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Rebecca Mansbach

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# ALTERED STANDARDS OF CARE: NEEDED REFORM FOR WHEN THE NEXT DISASTER STRIKES

REBECCA MANSBACH\*

Physicians and other health care workers, like many professionals, are held to a certain standard of care in their practice of medicine.<sup>1</sup> A breach of this standard will likely prove a physician was negligent.<sup>2</sup> However, in the wake of events like Hurricane Katrina and the H1N1 pandemic, there have been proposals to change the ordinary standard of care during declared emergencies.<sup>3</sup> This idea is called “altered standards of care,” and suggests that there should be different standards that health care workers are held to during an emergency.<sup>4</sup> Broadly, a public health emergency exists when a health situation’s “scale, timing or unpredictability threatens to overwhelm routine capabilities.”<sup>5</sup> There has been significant research into, and creation of, altered standards of care for volunteers and Good Samaritans who help during emergency situations.<sup>6</sup> Many of these regulations provide immunity to these individuals.<sup>7</sup> Nevertheless, there have been scant efforts to determine what standards of care should apply to private entities, such as hospitals and health care providers, during declared emergencies.<sup>8</sup> Standards of care are determined under state, not federal law,<sup>9</sup> and several states have actually begun to create statutes that provide tort immunity to

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\* J.D. Candidate, 2011, University of Maryland School of Law (Baltimore, Md.); B.S., 2008, Public Health, George Washington University (Washington, D.C.). Many thanks to Professor Leslie Meltzer Henry for her help and support.

1. *See infra* Part I.A.

2. *See infra* Part I.A.

3. *See infra* Part I.B.

4. *See infra* Part I.B.

5. Christopher Nelson et al., *Conceptualizing and Defining Public Health Emergency Preparedness*, 97 AM. J. PUB. HEALTH S9, S9 (2007).

6. *See infra* Part I.B.

7. *See infra* Part I.B.

8. *See infra* Part II.

9. *See infra* Part II.

health care providers.<sup>10</sup> But, these state statutes never really have been put into practice, nor do they cover the full issue of altered standards of care.<sup>11</sup> This paper proposes that “altered standards of care” truly contain two components: tort immunity for health care providers *and* guidelines on how these health care providers should allocate scarce resources during declared emergencies.<sup>12</sup> There are certain resources that are likely to be limited during an emergency, including ventilators; oxygen; intensive care unit beds; health care providers, especially critical care, burn, and surgical/anesthesia staff, and respiratory therapists; hospitals in general, specialty medications or intravenous fluids (which include vaccines, antibiotics, and antivirals); and medical transportation.<sup>13</sup> States should create specific guidelines regarding how to allocate these resources.

There is currently a lack of sufficient legislation to protect health care providers—few states have statutes that address altered standards of care,<sup>14</sup> and even if states do address them, they only provide tort immunity and do not address the second component.<sup>15</sup> Because of this, complete reform of immunity statutes protecting providers in the event of an emergency is needed. Without reform, providers may not be able to provide all the necessary care when the next disaster strikes. Part I of this paper discusses the basic standards of care for health care providers and explains why these standards cannot be used during a declared public health emergency.<sup>16</sup> Part II discusses the current state of the law and the implications of the current state statutes.<sup>17</sup> Next, Part III discusses the ethical questions that arise from setting the specific altered standards of care guidelines.<sup>18</sup>

### I. STANDARDS: WHY WE CARE?

During every day events, a health care provider owes a fiduciary duty to his or her patients,<sup>19</sup> however, as discussed below, this duty changes once an emergency is declared.<sup>20</sup> Before discussing what “altered standards

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10. *See infra* Part II.B.

11. *See infra* Part II.B.

12. *See infra* Part I.

13. INST. OF MED., GUIDANCE FOR ESTABLISHING CRISIS STANDARDS OF CARE FOR USE IN DISASTER SITUATIONS: A LETTER REPORT 60 (2009).

14. *See infra* Part II.B.

15. *See infra* Part II.

16. *See infra* Part I.

17. *See infra* Part II.

18. *See infra* Part III.

19. Michelle H. Lewis et al., *The Locality Rule and the Physician's Dilemma: Local Medical Practices vs the National Standard of Care*, 297 JAMA 2633, 2633 (2007).

20. *See infra* Part I.B.

of care” are and how they apply in declared public health emergencies, it is necessary to discuss the basic standards of care for health care providers.<sup>21</sup>

### *A. Standards of Care for the Medical Practice*

In many professions, members are held to a certain standard of care, and health care providers are no different.<sup>22</sup> Traditionally, the standard of care for physicians is to exercise the “degree of care and skill which is expected of a reasonably competent practitioner in the same class to which the physician belongs acting in the same or similar circumstances.”<sup>23</sup> However, this standard is not defined uniformly throughout the country,<sup>24</sup> and traditionally courts have “allowed the medical profession to set its own standards of care by defining the standards according to medical custom.”<sup>25</sup> There are two approaches that states typically use when setting medical standards of care:<sup>26</sup> the custom-based approach, which focuses on whether a physician’s actions are “consistent with what other physicians customarily do under similar circumstances[,]”<sup>27</sup> and the normative approach, which defines the standard as “what a reasonable physician would have done under the circumstances.”<sup>28</sup> Regardless of which approach a state takes, if a physician does not follow the standard of care, he or she likely will be found negligent for his or her actions.

Both of the approaches for setting basic medical standards of care center on treating individual patients and require the “allocation of all appropriate health and medical resources to improve the health status and/or save the life of each individual patient.”<sup>29</sup> The physician-patient relationship is a fiduciary relationship of the “highest degree,”<sup>30</sup> and involves “every element of trust, confidence and good faith.”<sup>31</sup> In the medical practice, the fiduciary duty of a physician runs only to the

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21. See *infra* Part I.A.

22. See, e.g., 1 AM. JUR. 2D *Accountants* § 13 (2005) (explaining that the standard of care for accountants is similar to the standard applied to doctors, lawyers, architects, and engineers, and that the standard requires reasonable care and competence).

23. 61 AM. JUR. 2D *Physicians, Surgeons, and Other Healers* § 188 (2002).

24. Lewis et al., *supra* note 19, at 2633.

25. *Id.*

26. See *id.* at 2633–34 (describing the customs-based and normative approaches to defining physicians’ standard of care).

27. *Id.* at 2633.

28. *Id.* at 2633–34.

29. HEALTH SYS. RESEARCH, INC., AHRQ PUB. NO. 05-0043, ALTERED STANDARDS OF CARE IN MASS CASUALTY EVENTS 8 (2005) [hereinafter AHRQ], available at <http://www.ahrq.gov/research/altstand/altstand.pdf>.

30. Lockett v. Goodill, 430 P.2d 589, 591 (Wash. 1967).

31. *Id.*

individual patient<sup>32</sup>—the physician is a skilled professional who has knowledge that the patient does not possess and thus, the relationship is based on confidence that the physician will act in the best interest of the individual patient.<sup>33</sup>

Furthermore, the classic physician-patient relationships, which are “individual interactions,”<sup>34</sup> are viewed through the lens of medical ethics.<sup>35</sup> Important issues in the field of medical ethics include “treatment questions, as well as regulating abuses of power between a powerful individual (usually a physician) and a vulnerable one (usually the patient).”<sup>36</sup> Scholars say there are four key principles upon which medical ethics rely—autonomy, nonmaleficence, beneficence, and justice.<sup>37</sup> Autonomy encompasses the idea that “the patient should remain free from coercion,” and the physician is “free to choose whom to serve.”<sup>38</sup> But most importantly, autonomy is about self-governance.<sup>39</sup> The ethical principle of nonmaleficence is rooted in the idea of doing no harm to the patient,<sup>40</sup> Beneficence is about “act[ing] in ways that are beneficial for the patient,”<sup>41</sup> and it implicates principles of providing competent care, respecting rights of the patient, protecting patient information, and maintaining the centrality of the physician’s responsibility to the patient.<sup>42</sup> Lastly, justice in medical ethics usually “entails respecting individual rights and acting fairly in the distribution of limited resources to individual patients.”<sup>43</sup>

### *B. Standards of Care for Public Health Emergencies*

Although basic standards are sufficient in the majority of circumstances, they do not account for situations where there is a widespread, declared public health emergency—such as events like September 11th, Hurricane Katrina, or a pandemic flu—where resources

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32. See 61 AM. JUR. 2D *Physicians, Surgeons, and Other Healers* § 142 (2002) (explaining the relationship between physician and patient).

33. *Id.*

34. E.g., Geoffrey R. Swain et al., *Preparedness: Medical Ethics Versus Public Health Ethics*, 14 J. PUB. HEALTH MGMT. PRAC. 354, 354 (2008).

35. *Id.*

36. *Id.*

37. *Id.*

38. *Id.*

39. *Id.*

40. *Id.* at 355.

