Threats of biological terror attacks, the Severe Acute Respiratory Syndrome (SARS) epidemic of 2003–2004 and a fear of pandemic disease such as avian influenza have spurred critical reevaluation of strategies for containing communicable diseases. This reevaluation—and in many cases revamping of laws—creates new demands on lawyers who advise health-care organizations. Private practice attorneys will be challenged to understand state and federal laws, regulations and agencies involved in homeland security and emergency preparedness and response, in order to counsel health-care clients before and during emergencies.1

As this area of law is still in its infancy, there is not a rich history and body of literature on the subject. One must look at existing laws, listen to concerns of individuals involved in preparedness activities and try to anticipate issues that may arise.

Preparedness and the Government
The roles of federal, state and local governments in emergencies sometimes overlap, causing conflict and confusion. Which level of government can best fulfill preparedness responsibilities? Each has its own strengths and weaknesses.
The federal government has responsibility and authority to coordinate national preparedness. It has a relatively large budget and access to agencies that might participate in preparedness planning, and it has ability to monitor activity on a national level. The federal government can also coordinate interstate initiatives. Bureaucracy, political considerations and constitutional limitations, however, diminish its abilities.

State governments have less money, manpower and political sway but they can better focus their activities. Due to their smaller size, they are easier to navigate than the federal government. States might also have exclusive jurisdiction over parts of preparedness, based on their police powers. Planning in the health-care delivery system usually falls under the purview of state, not federal, government.

Local governments have the most limited resources. They also have the smallest bureaucracies and the most homogenous constituency. While not everyone in a local political subdivision will support the same preparedness plan, they are from a relatively local area. Their desire to safeguard the locality might make it easier to develop local preparedness plans. Most “first responders” are based at the local level.

Conflicts arise between the three levels of government for many reasons. Jurisdictional issues present a source of angst. Federal, state and local boundaries blur, however, in applying specific preparedness programs. For example, public health activities are within a state’s purview under its police powers. The federal government might want states to report incidences of specific diseases and illnesses to the Centers for Disease Control (CDC). States might not want to report for fear of repercussions. For example, some states were afraid to report Human Immunodeficiency Virus for fear of that it would drive infected persons underground. In such a case, is the state required to report? What authority does the federal government have for requiring such reporting?

The emergency preparedness and response landscape is sprinkled with many other components—the most dominant being a legal framework for preparing and responding to public health emergencies. Within this framework are national, state and local statutes and regulations. These laws can help or hinder an effective emergency response. Laws regarding isolation and quarantine, emergency services and disasters and public health are of utmost importance for a successful preparedness program. While many laws have been amended since September 11, 2001, some laws are archaic and unwieldy.

**Preparedness and Health-Care Delivery Systems**

Our health-care delivery system is fragmented, and access to services varies. Physicians, allied health care professionals (such as nurses and physician’s assistants), and emergency medical services (EMS) workers are primary components of the first-responder system. Hospitals and other institutions provide equipment and technology needed to deliver care. The other institutions include ambulatory care centers, diagnostic centers, home-health agencies, urgent-care centers and long-term care facilities.

The government is a payor and regulator, but care delivery is a private sector function. This juxtaposes the government’s responsibility for preparedness activities, the need for the health-care delivery systems to play a large part in preparedness planning, and the government’s lack of involvement in health care delivery. Public-private cooperation is needed among the government, public health agencies and the private sector health care delivery system.

The health-care system is already taxed: Hospitals are overcrowded and waits in the emergency room are excessive. There is a national shortage of more than 168,000 health care professionals. Physicians work harder, are paid less and pay higher malpractice insurance premiums. EMS agencies are taxed. The system has very limited ability to “surge”— to handle an influx of patients created by a public health emergency.

It was once thought that, in the event of biological attacks or another public health emergency, health-care delivery systems would only operate for a few hours before federal reinforcements and resources would arrive. This is a myth. U.S. Secretary of Health and Human Services Michael O. Leavitt says that local and state systems will have to operate for unspecified amounts of time before federal resources will be allocated. The timing will vary based on the seriousness of the incident. If a biological attack affects numerous states or regions of the country, local systems will have to operate longer than if the event is localized in one state or region. Due to the existing strain on health-care delivery systems, the prospect of handling a public health emergency without federal resources complicates preparedness planning.

**Preparedness, Health-Care Delivery Systems and Counsel**

Health-care providers and institutions should understand what would be expected of them and the laws that will govern them in a public health emergency. They need to know the roles of other players and the effect it will have on them. Understanding a public health officer’s role, responsibilities and authority might make cooperation easier.

