help to

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141. See Hoffman et al., *Law, Liability, and Pub. Health*, *supra* note 4, at 122.

142. See discussion *supra* Part I.C.

143. See discussion *supra* Part I.C.

144. See discussion *supra* Part I.C.

145. See Ahronheim, *supra* note 35, at 198–99.

146. Ahronheim, *supra* note 35, at 199; See Council on Ethical & Judicial Affairs, Am. Med. Ass’n, Code of Medical Ethics of the American Medical Association § 9.06, at 355 (2014–15 ed., 2014) (recognizing physicians have the right to decline to treat a patient); See *id.* § 9.067, at 363 (recognizing that physicians need to weigh the ability to treat future patients against treating the instant patient).

147. See discussion *supra* Part I.

address the immunity gap that private actor physicians fall into during disasters. Federally, and across all four PNEMA states, government actor medical practitioners receive immunity from civil liability as long as their actions are within the scope of their duties and not grossly negligent, wanton, or reckless.<sup>148</sup>

Two states, Washington and Oregon, have statutory schemes in place that could offer volunteer medical practitioners immunity for their acts and omissions during the disaster. Both approaches require that the volunteers be preregistered with a government authority; however, Washington's approach also includes a restriction mandating that the preregistered volunteers not receive compensation if they wish to receive immunity.<sup>149</sup> By including such restrictions, Washington and the other PNEMA member states, with the exception of Oregon, have stripped the frontline medical practitioners, particularly doctors and nurses staffing emergency rooms and trauma centers, of the ability to enjoy the same liability protections that are extended to federal or state government actors or Good Samaritan volunteers.<sup>150</sup>

Those in favor of maintaining the legal status quo seek to ensure that society will continue to hold paid medical practitioners responsible for their actions by allowing injured patients to recover damages. Accountability is important because we equate being held accountable with providing a better quality of care. But, should paid medical practitioners not be held to the same standard as their volunteer counterparts when practicing in a disaster area? If the care provided by medical practitioners with immunity was notably below par and harming patients, why does such widespread support for volunteer medical provider immunity exist? Paid, governmental, and volunteer medical practitioners should be held to the same standards of care and liability. Granting immunity to paid medical practitioners during times of disaster will not destroy the quality of care they give to their patients, just as it has not destroyed the quality of care that volunteer or government actor medical practitioners give to their patients. Granting immunity to paid medical practitioners during disasters will perpetuate an idea of "same conditions, same care, and same standards."

Is it proper to extend the "benefit" of immunity to paid medical practitioners during disasters when responding to the sick and injured is what they are being paid to do? Being a medical practitioner in a disaster area is well beyond the scope of what is required of a medical practitioner in ordinary circumstances. The difference is so distinct that the State of

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148. See discussion *supra* Part I.

149. See discussion *supra* Part I.C.3(c), (d).

150. See discussion *supra* Part I.C.

Oregon will not allow any registered volunteer medical practitioner to respond to a disaster without first receiving special training in the structure of the emergency response system, emergency response operations, emergency preparedness, disaster medicine, psychological first aid, disaster life support, and wilderness first aid or medicine.<sup>151</sup> Such training is crucial to enable medical providers to respond to conditions beyond their control that may call for them to perform above and beyond the call of duty.

In recent memory, the most well-known instance of medical practitioners caring for patients under dire circumstances are the events at Memorial Medical Center in New Orleans, Louisiana, during Hurricane Katrina in August of 2005.<sup>152</sup> At the start of the hurricane, Memorial sheltered 2,000 people, of which 200 were patients and 600 were staff.<sup>153</sup> On the day the hurricane struck, the city's power failed at 4:55 a.m.<sup>154</sup> The next day the storm had passed, but extensive flooding forced the hospital to remain on backup generators. After almost 48 hours of continuous operation, the backup generators failed at 2:00 a.m., two days after the storm.<sup>155</sup> The medical practitioners were then left in the dark to care for 130 patients, 52 of whom were critical.<sup>156</sup> The hospital's windows, smashed in by the hurricane, let in the oppressively humid heat, bringing the temperature in the building to over 100 degrees Fahrenheit and allowing the flood waters of New Orleans, tainted with raw sewage and corpses, to permeate the building.<sup>157</sup> After the storm began, help did not come for three days.<sup>158</sup> In light of these events, it is clear that practicing medicine is fundamentally different during a disaster and the laws applied to medical practitioners during disasters should reflect that difference.

It is unrealistic to expect the same standard of care under disaster conditions. We must not hinder paid medical practitioners with worries of liability. Instead, we must design the laws that apply to medical practitioners providing care under disaster conditions in a way that reflects the reality of the situations in which they operate. Thus, the laws governing medical practitioner immunity during disasters should be pragmatic and supportive to all medical practitioners, regardless of their paid,

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151. OR. ADMIN. R. 333-003-0140 (2016).

152. See generally SHERI FINK, FIVE DAYS AT MEMORIAL: LIFE AND DEATH IN A STORM-RAVAGED HOSPITAL (2013).

153. Sheri Fink, *The Deadly Choices at Memorial*, N.Y. TIMES (Apr. 12, 2016) (Magazine), <http://www.nytimes.com/2009/08/30/magazine/30doctors.html> [<https://perma.cc/3DKL-SET7>].

154. *Id.*

155. *Id.*

156. *Id.*

157. *Id.*

158. See *id.*

governmental, or volunteer status and should not place additional burdens on them.

