REPORT OF THE

REPRINT

Joint Subcommittee to Study the Feasibility of Offering Liability Protections to Health Care Providers Rendering Aid During a State or Local Emergency

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

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General Assembly Members

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The Honorable Stephen D. Newman, Vice-Chairman
The Honorable John M. O'Bannon, III
The Honorable Benjamin L. Cline
The Honorable Robert D. Hull
The Honorable Mark D. Sickles
The Honorable Frank M. Ruff, Jr.
The Honorable Ken Cuccinelli, II

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EXECUTIVE SUMMARY

At the 2007 Session of the General Assembly, the Joint Subcommittee to Study Liability Protections to Health Care Providers Rendering Aid during a State or Local Emergency was established pursuant to House Joint Resolution 701 and Senate Joint Resolution 390. The 13-member Joint Subcommittee was directed to examine the estimated benefits of granting enhanced liability protections for health care providers who respond to state or local emergencies as well as looking at how many other states provide these kinds of liability protections.

The Joint Subcommittee elected Delegate Phillip A. Hamilton and Senator Stephen D. Newman as its Chairman and Vice-Chairman, respectively. The Joint Subcommittee held three meetings during the 2007 Interim.

During the course of its three meetings, the Joint Subcommittee received extensive testimony from individuals in the fields of law and health care representing both the private and public sectors. At the first meeting held on August 30, 2007, the Joint Subcommittee received presentations from (1) Steven D. Gravely, J.D., M.H.A., a member of the Joint Subcommittee and an attorney specializing in health care, regarding the pros and cons of health care provider liability protections currently available under Virginia law; (2) Dr. Lisa Kaplowitz, M.D., M.S.H.A., Deputy Commissioner for Emergency Preparedness and Response, Virginia Department of Health, explaining the Department's role in emergency preparedness and response; and (3) Gerald C. Canaan, II, representing the Medical Society of Virginia, explaining health care provider liability from the standpoint of the individual physicians.

The Joint Subcommittee held its second meeting on September 27, 2007, and received presentations from (1) Michael Cline, State Coordinator of Emergency Management for the Virginia Department of Emergency Management, describing the process for emergency declarations in Virginia; (2) Katharine M. Webb, Senior Vice-President of the Virginia Hospital and Healthcare Association, discussing the provision of health care when facing limited resources; (3) J. Christopher LaGow, J.D., representing the Property Casualty Insurers Association of America, describing the relation between liability protections and insurance; and (4) the staff of the Joint Subcommittee presenting an overview of health care liability protections available in other states. In addition, four persons addressed the Joint Subcommittee during the public comment period.

At the end of the second meeting, the members of the Joint Subcommittee reached consensus on a number of legislative principles to be incorporated into draft legislation. These principles were as follows: (1) liability protections should extend to all health care providers; (2) liability protections should cover both natural and man-made disasters; (3) liability protections should apply both before and after the declaration of a state of emergency; (4) liability protections should apply to all care provided during a disaster or emergency, regardless of the possible scarcity of resources; (5) volunteer health care providers should be allowed to recover their actual expenses incurred during the rendition of care; (6) the Good Samaritan statute should be broadened to include care rendered in

response to an accident or emergency that is not necessarily rendered at the scene; and (7) the exceptions to the definition of a patient found in Va. Code § 8.01-581.1 should include a reference to Va. Code § 44-146.23, the liability provision of the Commonwealth of Virginia Emergency Services and Disaster Law of 2000. In preparation for the third meeting, the Chairman directed staff to prepare draft legislation consistent with these legislative principles.

On October 16, 2007, the Joint Subcommittee's third and final meeting was held. The meeting was dedicated to the discussion and review of the draft legislation prepared in accordance with the legislative principles endorsed at the second meeting. Staff reviewed the provisions of the draft legislation with the members of the Joint Subcommittee. In addition, three persons addressed the provisions of the draft legislation during the public comment period.

The Joint Subcommittee unanimously adopted several changes to the draft legislation; the majority were refinements and clarifications of the language concerning when the liability protections would apply and what conduct would be covered. The Chairman also noted that the study resolutions dealt with the issue of liability protections for health care providers during a declared disaster or emergency and the members unanimously agreed that the portions of the legislative draft involving the Good Samaritan statute and other statutes related to the Good Samaritan statute were beyond the scope of the study resolutions. Incorporating these changes, the Joint Subcommittee unanimously agreed on the following recommendations for legislation to be introduced during the 2008 Session of the General Assembly:

> 1. Add a new Code section that provides immunity from civil liability to health care providers who, in the absence of gross negligence or willful misconduct, respond to an event defined as a "disaster," "emergency," or "major disaster," provided that a state or local emergency has been or is subsequently declared. Any failure to deliver care at the same level as under non-disaster circumstances is not a breach of any duty owed by the provider where the failure results from a lack of necessary resources.
>
> 2. Combine the definitions of the terms "man-made disaster" and "natural disaster" located in Va. Code § 44-146.16 into one inclusive term "disaster" and add the term "communicable disease of public health threat" to the definition of "disaster" in Va. Code § 44-146.16.
>
> 3. Amend the definition of disaster in Va. Code § 8.01-225.01 to include a "disaster," "emergency," or "major disaster."
>
> 4. Allow a person who holds a license or certificate evidencing their professional or mechanical skills, including a health care provider, and who, without compensation, renders aid involving that skill during a disaster, to be reimbursed for his actual and necessary expenses.