41. *Id.*

42. *Id.*

43. *Id.*

and personnel are scarce.<sup>44</sup> Broadly, a public health emergency occurs when “health consequences have the potential to overwhelm routine community capabilities to address them.”<sup>45</sup> Thus, altered standards of care will become an issue when the federal or a state government declares that a public health emergency exists, and this will occur when a health situation’s “scale, timing or unpredictability threatens to overwhelm routine capabilities.”<sup>46</sup> Without announcing the applicable standards before such emergencies, it will be difficult to determine (1) during the event how personnel should respond, (2) after the event what should have been the custom, and (3) after the event what a reasonable physician would have done in the unpredictable emergency.<sup>47</sup>

Altered standards of care for emergency situations can solve this problem.<sup>48</sup> The phrase “altered standards of care” has been used to describe “standards that are acceptable when adequate resources are not available to meet the usual standard of care” furnished by health care providers.<sup>49</sup> Instead of honoring the traditional focus on the individual, altered standards of care shift scarce resources in ways that save the largest number of lives possible.<sup>50</sup> Following from these altered standards of care is the tort immunity afforded to health care providers who render assistance during an emergency.<sup>51</sup> Because physicians need to make quick decisions about how to allocate scarce resources, tort immunity is necessary to shield health care providers from liability for these decisions.<sup>52</sup> Thus, the term “altered standards of care” truly has two components—tort immunity<sup>53</sup> and the specific guidelines on resource allocation that health care providers should follow during a declared public health emergency.<sup>54</sup>

Unlike the typical physician-patient relationship, actions taken by health care providers in declared public health emergencies are viewed

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44. Donna Levin et al., *Altered Standards of Care During an Influenza Pandemic: Identifying Ethical, Legal, and Practical Principles to Guide Decision Making*, 3 DISASTER MED. & PUB. HEALTH PREPAREDNESS S132, S132 (2009).

45. Nelson et al., *supra* note 5, at S9.

46. *Id.*

47. *See* Levin et al., *supra* note 44, at S132–33 (addressing the medical and legal circumstance that may arise before, during, and after a public health emergency).

48. *Id.* at S133.

49. *Id.*

50. AHRQ, *supra* note 29, at 8.

51. Levin et al., *supra* note 44, at S138.

52. *See id.* at S132–33, S138 (describing the quick decision-making that providers might need to engage during an emergency and advocating that those providers who abide by the altered standards of care in making those decisions not be liable for malpractice).

53. *Id.* at S133.

54. *See id.* (arguing that health care providers in Massachusetts lack standards to guide their practice during a public health emergency).

through the lens of public health ethics.<sup>55</sup> During a declared public health emergency, the fiduciary duty a physician may have with new patients is inapplicable—the duty is now to the public in general and is judged by an altered standard with a goal of saving the most lives. Thus, there is a shift from autonomy based ethics to utilitarian ethics or public health ethics.<sup>56</sup> Public health ethics “promot[e] the common good over protecting individual autonomy.”<sup>57</sup> Instead of applying to individual interactions, public health ethics apply to “institutional actions or population-level interventions.”<sup>58</sup> The four principles of medical ethics discussed above do not fit well into the framework of public health activity because they focus on the autonomy of individual patients, providing treatment that does not harm a specific patient, supplying beneficial treatment to each specific individual, and justice that respects individual rights.<sup>59</sup> In public health actions, because so many people are affected, there will always be a difference of opinion as to what is a coercive, harmful, or beneficial treatment.<sup>60</sup> Thus, in public health ethics the principles focus on “interdependence,” which “recognize[s] that the health of some often depends on the health of others;”<sup>61</sup> “community trust;”<sup>62</sup> “fundamentality,” which focuses on the “underlying and primary causes of disease as well as the key requirements for healthy communities;”<sup>63</sup> and “justice.”<sup>64</sup> Because public health ethics take into account these community-based principles, they are the appropriate framework to use when addressing and planning responses to “large-scale, catastrophic, or sustained emergency events.”<sup>65</sup>

Because the goal of altered standards of care is to save the most lives, it must be viewed in the framework of public health ethics, and it must fall within the broader field of public health. Public health, however, has been a difficult field to define.<sup>66</sup> Nevertheless, most definitions are in agreement that that public health is the “health of populations,” rather than the “health

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55. Swain et al., *supra* note 34, at 354.

56. *Id.* at 355–56.

57. Douglas B. White et al., *Who Should Receive Life Support During a Public Health Emergency? Using Ethical Principles to Improve Allocation Decisions*, 150 ANNALS INTERNAL MED. 132, 132 (2009).

58. Swain et al., *supra* note 34, at 354.

59. *Id.* at 354–55.

60. *Id.*

61. *Id.* at 355.

62. *Id.*

63. *Id.*

64. *Id.* While “justice” in the context of traditional medical ethics is focused on individual rights and fairness in the distribution of resources, the notion of “justice” in public health ethics is concerned with ensuring population-wide access to the necessary conditions for health. *Id.*

65. *Id.* at 357.

66. PUBLIC HEALTH LAW AND ETHICS: A READER 2 (Lawrence O. Gostin ed., 1st ed. 2002).

of individuals.”<sup>67</sup> Furthermore, scholars generally acknowledge that “this goal is reached by a generally high level of health throughout the society, rather than the best possible health for a few.”<sup>68</sup> Based solely on this idea, altered standards of care fit into the public health field.

The creation of altered standards of care is governed by public health law and tort law. Public health law is defined as “the study of the legal powers and duties of the state, in collaboration with its partners. . . , to ensure the conditions for people to be healthy. . . , and of the limitations on the power of the state to constrain for the common good the autonomy, privacy, liberty, proprietary, and other legally protected interests of the individuals.”<sup>69</sup> The goal of public health law is to “pursue the highest possible level of physical and mental health in the population, consistent with the values of social justice.”<sup>70</sup> The creation of professional regulations for health care providers, which altered standards of care fall under, is one public health law intervention that can be used to create optimal health in the population in the event of an emergency. Altered standards of care also are governed by tort law. Traditionally, if a health care provider breaches the standard of care and the patient subsequently brings suit for negligence, the provider may be found negligent and thus, liable.<sup>71</sup> However, with altered standards of care, there is a presumption that a health care provider will be granted tort immunity for the harmful results of any rendering aid pursuant to those altered standards.<sup>72</sup>

Providing tort immunity to individuals rendering aid in an emergency is not a new concept.<sup>73</sup> Unlike health care providers and other private entities, volunteers responding to emergencies already have “extensive liability protection.”<sup>74</sup> This protection extends from Good Samaritan Laws and the Volunteer Protection Act of 1997,<sup>75</sup> which prompted most states to adopt their own volunteer immunity statutes.<sup>76</sup> However, it is unlikely that most health care providers are captured by these statutes because they likely

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67. *Id.* at 3.

68. *Id.*

69. LAWRENCE O. GOSTIN, *PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT* 4 (2d ed. 2008).

70. *Id.*

71. See 61 AM. JUR. 2D *Physicians, Surgeons, and Other Healers* § 189 (2002) (explaining that a health care provider has a duty to use reasonable care and skill in diagnosis and treatment and is liable to individual patients for a failure to exercise the needed skill and care).

72. Levin et al., *supra* note 44, at S138.

73. See Sharona Hoffman, *Responders' Responsibility: Liability and Immunity in Public Health Emergencies*, 96 GEO. L.J. 1913, 1943–44 (2008) (discussing Good Samaritan statutes and the Volunteer Protection Act of 1997).

74. *Id.* at 1943.

75. 42 U.S.C. §§ 14501–14505 (2006).

76. Hoffman, *supra* note 73, at 1943–45.



will be deemed employees of a health care facility, and not just volunteers or Good Samaritans.<sup>77</sup>

## II. ANALYSIS OF THE CURRENT STATE OF THE LAW

Several states already have statutes that address the tort immunity aspect of altered standards of care for health care providers,<sup>78</sup> however, states differ greatly in the protection they offer and to whom they offer it.<sup>79</sup> There is also a model act that would provide for immunity for private individuals.<sup>80</sup> This act is the Model State Emergency Health Powers Act (Model Act), which was developed by the Centers for Law & the Public's Health at Johns Hopkins and Georgetown Universities and has been highly criticized by academics.<sup>81</sup> All of these statutes,<sup>82</sup> including the Model Act,<sup>83</sup> only discuss tort liability and immunity and do not discuss the general issue of appropriate guidelines for the allocation of scarce resources during a declared public health emergency.

### A. *The Model State Emergency Health Powers Act*

In response to September 11th, the Centers for Law & the Public's Health at Johns Hopkins and Georgetown Universities sought to create the Model Act in order to provide an example to states of how to grant "specific emergency powers to state governors and public health authorities."<sup>84</sup> The Model Act "requires the development of a comprehensive plan to provide a coordinated, appropriate response in the event of a public health emergency."<sup>85</sup> An article outlining the Model Act states that the act is designed for state legislative consideration because the

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77. *Id.* at 1943–44.

78. *See infra* Part II.B.

79. *See Hoffman, supra* note 73, at 1946–50 (discussing health care provider liability laws in Arizona, Delaware, Hawaii, New Jersey, Wisconsin, Wyoming, Louisiana, Maine, California, Michigan, and Minnesota).

80. MODEL STATE EMERGENCY HEALTH POWERS ACT § 804(b) (Ctr. for Law & the Pub.'s Health 2001).

81. *See e.g.*, George J. Annas, *Bioterrorism, Public Health, and Civil Liberties*, 346 NEW ENG. J. MED. 1337, 1338–41 (2002) (arguing that the Model Act is flawed because, *inter alia*, its grant of authority to respond to attacks or epidemics is too broad and, further, it might not be prudent to put public health officials in charge of responding to every emergency that might arise); Matthew McCoy, *Autonomy, Consent, and Medical Paternalism: Legal Issues in Medical Intervention*, 14 J. ALTERNATIVE & COMPLEMENTARY MED. 785, 789–90 (2008) (arguing that the Model Act is far too broad in that it permits public health officials to "take over *all* health care functions and facilities in the state") (emphasis in original).

82. *See infra* Part II.B.

83. MODEL STATE EMERGENCY HEALTH POWERS ACT § 804(b).

84. *Id.* pmb1.