Hospitals are often surprised when told what might occur during a public health emergency. A National Defense University study regarding hospital readiness found that, despite the investment of significant resources in preparedness, rural hospitals are ill-prepared for mass casualties and infectious disease incidents. Urban community hospitals did not fare much better. Literature on surge capacity has indicated the same. Due to an apparent lack of preparedness and understanding of health-care providers and institutions, counsel will be asked for advice and guidance. These calls might come in the midst of an emergency, leaving little time for research and reflection. Health-care attorneys should con-
sider the following issues now so that they can educate clients before a public health emergency and reeducate and advise clients during an emergency.

**Government Authority Parameters**

During a public health emergency, officials will have the power to influence health-care providers, institutions, private citizens and businesses. Since these officials rarely have exercised such powers, doing so might be met by skepticism and resistance. One can imagine a hospital administrator frantically calling his lawyer because a public health officer just presented him with an order that authorizes the officer to take control of the hospital for the duration of the emergency. Meanwhile, a small-business owner might consult counsel to find out whether he or she can fire an employee who is afraid to leave the house and come to work. The local sheriff might consult counsel to find out whether deputies should arrest a man who they believe is under home quarantine. The man under home quarantine might ask an attorney how he is supposed to obtain food and other necessities without leaving his house.

The role of courts in public health emergencies is another issue. Once a public health officer quarantines an emergency room, can the hospital appeal? If so, how? While the appeal is being processed, how will the emergency room be classified? Will it be quarantined? Will the hospital be entitled to an injunction? Clients might question the consequences of disobeying a public health order. While attorneys may not advise their clients to disobey the law, they may explain the consequences. For example, a private citizen under home quarantine might ask about the ramifications of disobeying the order if he goes to the grocery store for milk and bread.

That citizen might ask questions of redress. The client might have been ordered to stay at home because he was allegedly exposed to avian influenza in Asia. He explains that he has never been to Asia nor associated with anyone who has been to Asia, and he cannot possibly have avian influenza. He is obeying the home quarantine, but considers it to be false imprisonment. He wants to sue. Whom should he sue? What type of recovery can he seek? Against what, if any, government institution could a judgment be enforced?

Clients might ask many questions regarding the government’s authority during a public health emergency. A lawyer must know public health emergency statutes and regulations, emergency and disaster laws, and state isolation and quarantine laws. He must know not only about the limits of the government’s power, but also the scope of appeal and redress.

**Impact of “Quarantined” Designation**

During a public health emergency, it might be necessary for public health authorities to close and quarantine its emergency department after a patient entered with an envelope of powder, which spilled and contaminated the entire department. The white powder was not anthrax, but the department was closed for five hours. When faced with this type of situation, health-care institutions might ask counsel about the power of the public health authority. Counsel might be asked if a hospital can suspend discharges until public health authorities can determine that current patients do not pose a threat.

**Emergency Medical Treatment and Active Labor Act Compliance**

Hospitals might have questions about compliance with the Emergency Medical Treatment and Active Labor Act (EMTALA) during public health emergencies. EMTALA requires a hospital emergency department to stabilize all patients before transfer. During a disaster, a hospital may find it hard to comply with EMTALA requirements. A hospital might close its doors to keep from being overwhelmed. They may be redirected to triage patients at an off-site location that is more suitable for large numbers of people.

It is not clear that battlefield triage is EMTALA-compliant. Turning away an individual who comes to a closed emergency room might also violate the EMTALA. The U.S. Department of Health and Human Services (HHS) suggests that hospitals would not be relieved of their EMTALA duties when experiencing capacity issues due to a public health emergency.

It is also possible that a hospital might transfer a potentially infectious patient before evaluating or stabilizing the patient. Normally, this would violate the EMTALA. HHS says, however, that if the transfer is done pursuant to a community plan, it might not violate the statute. It is not clear how the federal government will enforce EMTALA during public health emergencies.

**Credentialing**

Investigating credentials of health-care workers might be a problem. It is a
lengthy process that usually cannot be done quickly.

During a public health emergency, hospitals will want all available medical providers. Most will want to participate and provide aid. This includes regular medical staff physicians, hospital employees and retired and out-of-state health-care providers. If a provider is not licensed within the state, the hospital usually cannot credential him or her. A state’s Emergency Medical Assistance Compact (EMAC) may credential out-of-state providers by requiring the receiving state to honor the license of the host state. The State Board of Medicine or Nursing may establish emergency regulations to reinstate retired providers. Without such a regulation, however, there is not much that a hospital can do. Counsel must be familiar with the professional regulatory board regulations, as well as his state’s EMAC in order to assist hospitals with credentialing questions.

Where providers are credentialed at other institutions in the state are needed to provide care, hospitals might be able to establish reciprocal credentialing agreements. These agreements are necessary before an emergency occurs.

Volunteer Management, Integration and Liability

Volunteer management, integration and liability might also need to be addressed. A variety of volunteers may assist during an emergency. They include regular health-care personnel who are not scheduled to work at the time of the emergency, health-care personnel from other institutions, retired or out-of-state health care personnel, members of medical and public health volunteer organizations and individuals with no health care background or experience.