### III. EXPANDING EMERGENCY RESPONSE EFFECTIVENESS WITH EQUAL IMMUNITY

To simplify emergency management procedures and provide a greater level of certainty and confidence to the medical community and lawyers regarding how liability will be assessed after a disaster, Washington, Oregon, Idaho, and Alaska should adopt the private liability scheme proposed in the Model State Emergency Health Powers Act (MSEHPA).<sup>159</sup>

The Center for Law and the Public's Health at Georgetown and Johns Hopkins Universities drafted the MSEHPA at the request of the Centers for Disease Control and Prevention.<sup>160</sup> It is model legislation intended for consideration by the states as they draft their own legislative responses to disasters and emergencies that impact public health.<sup>161</sup> The MSEHPA recognizes that "if . . . health professionals . . . are to fulfill their responsibilities for preventing and responding to a serious health threat, they should not fear unwarranted liability."<sup>162</sup>

The MSEHPA seeks to "provide[] responsible state actors with the powers they need to detect and contain a potentially catastrophic disease outbreak and, at the same time, protect[] individual rights and freedoms."<sup>163</sup> The MSEHPA accomplishes this goal in part by providing private liability immunity during a public health emergency to the following actors and stating:

Any private person, firm, or corporation and employees and agents of such person, firm, or corporation, who renders assistance or advice at the request of the State or its political subdivisions under the provisions of this Act shall not be liable for causing the death of, or injury to, any person or damage to any property except in the event of gross negligence or willful misconduct.<sup>164</sup>

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159. CTR. FOR LAW & THE PUB.'S HEALTH AT GEORGETOWN & JOHNS HOPKINS UNIV., THE MODEL STATE EMERGENCY HEALTH POWERS ACT (2001), <http://www.aapsonline.org/legis/msehpa2.pdf> [<https://perma.cc/E43L-2S9M>].

160. Lawrence O. Gostin, *The Model State Emergency Health Powers Act: Public Health and Civil Liberties in a Time of Terrorism*, 13 HEALTH MATRIX 3, 4 (2003).

161. *Id.* at 5.

162. *Id.* at 19.

163. *Id.* at 5.

164. THE MODEL STATE EMERGENCY HEALTH POWERS ACT, *supra* note 159, at § 804(b)(3).

During a state of emergency, the states involved need to call upon all of their medical practitioners to help care for the ill or injured.<sup>165</sup> The breadth of the private actor immunity should include even those medical practitioners who are being paid during the emergency because the conditions in which they are required to perform are no less dire than those in which volunteer medical practitioners find themselves. Reading the MSEHPA's private liability exemption as including paid medical practitioners also helps to further its goal of providing the State with the powers it needs to address a health related emergency by ensuring that (1) no medical practitioners elect to leave in an attempt to avoid potential liability, thus ensuring the maximum numbers of medical practitioners are available to respond to the emergency; (2) medical practitioners will be less likely to engage in the practice of "defensive medicine";<sup>166</sup> and (3) medical resources will be used more efficiently in the absence of defensive medicine, which is of critical importance because supplies may become scarce during the emergency.

However, limitations on liability should not preclude recovery. Rather than having injured patients seek damages against individual medical practitioners, it could be more efficient, and equitable, for injured patients to submit claims to a victims' compensation fund created by the individual states. Such funds already exist under the PREP Act.<sup>167</sup> The development of such a compensation fund will encourage medical practitioners to participate in emergency response efforts by addressing their apprehension about injury liability while attempting to practice in disaster zone conditions. Further, the legal system will also ensure that patients who are injured will be able to recover damages for their losses.

#### CONCLUSION

The implementation of the MSEHPA approach across all PNEMA states will serve many purposes, including simplifying a presently haphazard patchwork of immunity statutes and liability standards, incentivizing medical practitioner participation in emergency response to disaster, and promoting the more efficient use of both personnel and resources when responding to a disaster. However, the most important

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165. See *Homeland Security Presidential Directive/HSPD-21: Public Health and Medical Preparedness*, FED'N OF AM. SCIENTISTS (Oct. 18, 2007), <http://fas.org/irp/offdocs/nspd/hspd-21.htm> [<https://perma.cc/DZ6N-DP3Z>].

166. Defensive medicine is the practice by a physician of ordering many tests or consultations as a means of self-protection against charges of malpractice in the event of an unfavorable outcome of treatment. THE RANDOM HOUSE DICTIONARY OF THE ENGLISH LANGUAGE 522 (2d ed. 1987).

167. HEALTH RES. & SERVICES ADMIN., COUNTERMEASURES INJURY COMP. PROGRAM FACT SHEET, <http://www.hrsa.gov/cicp/cicpfactsheet.pdf> [<https://perma.cc/ML2X-KLZ5>]. The Countermeasures Injury Compensation Program is the injury compensation fund for the PREP Act.

outcome of implementing the MSEHPA approach would be closing the liability gap and eliminating the home-field disadvantage many doctors experience. Under normal conditions, the burden of potential liability is an important part of maintaining a safe medical system by serving as a deterrent to negligent or reckless medical treatment. But in a time of crisis, the burden of potential liability is amplified by the chaos of mass-triage, having to practice medicine in potentially dangerous conditions, and the sudden unreliability of available, required medical facilities and supplies.

During a crisis, the burden of liability is amplified to the point that it may prove to be harmful to patients by incentivizing a doctor to practice defensive medicine and utilize more than the minimum supplies required. Further, the burden may bias a doctor's triage evaluation towards recommending a "judgment call" patient be listed as an expected fatality instead of providing care that may have an increased risk of complications or death, and therefore liability, because of the conditions posed by the crisis. By temporarily waiving the burden of liability during a crisis, we give doctors more options for allocating medical resources and determining the best course of treatment for their patient. By being flexible during a crisis and removing the usual restraints imposed by the burden of liability, we are furthering the ultimate goal of better protecting and preserving the health of disaster victims and the public at large.