85. *Id.*

“power to act to preserve the public’s health is constitutionally reserved primarily to the states as an exercise of their police powers.”<sup>86</sup> Because states have broader police power than the federal government, they have more flexibility in legislating this type of statute. Some states, prior to the Model Act, even had attempted to develop “public health response plans.”<sup>87</sup> However, at the time the Model Act was created, many of these state statutes had either become obsolete or were inconsistent and inadequate.<sup>88</sup>

The purpose behind the Model Act has been described as providing “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>89</sup> The Model Act’s preamble discusses this goal when it states that the exercise of emergency power is “designed to promote the common good,”<sup>90</sup> but it recognizes that these powers “must respect the dignity and rights of persons.”<sup>91</sup> However, scholars have criticized the Model Act for failing to recognize and respect individual liberties and rights.<sup>92</sup>

The Centers for Law & the Public’s Health have created several versions of the Model Act, and its first iteration was even more highly criticized.<sup>93</sup> One of the major criticisms was that the Act was too broad and that it created criminal sanctions that were a consequence of physicians not rendering aid and citizens not receiving required treatment.<sup>94</sup> In the current version, there are now only civil penalties for citizens and physicians who fail to render aid.<sup>95</sup>

In regards to altered standards of care, the Model Act provides immunity for private individuals during declared public health emergencies<sup>96</sup> and specifically, in Section 804(b) the Model Act provides

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86. Lawrence O. Gostin et al., *The Model State Emergency Health Powers Act: Planning for and Response to Bioterrorism and Naturally Occurring Infectious Disease*, 288 JAMA 622, 622 (2002).

87. *See Id.* at 623 (noting that some states had developed bioterrorism response plans prior to September 11th, the event that served as the impetus for the Model Act).

88. *Id.* at 623–24.

89. *Id.* at 622.

90. MODEL STATE EMERGENCY HEALTH POWERS ACT pmb1.

91. *Id.*

92. *See supra*, note 81 and accompanying text (detailing criticisms of the Model Act).

93. *See* Daniel S. Reich, *Modernizing Local Responses to Public Health Emergencies: Bioterrorism, Epidemics, and the Model State Emergency Health Powers Act*, 19 J. CONTEMP. HEALTH L. & POL’Y 379, 382 n.11 (2003) (discussing the various drafts of the Model Act). For criticisms of the original draft, *see* Annas, *supra* note 81, at 1338.

94. Annas, *supra* note 81, at 1338.

95. *Id.* at 1340.

96. MODEL STATE EMERGENCY HEALTH POWERS ACT § 804(b).

broad immunity to a large number of private entities.<sup>97</sup> This immunity is generally given to any private person who shelters individuals, who aids the state, or who provides assistance of any kind.<sup>98</sup> However, in Sections 804(b)(2) and (b)(3), the Model Act provides liability for private individuals who act with gross negligence or willful misconduct.<sup>99</sup> Section 804(b)(1), which addresses the liability of a person that allows others to take shelter on his or her property during the emergency, does not have a gross negligence or willful misconduct exception.<sup>100</sup>

If adopted, the Model Act would be a very broad statute because of how it defines a public health emergency.<sup>101</sup> Specifically, section 104(m), defines public health emergency as an “occurrence or imminent threat of an illness or health condition<sup>102</sup> that is believed to be caused by” certain events such as bioterrorism, the appearance of an infectious agent, a natural disaster, a chemical attack, or a nuclear attack.<sup>103</sup> The event must also pose a “high probability of any of the following harms:” a large number of deaths, a large number of serious or long-term disabilities, or widespread exposure to an infectious or toxic agent that poses risk of future harm.<sup>104</sup> Essentially, the Model Act encompasses most emergency situations, including events like Hurricane Katrina, pandemic flu, and an anthrax attack.<sup>105</sup>

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97. *Id.* Section (b)(1) provides tort immunity to private persons who allow the use of their private property for shelter during the emergency from negligently causing any death or injury; Section (b)(2) provides civil immunity to any private person and any corporation and its employees under contract with the state for negligently causing any death or injury except in the event of gross negligence or willful misconduct; and Section (b)(3) provides tort immunity to any private person or any corporation and its employees who render assistance at the request of the State for negligently causing any death or injury except in the event of gross negligence or willful misconduct. *Id.*

98. *Id.* § 804(b).

99. *Id.* §§ 804(b)(2)–(3).

100. *Id.* § 804(b)(1).

101. *See id.* § 104(m) (defining “public health emergency” as capturing, *inter alia*, an act of bioterrorism, a natural disaster, and a chemical attack).

102. *Id.*

103. *Id.* The Act specifically states that a “public health emergency is an occurrence or imminent threat of an illness or health condition that: (1) is believed to be caused by the following: (i) bioterrorism; (ii) the appearance of a novel or previously controlled or eradicated infectious agent or biological toxin; (iii) [a natural disaster]; (iv) [a chemical attack or accidental release; or] (v) [a nuclear attack or accident]; and (2) poses a high probability of any of the following harms: (i) a large number of deaths in the affected population; (ii) a large number of serious or long-term disabilities in the affected population; or (iii) 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.” *Id.*

104. *Id.*

105. *See id.* (providing that the Model Act would apply to situations including bioterrorism and natural disasters).

In sum, the Model Act provides broad immunity for private entities, including health care providers<sup>106</sup> and hospitals that are likely to render assistance in a public health emergency pursuant to the State's request.<sup>107</sup> Although the Model Act provides broad immunity to health care providers and other private individuals,<sup>108</sup> it is only a model act—not an enacted law. However, many states have enacted statutes modeled after the Model Act.<sup>109</sup> As of 2006, thirty-eight states and the District of Columbia have passed sixty-six bills “that include provisions from or closely related to the Act,”<sup>110</sup> and twenty-three states have passed bills that are patterned after the Model Act's Section 804, Immunity for Private Actors.<sup>111</sup> It is likely more states will do so in the future. Though it is only a prototype, the Model Act clearly has influenced the states that created and passed their own statutes regarding public health emergencies.

The Model Act also includes several shortcomings. For example, one of the three subsections of the private liability section of the Model Act (the subsection that pertains to private individuals who allow use of their property during an emergency), lacks a provision that would provide liability for gross negligence and willful misconduct.<sup>112</sup> Private individuals who allow their property to be used for shelter should be immune from liability, just like professional actors, unless they act with gross negligence or willful misconduct.<sup>113</sup> Moreover, the Model Act does not mention anything about appropriate guidelines for resource allocation for health care providers during an emergency.<sup>114</sup>

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106. The Act defines health care provider in Section 104(e) as “any person or entity who provides health care services including, but not limited to, hospitals, medical clinics and offices, special care facilities, medical laboratories, physicians, pharmacists, dentists, physician assistants, nurse practitioners, registered and other nurses, paramedics, emergency medical or laboratory technicians, and ambulance and emergency medical workers.” *Id.* § 104(e). Although the term “health care provider” is not used in Section 804, which provides immunity, the section does apply to any private individual who renders aid or assistance, a role that health care providers will likely be taking on in an emergency. *Id.* § 804(b).

107. *Id.* § 804(b).

108. *Id.*

109. THE CTR. FOR LAW AND THE PUBLIC'S HEALTH, THE MODEL STATE EMERGENCY HEALTH POWERS ACT, LEGISLATIVE SURVEILLANCE TABLE 1 (2006) [hereinafter LEGISLATIVE TABLE], available at <http://www.publichealthlaw.net/MSEHPA/MSEHPA%20Surveillance.pdf>.

110. *Id.* Providing more updated information regarding which states have passed these types of liability statutes is beyond the scope of this paper and discussion.

111. *Id.* at 4.

112. MODEL STATE EMERGENCY HEALTH POWERS ACT § 804(b)(1).

113. *See id.* § 804(b) (providing liability for gross negligence and willful misconduct only for individuals who act in performance of a contract with the State or at the State's request, but not for those who permits the use of their premises during an emergency).

114. *See id.* §§ 102–103, 401–405 (detailing the legislative findings and purposes driving the Model Act and the protocols for a public health emergency, but not providing specific resource allocation guidance). Section 103(a) provides that one of the Model Act's purposes is to “require

Critics have argued that by providing broad immunity to health care providers, the Model Act leaves providers unaccountable for any actions they may take during a declared emergency, no matter how arbitrary, and that the act could therefore lead to public mistrust.<sup>115</sup> An argument can be made that if there were only tort immunity, health care providers could make resource allocation determinations based on any principle they felt appropriate. For example, health care providers could decide to give important vaccines only to their family members and friends, and provide whatever reasoning they choose, because they would not be held accountable for that action unless it was grossly negligent. However, if specific guidelines on how scarce resources should be allocated were in place, health care providers could not just choose to give what resource they want to whomever they want, because there would be standard protocols in place. Thus, if the Model Act contained specific resource allocation methods, which is the second component of altered standards of care, this would help solve the problem of accountability and public mistrust. Because the Model Act is so influential, it should encompass all of the components of altered standards of care, so that when other states follow suit they will also have comprehensive altered standards of care statutes.

### *B. Selected State Statutes*

Several states have enacted tort immunity statutes for health care providers or private entities during a public health emergency, but they greatly vary from state to state on issues of who is afforded protection from liability, how they receive that immunity, and for what events these standards arise.<sup>116</sup>

#### *1. Maryland: Health Care Provider Liability Under Governor's Health Emergency Powers*

Maryland provides tort immunity to health care providers under the State's statute that describes the governor's health emergency powers.<sup>117</sup> This statute states "[a] health care provider is immune from civil or criminal liability if the health care provider acts in good faith and under a

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the development of a comprehensive plan to provide for a coordinated, appropriate response in the event of a public health emergency[.]" but is silent about resource allocation specifically. § 103(a). Further, section 403(a)(2) directs the governor to "[u]tilize all available resources of the State government and its political subdivisions, as reasonably necessary to respond to the public health emergency[.]" but again does not specify how resources should be allocated. § 403(a)(2).