Each type of volunteer has unique issues. For instance, when a regular employee who is not scheduled to work helps in an emergency, will she be paid overtime? Must she be assigned to her normal job duties, or may she be asked to do something outside of her job description?

Medical and public health volunteer organizations have been created to aid during emergencies. The Medical Reserve Corps (MRC) is composed of both health-care providers and lay individuals. This program was started through HHIS and is implemented through units established in localities across the country. Lay individuals with no health-care background and no affiliation with any volunteer group may also want to help.

If a principle-agent relationship does exist, counsel may be able to comfort the institution by finding immunity through the state emergency services and disaster statute.

Who is responsible for delegating tasks to the volunteers? If the attending emergency physician delegates a task to the head of the MRC and the MRC assigns the task to individual members, who will be responsible if the individual is negligent? A hospital, together with counsel, might consider preparing for volunteer services in advance of an emergency. It could then create agreements with volunteer groups that delineate the management and liability structure of the relationship.

Counsel might also be asked to address volunteer liability in terms of both the volunteer’s own liability for acts and the institution’s liability for the acts of the volunteer. Volunteer liability varies from state to state, so it is important that counsel be familiar with state law. The federal Volunteer Protection Act (VPA) does provide some immunity from civil liability for volunteers, but this law has loopholes that leave volunteers exposed. Other possible sources of immunity include state volunteer protection acts; charitable immunity; if the volunteer is part of a charitable organization and it is a viable doctrine; Good Samaritan immunity; sovereign immunity; emergency services and disaster law immunity; and EMAC provisions that may extend immunity to out-of-state volunteers.

Any institutional liability for the acts of volunteers will be tied to both credentialing and management issues. Institutional liability may be based on respondent-superior liability or negligent credentialing where the volunteer is seen as an agent of the institution. Counsel may help design volunteer policies for health-care institutions so that the institution can ensure that it will not be construed as the principal nor the volunteer as its agent. If a principle-agent relationship does exist, counsel may be able to comfort the institution by finding immunity through the state emergency services and disaster statute.

Communicable Disease Containment Laws

Counsel will also have to be familiar with state laws governing communicable disease containment, such as quarantine and isolation. Most states, including Virginia, have modified their laws and continue modification as new threats emerge. These laws enable public health authorities to detain persons suspected of having a communicable disease, but sometimes the laws are vague and confusing. In 2004, the Virginia legislature overhauled Virginia’s quarantine and isolation statutes so that
The statutes also provide mechanisms for judicial review of orders of quarantine and isolation. Counsel must, therefore, be familiar with the amended statutes.

Detainment of persons suspected of having a communicable disease can raise civil liberty and liability concerns. Health-care providers might have to grapple with these concerns during an emergency if they are being asked to enforce detainment orders. In the early stages of an emergency department quarantine, health care providers may be asked to ensure that people do not leave. The health care providers might worry about personal liability when enforcing such orders and wish to consult counsel. Counsel will have to be conversant with these laws, which may prove difficult. The statutory law is relatively undeveloped in most states, and there is a dearth of case law on this issue, since quarantine has not been used in the U.S. on a large scale in nearly one hundred years.

Emergency preparedness and response activities present significant legal issues for the public and private sector. Health-care providers will likely be at the epicenter of any emergency. Providers and their legal counsel must be prepared to respond effectively to future emergencies that can occur at any time. Counsel to health-care providers will be challenged to master this emerging area of law.

Endnotes:
1 For the remainder of this article, “public health emergency” will be used to encompass biological attacks, communicable disease outbreaks such as SARS and any other public health emergency to which hospitals and health-care providers may be asked to respond.
2 See Summary of Notifiable Diseases—United States, 2001 (MMWR 50(53)1-108). This article outlines the history of notifiable diseases within the United States. In 1912, the first list of nationally notifiable infectious disease list was created. The list is updated periodically, but since 1961 the Centers for Disease Control has been responsible for collecting information on these nationally notifiable diseases.
8 Comments made by Secretary Leavitt at the Virginia Pandemic Influenza Summit in Richmond, Virginia on March 23, 2006.
11 See supra note 7.
13 Id.
17 EMAC Model Legislation, available at http://www.emacweb.org/EMAC/About_EMACModel_Legislation.cfm (last visited January 13, 2005), as adopted by forty-seven states, two territories and the District of Columbia. Article V provides “[w]henver any person holds a license, certificate, or other permit issued by any state party to the compact evidencing the meeting of qualifications for professional, mechanical, or other skills, and when such assistance is requested by the receiving party state, such person shall be deemed licensed, certified, or permitted by the state requesting assistance to render aid involving such skill to meet a declared emergency or disaster, subject to such limitations and conditions as the governor of the requesting state may prescribe by executive order or otherwise.”
19 42 U.S.C. § 14501 et seq.
20 Charitable immunity has been eliminated in some states.