115. *E.g.*, Annas, *supra* note 81, at 1341.

116. Hoffman, *supra* note 73, at 1946–50.

117. MD. CODE ANN., PUB. SAFETY §§ 14-3A-01 to -08 (LexisNexis Supp. 2009) (providing the governor's health emergency powers).

catastrophic health emergency proclamation.”<sup>118</sup> A catastrophic health emergency is defined as a “situation in which extensive loss of life or serious disability is threatened imminently because of exposure to a deadly agent.”<sup>119</sup>

Maryland’s statute is very limited.<sup>120</sup> It only applies to health care providers<sup>121</sup> (which includes any health facility such as a hospital)<sup>122</sup> and does not apply to any other private individual who may render aid or provide shelter, such as private companies who allow the use of their property for shelters.<sup>123</sup> The statute is also particularly limited as to when its powers may be invoked—pursuant only to the proclamation of a catastrophic health emergency,<sup>124</sup> which is defined as a situation where extensive illness or death is threatened by exposure to a deadly agent.<sup>125</sup> A deadly agent is defined as a biological or viral agent such as anthrax or Ebola, a chemical agent, or radiation, all of which are capable of causing extensive loss of life or serious disability.<sup>126</sup> Thus, this statute can be applied only in situations such as a bioterrorist attack or perhaps a pandemic flu that is declared a catastrophic health emergency by the governor, but not in events similar to Hurricane Katrina or September 11th, where there were no specific chemical or biological agents, rather just

118. *Id.* § 14-3A-06.

119. *Id.* § 14-3A-01(b).

120. See Franklin H. Alden, Comment, *Liberty or Death: Maryland Improves Upon the Model State Emergency Health Powers Act*, 8 J. HEALTH CARE L. & POL’Y 185, 188 (2005) (comparing Maryland’s law to the Model Act and noting the ways in which the former is more restrictive of the broad powers granted to the State during a public health emergency).

121. § 14-3A-06.

122. *Id.* §14-3A-01(e). This section of the statute defines a health care provider as “(1) a health care facility as defined in § 19-114(d)(1) of the Health-General Article; (2) a health care practitioner as defined in § 19-114(e) of the Health-General Article; and (3) an individual licensed or certified as an emergency medical services provider under § 13-156 of the Education Article.” *Id.* In the Health-General Article, health care practitioner is defined as “any individual who is licensed, certified, or otherwise authorized under the Health Occupations Article to provide health care services.” MD CODE ANN., HEALTH-GEN. §19-114(e) (LexisNexis 2009). A health care facility is defined as a hospital, limited service hospital, a related institution, an ambulatory surgical facility, rehabilitation inpatient facility, home health agency, hospice, or any other health institution that requires a certificate of need. *Id.* § 19-114(d)(1).

123. MD CODE ANN., PUB. SAFETY § 14-3A-06.

124. *Id.*

125. *Id.* § 14-3A-01(b). A deadly agent is defined as the following:

- (1) anthrax, ebola, plague, smallpox, tularemia, or other bacterial, fungal, rickettsial, or viral agent, biological toxin, or other biological agent capable of causing extensive loss of life or serious disability;
- (2) mustard gas, nerve gas, or other chemical agent capable of causing extensive loss of life or serious disability; or
- (3) radiation at levels capable of causing extensive loss of life or serious disability.

*Id.* § 14-3A-01(c)

126. *Id.* § 14-3A-01(c).

extensive injury and loss of life due to unpredictable natural or man-made disasters.<sup>127</sup> Furthermore, health care providers' immunity is only available when there is a specific proclamation by the governor that there is a catastrophic health emergency.<sup>128</sup> Maryland's statute also only discusses liability issues and does not provide any guidance for allocating limited resources during emergencies.<sup>129</sup>

## 2. Arizona: Tort Immunity for Individuals Who Take Actions Based on Government Requirements

Arizona's statute provides immunity to individuals who undertake actions pursuant to government requirements.<sup>130</sup> The Arizona statute is in the Enhanced Surveillance and Public Health Emergencies article<sup>131</sup> and states, "[a] person or health care provider undertaking any activity required by this article, including reporting, participating in quarantine or isolation procedures, is immune from civil or criminal liability if the person or health care provider acted in good faith."<sup>132</sup> Like Maryland's law, the immunity provisions in Arizona's statute are very limited<sup>133</sup> because immunity for private individuals only applies if the individual is undertaking an action required by the government.<sup>134</sup> However, the statute is not limited to any specific emergency or to any proclamation of an emergency.<sup>135</sup> Arizona's statute does, however, elaborate that the standard for these individuals is that they must act in good faith.<sup>136</sup> But, the statute does not define "good faith," or indicate whether a standard of good faith specific to emergency circumstances might apply.<sup>137</sup> Arizona's statute also fails to address the second component of "altered standards of care," namely providing

127. *Id.* §§ 14-3A-01(b)-(c).

128. *Id.* § 14-3A-06.

129. *See id.* §§ 14-3A-01 to -08 (detailing health emergency powers, including specific guidance for isolation and quarantine, but providing no guidance for health resource allocation).

130. ARIZ. REV. STAT. ANN. § 36-790(B) (2009).

131. *Id.* §§ 36-781 to -790.

132. *Id.* § 36-790(B). Section 36-781(3) directs the reader to the Medical Records article of the Courts and Civil Proceedings title for the definition of a health care provider. A health care provider is: "(a) A person who is licensed pursuant to title 32 and who maintains medical records. (b) A health care institution as defined in § 36-401. (c) An ambulance service as defined in § 36-2201. (d) A health care services organization licensed pursuant to title 20, chapter 4, article 9." *Id.* § 12-2291(4).

133. *Id.* § 36-790(B). *See also* Hoffman, *supra* note 73, at 1946-47 (suggesting that state law public health emergency liability protections either provide protection for those acting on government or legal authority or "provid[e] immunity in a much broader set of circumstances," and noting that Arizona's law falls into the former category).

134. § 36-790(B).

135. *Id.*

136. *Id.*

137. *Id.*

guidelines for health care providers to follow when making decisions about the allocation of scarce resources during an emergency.<sup>138</sup>

### 3. Michigan: Health Care Provider Immunity Provided for in a General Emergency Statute

Several states also provide immunity to individuals in statutes that address a general state of emergency and not a public health emergency.<sup>139</sup> One such state is Michigan,<sup>140</sup> where any health care provider who renders aid during a state of disaster at the express or implied request of the State is not liable for any injury except if conducted with willful or gross negligence.<sup>141</sup> In Michigan, a disaster is defined as “an occurrence or threat of widespread or severe damage, injury, or loss of life or property resulting from a natural or human-made cause,”<sup>142</sup> and includes events such as terrorist attacks, natural disasters, epidemics, and civil disorders.<sup>143</sup> Though this statute is broad in the sense that it covers many emergencies,<sup>144</sup>

138. See *id.* §§ 36-781 to -790 (governing, *inter alia*, procedure for patient tracking, information sharing, and isolation and quarantine during an enhanced surveillance advisory, but providing no guidance for health resource allocation).

139. E.g., MICH. COMP. LAWS ANN. § 30.411 (West 2004 & Supp. 2010).

140. *Id.*

141. *Id.* § 30.411(4) (West Supp. 2010). This section states:

A person licensed to practice medicine or osteopathic medicine and surgery \* \* \* or a licensed hospital, \* \* \* whether licensed in this or another state or by the federal government or a branch of the armed forces of the United States, \* \* \* or an individual listed in subsection (6), who renders services during a state of disaster declared by the governor and at the express or implied request of a state official or agency or county or local coordinator or executive body, is considered an authorized disaster relief worker or facility and is not liable for an injury sustained by a person by reason of those services, regardless of how or under what circumstances or by what cause those injuries are sustained. The immunity granted by this subsection does not apply in the event of \* \* \* an act or omission that is willful or gross negligence. If a civil action for malpractice is filed alleging \* \* \* an act or omission that is willful or gross negligence resulting in injuries, the services rendered that resulted in those injuries shall be judged according to the standards required of persons licensed in this state to perform those services.

*Id.* Section 30.411(6) states that Subsection (4) applies to the following individuals:

(a) Any of the following, if licensed in this or another state or by the federal government or a branch of the armed forces of the United States: (i) A registered nurse. (ii) A practical nurse. (iii) A nursing student acting under the supervision of a licensed nurse. (iv) A dentist. (v) A veterinarian. (vi) A pharmacist. (vii) A pharmacist intern acting under the supervision of a licensed pharmacist. (viii) A paramedic. (b) A medical resident undergoing training in a licensed hospital in this or another state.

*Id.* § 30.411(6).

142. MICH. COMP. LAWS ANN. § 30.402(e) (West 2004).

143. *Id.*

144. *Id.*



liability protection is provided only if the State declares that there is an emergency or disaster, and if the health care provider acts upon request of the State.<sup>145</sup> Michigan, similar to the other state statutes discussed, does not address the actual allocation principles that should be used during an emergency and only implicates the immunity component of “altered standards of care.”<sup>146</sup>

#### 4. Louisiana: Private Liability Established in the Public Health Emergency Powers Act

Louisiana is an example of a state that modeled private individual tort immunity in its emergency health powers act<sup>147</sup> on the Model Act.<sup>148</sup> Similar to the Model Act, Louisiana’s is a broad statute that covers a wide range of individuals<sup>149</sup> in many different events.<sup>150</sup> In its definition of a public health emergency, Louisiana’s statute is broader as to what a qualifying event entails.<sup>151</sup> Not only does a public emergency include a bioterrorist event<sup>152</sup> or the appearance of a novel or previously controlled or eradicated infectious agent or biological toxin,<sup>153</sup> but also any disaster, including natural disasters (hurricanes, floods, forest fires, etc.)<sup>154</sup> and man-made disasters (nuclear attack, accidental release or chemical attack, civil disturbances, hostile military action, etc.).<sup>155</sup> All of these events must also have a high probability of a large number of deaths,<sup>156</sup> a large number of serious or long-term disabilities,<sup>157</sup> or “widespread exposure to an infectious or toxic agent that poses a significant risk of substantial future

145. MICH. COMP. LAWS ANN. § 30.411(4) (West Supp. 2010).

146. MICH. COMP. LAWS ANN. § 30.411 (West 2004 & Supp. 2010).

147. LA. REV. STAT. ANN. § 29:771(B)(2) (2007).

148. Compare *id.*, (providing both state immunity and private liability protections), with MODEL STATE EMERGENCY HEALTH POWERS ACT § 804(b) (2001) (containing substantially the same language as the Louisiana statute).

149. See LA. REV. STAT. ANN. § 29:771(B)(2) (providing liability protection for, *inter alia*, owners of real estate; private persons; firms, corporations, and their employees and agents; and health care providers).

150. See *id.* § 29:762(12) (defining “public health emergency” to include, *inter alia*, acts of bioterrorism, natural disasters, and widespread exposure to infection or toxins).

151. *Id.*

152. *Id.* § 29:762(12)(a)(i).

153. *Id.* § 29:762(12)(a)(ii).

154. *Id.* § 29:762(12)(a)(iii).

155. *Id.*

156. *Id.* § 29:762(12)(b)(i).

157. *Id.* § 29:762(12)(b)(ii).

harm[.]”<sup>158</sup> The Model Act requires the same circumstances be present in order for an event to qualify as a public health emergency.<sup>159</sup>

Like the Model Act, the Louisiana statute provides tort liability immunity to private individuals who allow their property to be used for shelter during a state of public health emergency.<sup>160</sup> Louisiana’s private liability statute also includes two provisions that provide for the liability of those who act pursuant to a government contract or who render aid at the request of the state.<sup>161</sup> However, Louisiana also includes a specific provision that creates tort immunity for any health care providers that render aid during a public health emergency unless they act with gross negligence or willful misconduct.<sup>162</sup> The Model Act contains no similar provision.<sup>163</sup> Though it is likely that health care providers would be covered

158. *Id.* § 29:762(12)(b)(iii).

159. MODEL STATE EMERGENCY HEALTH POWERS ACT § 104(m) (2001).

160. LA. REV. STAT. ANN. § 29:771(B)(2)(a). This section states:

During a state of public health emergency, any person owning or controlling real estate or other premises who voluntarily and without compensation grants a license or privilege, or otherwise permits the designation or use of the whole or any part or parts of such real estate or premises for the purpose of sheltering persons, together with that person’s successors in interest, if any, shall not be civilly liable for negligently causing the death of, or injury to, any person on or about such real estate or premises under such license, privilege, or other permission, or for negligently causing loss of, or damage to, the property of such person.

*Id.*

161. *Id.* §§ 29:771(B)(2)(b), (d). Section (B)(2)(b) states:

During a state of public health emergency, any private person, firm or corporation and employees and agents of such person, firm or corporation in the performance of a contract with, and under the direction of the state or its political subdivisions under the provisions of this Chapter shall not be civilly 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.

*Id.* § 29:771(B)(2)(b). Similarly, § 29:771(B)(2)(d) states:

During a state of public health emergency, 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 Chapter shall not be civilly 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.

*Id.* § 29:771(B)(2)(d).

162. *Id.* § 29:771(B)(2)(c). This section explicitly states that, “[d]uring a state of public health emergency, any health care providers shall not be civilly 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.” *Id.* Health care providers are defined as, “a clinic, person, corporation, facility, or institution which provides health care or professional services by a physician, dentist, registered or licensed practical nurse, pharmacist, optometrist, podiatrist, chiropractor, physical therapist, psychologist, or psychiatrist, and any officer, employee, or agent thereof acting in the course and scope of his service or employment.” *Id.* § 29:762 (4).

163. MODEL STATE EMERGENCY HEALTH POWERS ACT § 804(b).

under Section (B)(2)(d) of this statute, which provides immunity to any individual that renders aid at the request of the state,<sup>164</sup> Section (B)(2)(c) makes it clear that they will be protected against tort liability in a broader set of circumstances.<sup>165</sup>

Louisiana's is a great example of a private liability protection statute that adequately addresses a public health emergency<sup>166</sup>—it provides immunity to a large number of people who are likely to help in the event an emergency arises<sup>167</sup> with a broad definition of what a public health emergency really is.<sup>168</sup> However, similar to the Model Act and every other state statute discussed,<sup>169</sup> there is no mention of the existence of guidelines for how to allocate limited resources during an emergency.<sup>170</sup> In light of this omission, Louisiana health care providers have begun to discuss and create guidelines on their own.<sup>171</sup> These draft guidelines identify “several categories of patients. . .who would not be admitted to hospitals when beds and ventilators are no longer available[]”<sup>172</sup> and “call for doctors to take off life support patients thought to have a higher risk of dying to make way for others with a better prognosis if there are not enough intensive care resources to go around.”<sup>173</sup>

### III. CREATING ALTERED STANDARDS OF CARE AND SPECIFIC GUIDELINES

State statutes that either provide limited immunity to some private individuals during some emergencies, or have no liability protection need to

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164. LA. REV. STAT. ANN. § 29:771(B)(2)(d).

165. *Id.* § 29:771(B)(2)(c).

166. *Id.* § 29:771(B)(2).

167. *Id.*

168. *Id.* § 29:762(12).

169. *See supra* Part II.B.1–II.B.3.

170. LA. REV. STAT. ANN. § 29:771(B)(2). Section 764(A) requires The Subcommittee on Chemical and Biological Terrorism of the Homeland Security Advisory Council to develop a public health emergency response plan, and directs that the plan be tailored to “include the unique aspects relevant to a public health emergency or bioterrorism incident.” *Id.* § 764(A)(2). Such plan must include provisions for, *inter alia*, “[t]he location, procurement, storage, transportation, maintenance, and distribution of essential materials, including but not limited to medical supplies, drugs, vaccines, antidotes, food, shelter, clothing and beds.” *Id.* § 764(A)(2)(a). The provision does not address or cross-refer to the liability protections for health care providers. *Id.*

171. Sheri Fink, *Louisiana Doctors Working on ‘Crisis Standards’ for when Medical System is Overwhelmed*, THE TIMES-PICAYUNE, Dec. 27, 2009, [http://www.nola.com/health/index.ssf/2009/12/post\\_16.html](http://www.nola.com/health/index.ssf/2009/12/post_16.html).

172. *Id.*

173. *Id.*

be changed.<sup>174</sup> Not only must every state provide tort immunity to health care providers and do so in a consistent manner, but they must also create specific guidelines for resource allocation during emergencies. This section gives a general overview of what altered standards of care should be and the process that is necessary to create these standards.

#### *A. History as an Example and Further Justification*

Altered standards of care are necessary in order to provide guidance, to protect health care providers from liability for the potential resource allocation decisions they are forced to make during an emergency, and to incentivize health care providers to act during an emergency where they may be personally affected.<sup>175</sup> The reasons to create altered standards of care arise not only from the need to provide guidance and protection for health care providers in the future,<sup>176</sup> but they are also borne out of past experience.<sup>177</sup>

During Hurricane Katrina, many ethical issues arose over the medical treatment that health care providers gave.<sup>178</sup> One of the main issues that arose from Hurricane Katrina is chronicled in a *New York Times Magazine* article entitled “The Deadly Choices at Memorial,”<sup>179</sup> which focuses on how several health care providers made decisions during the days following Katrina, including deciding to hasten the death of several ill patients.<sup>180</sup> The health care providers came to these questionable decisions after the hospital flooded, lost electricity, had no running water, and was running out of resources.<sup>181</sup> The hospital needed to be evacuated, and this had to be done through the very difficult-to-reach helipad of an adjacent parking garage.<sup>182</sup> In order to evacuate, the doctors effectively used a triage system<sup>183</sup> and decided that the healthiest patients would be the first to evacuate and the

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174. See *supra* Part II (detailing the immunity provisions in several public health emergency statutes and noting criticisms, but generally suggesting that liability protection is essential to an adequate public health emergency law).

175. Levin et al., *supra* note 44, at S132–33, S137–38.

176. *Id.* at S132.

177. See, e.g., G. Richard Holt, *Making Difficult Ethical Decisions in Patient Care During Natural Disasters and Other Mass Casualty Events*, 139 *OTOLARYNGOLOGY–HEAD & NECK SURGERY* 181, 181–82 (2008) (describing the unfortunate story of a doctor who provided care during Hurricane Katrina only to later face criminal charges—including homicide—as a result of the hard resource allocation decisions the emergency circumstances required her to make).

178. *Id.*

179. Sheri Fink, *The Deadly Choices at Memorial*, *N.Y. TIMES MAG.*, Aug. 30, 2009, at 28, available at [http://www.nytimes.com/2009/08/30/magazine/30doctors.html?\\_r=2&ref=magazine](http://www.nytimes.com/2009/08/30/magazine/30doctors.html?_r=2&ref=magazine).

180. *Id.*

181. *Id.*

182. *Id.*

183. *Id.*

sickest would be the last.<sup>184</sup> Each patient was given a number:<sup>185</sup> those who were “ones” were “in fairly good health and could sit up or walk[.]” and were first to be evacuated;<sup>186</sup> “twos” were “those who were sicker and would need more assistance[.]”<sup>187</sup> and those who were “threes” were “slated to be evacuated last[.]” and were patients who were very ill and those with do not resuscitate orders.<sup>188</sup> However, as evacuation slowed, several doctors believed that the remaining “threes” in the hospital would not survive the evacuation and were left with two options—abandon the patients or quicken their deaths.<sup>189</sup> Several doctors, including Dr. Anna Pou, ultimately gave several patients morphine in order to “ease the patients out of a terrible situation.”<sup>190</sup>

The principal doctor involved in the administration of morphine, Dr. Pou, had charges brought against her, but a Grand Jury ultimately did not indict her.<sup>191</sup> Nevertheless, Dr. Pou has several civil suits for wrongful death currently pending against her.<sup>192</sup> If, prior to this event, the state had established some sort of altered standard of care in regards to a triage system,<sup>193</sup> this doctor who helped for days in a hospital without electricity and without access to additional resources would likely not be facing civil liability.<sup>194</sup> Dr. Pou would have been aware of specific triage standards that were supported by the state,<sup>195</sup> and if she had followed them, she might have remained immune from any sort of liability.

Other ethical issues also will be addressed in several pending Hurricane Katrina cases claiming that health care providers did not give adequate care to their patients during the subsequent flooding from the hurricane. Several of these cases have been brought by plaintiffs who were

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184. *Id.*

185. *Id.*

186. *Id.*

187. *Id.*

188. *Id.*

189. *Id.*

190. *Id.*

191. *Id.*

192. *Id.*

193. *See id.* (describing the confusion and lack of experience with triage protocol that led Dr. Pou and her colleagues to take the action they did during Katrina); *see also* Susan Okie, *Dr. Pou and the Hurricane—Implications for Patient Care During Disasters*, 358 *NEW ENG. J. MED.* 1, 5 (2008) (arguing that Dr. Pou’s experience illustrates the need for discussion about the provision of medical care during a “disaster that strains medical resources”).

194. *See* Okie, *supra* note 193, at 5 (tracing the current state of the altered standards of care debate and noting the need to better equip caregivers for “the kind of ordeal that [Dr.] Pou and her colleagues faced after the deluge”).

195. Fink, *supra* note 171.

prisoners and nursing home patients during the storm.<sup>196</sup> During emergency situations like Hurricane Katrina, facilities such as prisons and nursing homes face issues unique to them. For example, nursing homes are likely to have many patients that are not mobile enough to be evacuated and many that cannot be left to care for themselves.<sup>197</sup> In the case of prisons, prisoners are expected to receive adequate care because they are wards of the state and should not be abandoned without a way to care for themselves.<sup>198</sup> These cases demonstrate that altered standards of care also must address the non-traditional situations in which health care is provided. Thus, before another emergency, states must look to creating standards that address how medical care will be provided during an emergency in nursing homes, prisons, or other non-hospital health facilities.

Several other events in recent history explain the need for altered standards of care. The Severe Acute Respiratory Syndrome (SARS) outbreak exemplifies how a widespread pandemic could affect available resources. In Toronto, about thirty percent of SARS cases were admitted to the Intensive Care Unit (ICU), and twenty-five percent were placed on ventilators.<sup>199</sup> In Singapore, ninety-eight percent of SARS patients admitted to the ICU developed Acute Respiratory Distress Syndrome.<sup>200</sup>

Even in recent months we have seen mass casualty events implicate the need for altered standards of care—for example, the 2010 earthquake in Haiti.<sup>201</sup> When an Israeli field hospital began to treat patients in Haiti, it set

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196. See, e.g., *August v. Gusman*, No. 06-3962, 2009 WL 1212401 (E.D. La. Apr. 30, 2009) (dismissing the defendants' motion for summary judgment in a case where a prisoner claims that the prison doctor failed to evacuate the prison in a timely manner, and alleges unsafe conditions of confinement and that he did not receive proper medical treatment during the storm); *Mineo v. Underwriters of Lloyds, London*, 997 So. 2d 187 (La. Ct. App. 2008) (dismissing a case filed by the children of a nursing home resident who died after he was not evacuated during the storm because the claim was sounded in medical malpractice).

197. See *Mineo*, 997 So. 2d at 190 (claiming, *inter alia*, the a nursing home was negligent for failing to assess a resident's condition and provide needed resources for his care in the wake of Katrina); see also Anne Hull & Doug Struck, *At Nursing Home, Katrina Dealt Only the First Blow; Nuns Labored for Days in Fatal Heat to Get Help for Patients*, WASH. POST, Sept. 23, 2005, at A1 (describing the distress and disorder wrought by Katrina as nursing home staff were forced to choose between moving "fragile patients on jammed roadways" or keeping them at the facility).

198. See *August*, 2009 WL 1212401, at \*4–5 (discussing the conditions under which prison staff may be found to have violated a prisoner's constitutional right to care); see also Ira P. Robbins, *Lessons from Hurricane Katrina: Prison Emergency Preparedness as a Constitutional Imperative*, 42 MICH. J.L. REFORM 1, 4 (2008) (explaining the source of prison officials' legal obligations to protect prisoners from serious threats and to provide food, water, and medical care).

199. Kirsty Challen et al., *Clinical Review: Mass Casualty Triage—Pandemic Influenza and Critical Care*, 11 CRITICAL CARE 212, 1–2 (2007).

200. *Id.* at 2.

201. Ofer Merin et al., *The Israeli Field Hospital in Haiti—Ethical Dilemmas in Early Disaster Response*, 362 NEW ENG. J. MED. e38(1), e38(1) (2010).

up an ad hoc triage system and based its decision on whether to treat a patient on three questions—“how urgent is this patient’s condition? Do we have adequate resources to meet this patient’s needs? And assuming we admit this patient and provide the level of care required, can the patient’s life be saved?”<sup>202</sup> Although Haitian earthquake victims benefited from the Israeli hospital team, it is likely that there will be backlash for the decisions the team made regarding who to treat and what treatment to provide. Some of the treatment decisions the Israeli field hospital had to make were deciding not to treat those who were the worst off so that it could treat those with a greater chance of rehabilitation.<sup>203</sup> Although this particular event occurred outside of the United States, something similar could happen within our borders, and if it did, it is necessary to have policies in place beforehand so there is limited distrust and questioning of decisions made by health care providers.

History demonstrates that altered standards of care need to be established prior to an event because in-depth conversations just cannot occur during an on-going emergency.<sup>204</sup> A state must create an incentive for health care providers to work during an emergency,<sup>205</sup> protect health care providers from liability that results from rendering aid during an emergency, and provide guidance for how to allocate scarce resources. Lawrence Gostin, one of the creators of the Model Act, has even stated that in creating specific standards for public health emergency, it is necessary to gain the public’s trust and that this should be done by “engag[ing] the community through meaningful civic dialogue; act[ing] transparently in the formation and implementation of protocols; ensur[ing] consistency across hospitals and jurisdictions; and introduce[ing] mechanisms of accountability.”<sup>206</sup> The Institute of Medicine (IOM) has also joined the discussion on altered standards of care<sup>207</sup> and has laid out several visions

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202. *Id.* at e38(2).

203. *Id.*

204. White et al, *supra* note 57, at 132.

205. Some argue that this incentive does not need to be created because health providers already feel that they have a duty to provide aid during an emergency like a pandemic. *See, e.g.,* Sarah Damery et al., *Healthcare Worker’s Perceptions of the Duty to Work During an Influenza Pandemic*, 36 J. MED. ETHICS 12, 15–16 (2010). However, health care workers have also stated that they have a greater priority to their families. *Id.* at 16. Such sentiment suggests that, during an emergency, health care providers who feel that their family might be harmed are less likely to feel that they have a duty to help others. Altered standards of care are thus there to further incentivize health care providers to render aid.

206. Lawrence O. Gostin & Dan Hanfling, *National Preparedness for a Catastrophic Emergency: Crisis Standards of Care*, 302 JAMA 2365, 2365 (2009).

207. INST. OF MED., *supra* note 13, at 1. The IOM does not use the term “altered standards of care;” rather it uses the term “crisis standards of care,” which it defines as “a substantial change in usual healthcare operations and the level of care it is possible to deliver, which is made necessary

and key elements for the development of state altered standards of care.<sup>208</sup> The IOM states that these standards should be fair; have an equitable process that includes transparency, consistency, proportionality and accountability; encourage community and provider engagement, education, and communication; and have the rule of law.<sup>209</sup>

Based on these requirements, working groups should contain health care providers, legal experts, and ethics experts. Once the working group decides on a draft, it must be distributed to the public so that it has an opportunity to comment. The draft that is created must allocate resources equitably and proportionally, and must be triggered by a specific declaration of a public health emergency by public health authorities in each state. After these steps are taken, it is likely that a true set of altered standards of care, which include both tort immunity and specific guidance on how to act, can be created and be put into place so that the standards apply to all health care providers who render aid during a declared public health emergency.

### *B. Expanding on an Existing Component—Providing Tort Immunity*

The first component that states must provide is tort immunity to a wide range of private individuals who will either render assistance or provide shelter during a broadly defined emergency.<sup>210</sup> Following the lead of the Model State Emergency Health Powers Act and the Louisiana law, each state must develop a statute<sup>211</sup> that covers a broad range of public health emergencies,<sup>212</sup> as well as the private liabilities that arise in many emergency situations.<sup>213</sup> Each state must have a tort immunity provision to create consistency because the current system is a “patchwork” of

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by a pervasive (e.g. pandemic influenza) or catastrophic (e.g. earthquake, hurricane) disaster.” *Id.* at 3.

208. *Id.* at 3–5.

209. *Id.* at 3–4.

210. *See id.* at 6–7 (recommending that “necessary legal protections” be provided to caregivers who must act according to altered standards of care during a disaster situation, including protection that extends to adjustments in scope of practice).

211. These statutes must be legislated on the state, not federal, level. States control public health laws because the federal government has reserved this right to the states through their police power. *See Gostin et al., supra* note 86, at 622 (explaining that the “power to act to preserve the public’s health is constitutionally reserved primarily to the states as an exercise of their police powers”).

212. *Id.*; MODEL STATE EMERGENCY HEALTH POWERS ACT § 104(m). The definition for a public health emergency should include bioterrorism, pandemics, and natural or man-made disasters. It further should include all events where it is foreseeable that there may be a need to allocate scarce resources.

213. *See* LA. REV. STAT. ANN. § 29:771(B)(2) (providing liability protection for certain actors in public health emergency situations); MODEL STATE EMERGENCY HEALTH POWERS ACT § 804(b) (same).



statutes.<sup>214</sup> At the very least, the tort immunity component for each state should authorize public health authorities to declare a public health emergency and should give health care providers<sup>215</sup> protection from liability for all actions taken during these public health emergencies.

However, as Hurricane Katrina demonstrated, there should be some limitations on the liability protections included in these altered standards of care laws.<sup>216</sup> Most statutes, including the Model Act, provide for such limitations,<sup>217</sup> and they are a necessary component for all future provisions. Many statutes currently provide immunity unless an individual acts with gross negligence or willful misconduct.<sup>218</sup> The Model Act is not a perfect example, however; it does not create a gross negligence exception for private individuals who allow their property to be used for shelter.<sup>219</sup> For any tort immunity afforded to any individual—be it a private individual, corporation, health care provider, hospital, or volunteer—there must be an exception to immunity for individuals who act with gross negligence or willful misconduct. These limitations prevent doctors from abusing their discretion and choosing to care only for certain patients.

### *C. The Missing Link—Specific Guidelines for Allocation of Scarce Resources*

Although there are currently some statutes that touch on the tort liability issue of altered standards of care,<sup>220</sup> states' use of these statutes is likely to provoke criticism related to the broad immunity provided.<sup>221</sup> However, this criticism may be reduced if specific guidelines for resource allocation are provided before the event,<sup>222</sup> so that the hard decisions made by health care providers will not be questioned as frequently,<sup>223</sup> and in order to ensure "optimal functioning of health care systems and upholding

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214. INST. OF MED., *supra* note 13, at 48.

215. The definition of "health care providers" should also be broadly defined. It should include doctors, nurses, emergency responders, hospitals, nursing homes, hospice, and other non-traditional health care facilities including prisons.

216. *See supra* Part III.A. (describing the controversial "reverse triage" system put in place by health care providers working in the midst and aftermath of the storm).

217. *See supra* Part II. (detailing the immunity provisions of the Model Act and several state statutes, and noting that gross negligence or willful misconduct will often preclude attachment of immunity or that good faith is a prerequisite to protection).

218. *See supra* Part II.B.3–4 (detailing the Michigan and Louisiana laws).

219. MODEL STATE EMERGENCY HEALTH POWERS ACT § 804(b)(1).

220. *See supra* Part II.B.

221. *See, e.g.,* Annas, *supra* note 81, at 1341 (arguing that broad immunity for health care providers will lead to public mistrust of public health authorities).

222. Levin et al., *supra* note 44, at S132–33.

223. *Id.* at S132.

public trust.”<sup>224</sup> Furthermore, the IOM has stated that because federal liability statutes do not exist, state governments should explicitly tie liability protections for health care providers to specific guidelines for altered standards of care.<sup>225</sup>

The following section describes guidelines that could be created at either the institutional (e.g. hospital) or state level, and addresses the ethical underpinnings of creating these guidelines.<sup>226</sup> There are specific resources that are likely to be scarce during a public health emergency. These resources include ventilators, intensive care unit beds, health care providers (especially critical care), hospitals in general, specialty medications or intravenous fluids, and medical transportation.<sup>227</sup> Depending on what the scarce resource is, there should be specific guidelines for how to allocate that resource depending on the levels at which it is needed (i.e. state-wide or institution-specific). For example, a ventilator is a particular resource that is almost always scarce,<sup>228</sup> and states are aware of the number of ventilators that they have.<sup>229</sup> However, for other resources such as hospitals beds and staff, guidelines cannot be created on a state level, but must be regulated at an individual hospital or regional level within the state.

*1. Specific Guidelines for Implementing on the Regional Hospital Level and the Ethical Principles that Follow*

Guidelines that are implemented on either the individual hospital or regional level will pertain to the allocation of scarce resources that are different depending on one’s location, including staff, hospital beds, and certain medicines. The main issue behind allocating these types of resources is triage.<sup>230</sup> Triage will help decide who will receive certain care—or even a hospital bed—when there is a limited number of staff compared to patients. The objective of triage is to “use available medical resources as effectively and as efficiently as possible,” and the traditional rationale has been strictly utilitarian—do the greatest good for the greatest number.<sup>231</sup> As triage has grown, however, straight utilitarianism has been given less deference. There are several triage options that focus less on utilitarianism

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224. *Id.* at S132–33.

225. INST. OF MED., *supra* note 13, at 49.

226. *See infra* Part III.C.1.

227. INST. OF MED., *supra* note 13, at 60.

228. *Id.* at 33.

229. *See id.* at 60–61 (explaining that ventilators are an example of data that is tracked).

230. *Id.* at 65.

231. TOM L. BEAUCHAMP & JAMES F. CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS* 279 (6th ed. 2009).

and more on justice and other allocation principles.<sup>232</sup> All of those options are suitable for states to adopt in determining their system of triage during a declared public health emergency, but, what truly matters is the process the states use to determine the appropriate method.

Setting aside the specific methods of triage, the IOM states that several criteria should be met before triage methods can be used.<sup>233</sup> Thus, before implementing triage methods after a declaration of a public health emergency, each hospital or the hospital systems in a specific region must take certain pre-triage measures including: (1) identifying critically limited resources; (2) ensuring that the surge capacity<sup>234</sup> has already been employed; (3) attempting to reuse or adapt resources; and (4) making a request for necessary resources from health officials.<sup>235</sup> Once these are met, then triage can be employed.

Currently the triage system is not perfect.<sup>236</sup> For example, one author states that disaster triage is an “inexact science”<sup>237</sup> and is basically a determination of what “best preserves the ‘common good.’”<sup>238</sup> The author argues that this “purely utilitarian approach to triage will not be adequate,” instead a “modified utilitarian approach through the principle of distributive justice,” is the appropriate standard.<sup>239</sup> For triage, distributive justice means that the “benefits and burdens ought to be distributed equitably, that resources ought to be allocated fairly, and that one ought to act in such a manner that no one such person or group bears a disproportionate share of benefits or burdens.”<sup>240</sup> A triage system reflecting this idea would instill trust in the public as it conveys the notion that, although the overall goal during an emergency is to save the most lives possible, the way health care

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232. See *infra* notes 236–258 and accompanying text.

233. INST. OF MED., *supra* note 13, at 65.

234. Lavonne M. Adams, *Exploring the Concept of Surge Capacity*, ONLINE J. ISSUES NURSING (March 31, 2009), [http://www.medscape.com/viewarticle/704505\\_7](http://www.medscape.com/viewarticle/704505_7). This article defines surge capacity as “[t]he ability to obtain adequate staff, supplies and equipment, structures and systems to provide sufficient care to meet immediate needs of an influx of patients following a large-scale incident or disaster.” *Id.*

235. INST. OF MED., *supra* note 13, at 65. The IOM also states that the “regional, state, and federal resource allocation” must be “insufficient to meet demand” and “patient transfer or resource importation,” must “not [be] possible or will occur too late to consider bridging therapies.” *Id.*

236. See, e.g., Fink, *supra* note 171 (reporting that, despite the “nine well-recognized triage systems” in existence, there is often confusion and disagreement as to how triage should be performed in disaster situations).

237. George P. Smith, II, *Re-shaping the Common Good in Times of Public Health Emergencies: Validating Medical Triage*, 18 ANNALS HEALTH L. 1, 12 (2009).

238. *Id.*

239. *Id.* at 14.

240. *Id.*

providers will reach that goal would be fair and would not be based on any sort of discrimination.

Many individuals have also taken more of a multi-framework approach to triage that takes into account several ethical principles. Beauchamp and Childress, in their book *Principles of Biomedical Ethics*, examine a two-step triage method, which first bases decisions on medical criteria or “medical utility.”<sup>241</sup> Their medical utility scheme ranks those who have “major injuries and will die without immediate help,” but will survive if help is provided, first; “those whose treatment can be delayed without immediate danger are ranked second;” and people with “minor injuries are ranked third.”<sup>242</sup> Beauchamp and Childress’ second step is that after “medical utility is roughly equal for eligible patients,” methods of “chance or queuing” can be used.<sup>243</sup>

A more complex approach is supported by the authors of an article entitled *Principles for Allocation of Scarce Medical Interventions*.<sup>244</sup> The authors evaluated existing allocation systems and recommended their own.<sup>245</sup> The authors promote a multi-ethical approach called the complete lives system that incorporates five ethical principles: youngest-first, prognosis, save the most lives, lottery, and instrumental value.<sup>246</sup> This protocol prioritizes “younger people who have not yet lived a complete life and will be unlikely to do so without aid.”<sup>247</sup> The complete lives system is a good example of the type of discussion about the different levels of triage that needs to take place.

The Persad article’s further discussion into allocation principles will be a useful tool for working groups to include the ethical underpinnings that are necessarily implicated in the creation of guidelines. One such ethical principle for creating guidelines is treating people equally,<sup>248</sup> which includes allocating resources via a method of triage by lottery,<sup>249</sup> or by a method called “first-come, first-served.”<sup>250</sup> This method alone is unlikely to achieve the utilitarian goal of saving the most lives: if no medical criteria are used, it is unlikely that those who could survive with treatment will get treated. Another system of allocation and triage that could be used is

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241. BEAUCHAMP & CHILDRESS, *supra* 231, at 279.

242. *Id.*

243. *Id.*

244. Govind Persad et al., *Principles for Allocation of Scarce Medical Interventions*, 373 LANCET 423 (2009).

245. *Id.* at 423.

246. *Id.*

247. *Id.*

248. *Id.* at 423.

249. *Id.*

250. *Id.* at 424.

favoring the worst off, or prioritarianism,<sup>251</sup> which either treats those who are sickest first<sup>252</sup> or youngest first.<sup>253</sup> The final approach, and the one that is most in accordance with the goal of altered standards of care, is maximizing total benefits or utilitarianism,<sup>254</sup> which triages patients either with the goal of saving the most lives<sup>255</sup> or with the goal of saving the most life-years.<sup>256</sup> An additional ethical underpinning for triage is “promoting and rewarding social usefulness,”<sup>257</sup> which could promote instrumental value or reciprocity.<sup>258</sup> Each hospital or region must discuss these ethical principles, and decide, based on the resources that are available to it, how it wants to triage its patients.

Each hospital or region must also create a triage committee that makes these triage decisions.<sup>259</sup> Each individual health care provider should not make triage decisions, but instead there should be a small committee responsible for such determinations.<sup>260</sup> The committee will document each decision and its justification.<sup>261</sup> Having this committee will create more consistency, accountability, and transparency, and will avoid conflicts of interests within the triage system—all important elements necessary to creating altered standards of care.

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251. *Id.*

252. *Id.*

253. *Id.* at 425.

254. *Compare id.* (explaining triage strategies that aim to save the most lives or “life-years”), with *supra* notes 49–58 and accompanying text (defining and describing the concept of altered standards of care, which has the goal of saving the most lives during a crisis situation).

255. *Id.*

256. *Id.* This particular triage system is also referred to as “prognosis allocation,” and generally requires the caregiver to evaluate how many years treatment would add to the life of a person in need. *Id.* There are subtle differences in the determinations that might be made under such rubric. *Id.* For example, the authors note that “giving a few life-years to many differs from giving many life-years to a few.” *Id.*

257. *Id.*

258. *Id.* at 426. To illustrate the ethic of “instrumental value,” the authors provide the example of a triage system that would save the lives of persons who work to produce vaccines. *Id.* Ostensibly, the calculus is that, because they produce something of great value to society as a whole—and something especially valuable during certain public health crises—these workers’ lives have more instrumental value. The authors further explain that “[r]eciprocity allocation is backward-looking, rewarding past usefulness or sacrifice. *Id.* As example, the authors cite those who have donated organs or who have participated in risky medical research that benefits the greater good. *Id.*

259. INST. OF MED., *supra* note 13, at 80.

260. *Id.*

261. *Id.*

2. *Specific Guidelines for Implementing on the State Level and the Ethical Principles that Follow*

Ventilators are a resource that will become extremely scarce in a situation where there is a pandemic flu or some other widespread illness that affects respiration.<sup>262</sup> Several states have already created ventilator policies;<sup>263</sup> however, each state must do so and must tie these specific guidelines to the tort immunity given to health care providers.

An excellent example of how to create a ventilator policy and how to use ethical principles to underpin the ventilator policy can be seen in New York.<sup>264</sup> New York's draft guidelines included several "ethically acceptable"<sup>265</sup> protocols for allocating ventilators in a declared public health emergency, including: "pretriage requirements,"<sup>266</sup> "patient categories,"<sup>267</sup> "acute versus chronic care facilities,"<sup>268</sup> "clinical evaluation,"<sup>269</sup> "triage decision makers,"<sup>270</sup> "palliative care,"<sup>271</sup> "review of triage decisions,"<sup>272</sup> and "communication."<sup>273</sup>

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262. HEALTH SYS. RESEARCH, INC., AHRQ PUB. NO. 07-0001, MASS MEDICAL CARE WITH SCARCE RESOURCES: A COMMUNITY PLANNING GUIDE 55 (Sally J. Phillips & Ann Knebel eds., 2007), available at <http://www.ahrq.gov/research/mce/mceguide.pdf>.

263. See, e.g., Tia Powell et al., *Allocation of Ventilators in a Public Health Disaster*, 2 DISASTER MED. & PUB. HEALTH PREPAREDNESS 20, 20 (2008) (describing and discussing New York's ventilator allocation plan); INST. OF MED., *supra* note 13, at 27 (noting that New York and California have both developed policy around ventilator allocation).

264. Powell et al., *supra* note 263, at 20.

265. *Id.* at 21.

266. *Id.* at 22. This requirement states that "[b]efore rationing procedures are implemented, facilities should institute all available means of creating surge capacity. Hospitals should limit the noncritical use of ventilators, and elective procedures should be canceled and/or postponed." *Id.*

267. *Id.* This protocol states that all patients that are in critical condition, and not only those affected by the pandemic, should have access to ventilators. *Id.* Patients should be "assessed on medical/clinical factors alone, regardless of their work role." *Id.*

268. *Id.* This guideline suggests that only those in acute care facilities should be assessed using these standards; those in chronic care facilities should not be subjected to the same criteria. *Id.*

269. *Id.* at 23. For purposes of assessing who should receive care, the clinical evaluation proposed is based on the Ontario Health Plan for an Influenza Pandemic and on a sequential organ failure assessment (SOFA). *Id.* These assessments include exclusion criteria, an initial assessment, and time trials. *Id.* at 23–24.

270. *Id.* at 24. This requires that there be a triage officer that makes these decisions and calculates the SOFA score. *Id.*

271. *Id.* This protocol states that if a patient is extubated based on the pre-determined triage criteria, health care providers "should follow existing facility protocols for withdrawing and withholding life-sustaining care and for providing palliative care." *Id.*

272. *Id.* at 24–25. This protocol provides for the review of triage decisions, and states that there must be a review process that would "ensure that standards are followed consistently and correctly and would present an opportunity for correcting the draft guidelines or their implementation as needed." *Id.*

New York's guidelines focus mainly on the clinical criteria used to assess who can access a ventilator and base access on the sequential organ failure assessment (SOFA).<sup>274</sup> This is a clear medical assessment that is easily performed and can help health care providers make this decision.<sup>275</sup> However, some have argued that this criterion is an insufficient metric on which to base ventilator guidelines.<sup>276</sup> Professor Gostin has stated that SOFA "was not designed as [a] prospective predictor of survival and should not be used as the sole criterion for evaluation."<sup>277</sup> Furthermore, recent examination of an exercise that tested the number of ventilators that would be available in an emergency situation, as well as how the region would make decisions if there were not enough ventilators, revealed that guidelines for ventilators in the particular region should take a three tier approach.<sup>278</sup> Each tier articulates categories of patients who should not receive ventilators, and includes the possibility of using the SOFA score.<sup>279</sup>

States creating ventilator guidelines should follow a similar procedure to New York, but should additionally evaluate independently what medical criteria are best to use. It is likely that the SOFA score alone will not be sufficient. Providing these guidelines before a public health emergency arises will help health care providers make the important decisions that will be necessary and generate public trust that decisions will be made pursuant to specific protocols.

#### IV. CONCLUSION

The current immunity statutes are good stepping stones in the overall process of reform for emergency preparedness. However, most of the statutes are not broad enough to cover all possible events that may arise, or do not provide immunity to all private individuals that might render aid or provide shelter; most states do not even have statutes that cover the issue.<sup>280</sup> Furthermore, these state statutes only discuss tort immunity and do

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273. *Id.* at 25. This last requirement provides there must be communication between health care providers, patients, and health officials. *Id.*

274. *Id.* at 23.

275. *See id.* (suggesting that, despite its imperfections, the SOFA method is the best available triage system for an influenza pandemic because the system is based in "objective measures of function").

276. *See, e.g.,* Gostin & Hanfling, *supra* note 206, at 2366 (arguing that, because the SOFA method alone is does not adequately or accurately predict survival, it should not be the only criterion in a triage assessment).

277. *Id.*

278. John L. Hick & Daniel T. O'Laughlin, *Concept of Operations for Triage of Mechanical Ventilation in an Epidemic*, 13 ACAD. EMERGENCY MED. 223, 224-226 (2006).

279. *Id.* at 226 & tbl.4.

280. *See supra* Part II.

not discuss the second component of “altered standards of care”—specific resource allocation guidelines that health care providers will follow in the event that an emergency arises.<sup>281</sup> Because of this, there must be complete reform of immunity statutes protecting providers in the event of an emergency in order for health care providers to actually take on rendering aid and do so effectively in the event that another disaster strikes.

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281. *See supra* Part II.