5. Add a reference to Va. Code § 44-146.23 to the exceptions to the definition of the term "patient" in Va. Code § 8.01-581.1.

REPORT OF
THE JOINT SUBCOMMITTEE TO STUDY
THE FEASIBILITY OF OFFERING LIABILITY
PROTECTIONS TO HEALTH CARE PROVIDERS
RENDERING AID DURING A
STATE OR LOCAL EMERGENCY
TO
THE GOVERNOR AND THE GENERAL ASSEMBLY OF VIRGINIA
RICHMOND, VIRGINIA
2007

To: The Honorable Timothy M. Kaine, Governor of Virginia
and
The General Assembly of Virginia

I. Origin of the Study

A. Study Resolutions

The Joint Subcommittee to Study the Feasibility of Offering Liability Protections to Health Care Providers Rendering Aid during a State or Local Emergency was established pursuant to HJR 701 (patron: Hamilton) and SJR 390 (patron: Newman). The 13-member Joint Subcommittee was comprised of eight legislative members: Senators Stephen D. Newman, Ken Cuccinelli, II, and Frank M. Ruff, Jr., and Delegates Phillip A. Hamilton, John M. O'Bannon, III, Benjamin L. Cline, Robert D. Hull, and Mark D. Sickles; three nonlegislative citizen members: Mark J. Dietz, M.D., M.B.A., of the Virginia Hospital and Healthcare Association, Steven D. Gravely, Esq., and P. M. Colopy, M.D.; and two ex officio members with voting privileges: the Secretary of Health and Human Resources, the Honorable Marilyn B. Tavenner or her designee, and the Attorney General of Virginia, the Honorable Robert F. McDonnell or his designee.

The Joint Subcommittee was authorized to hold four meetings during the 2007 interim with the direct costs of the study not to exceed $8,800.

B. Study Directive

The enabling resolutions noted that health care providers who respond to a disaster or declared emergency often do not have access to the same level of resources that would be available under normal circumstances, and that the rendition of aid by such providers may potentially be circumscribed by these limitations, necessitating that such providers make decisions as to what level of care they can reasonably provide given these limitations. Additionally, the resolutions noted that while responding to a disaster or

declared emergency, health care providers may be required to render aid that is outside their scope of practice. The resolutions directed the Joint Subcommittee to "examine the estimated benefits to the citizens of the Commonwealth of enhanced liability protections for health care providers as well as determining how many other states provide these kinds of liability protections."

II. Background

There is an increased national focus on the ability of federal, state, and local governments, as well as other entities such as health care providers, to respond to disasters and emergencies, both natural and man-made, and to safeguard public health and safety that has arisen in the wake of such events as the terrorist attacks on September 11, 2001, and Hurricane Katrina. These and other disasters have highlighted the fact that the ability of health care providers to maintain the same quality and level of health care may potentially be compromised during such disasters and emergencies due to such factors as a potential lack of resources affecting the standard of care that can be reasonably provided. Furthermore, such disasters and emergencies give rise to questions regarding the liability of health care providers, both individual providers as well as institutional providers such as hospitals, who must render aid during a disaster or emergency, as well as to questions regarding the extent that such providers are or should be protected from liability. Legal exercises that were conducted in 2006 by the Office of the Attorney General of Virginia in conjunction with the health care community and designed to gauge how health care providers in the Commonwealth would act in response to a disaster or emergency served as the genesis of the present study.

Currently, health care providers in the Commonwealth may be entitled to invoke myriad liability protections under Virginia law, including: (1) the Commonwealth of Virginia Emergency Services and Disaster Law of 2000 (ESDL), Va. Code § 44-146.13 et seq.; (2) the Good Samaritan statute, Va. Code § 8.01-225; and (3) the Virginia State Government Volunteers Act (VSGVA), Va. Code § 2.2-3600 et seq. Each of these sources of potential immunity is subject to its own rules, procedures, and limitations delineating its scope and applicability. Thus, while health care providers who render aid during an emergency or disaster already may be afforded a certain degree of liability protection under current law, this protection arises from a complex patchwork of various laws, not all of which will be applicable in every case, thus limiting the immunity afforded to such providers who respond to an emergency or disaster.

In the past few years, the Commonwealth and the General Assembly of Virginia have repeatedly addressed the need for liability protections for health care providers in order to ensure that such providers are able to effectively respond to future disasters or emergencies. In 2003, HB 2184 was enacted, which added Va. Code § 8.01-225.01 to the Virginia Code.[1] This provision affords immunity to health care providers if they abandon the care of a current patient in order to respond to a man-made disaster, and serves the goal of encouraging such providers to respond to the health care needs resulting from such a disaster.

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[1] Chap. 507, 2005 Acts of Assembly.

Additionally, in 2005, the General Assembly again addressed the liability of health care providers, specifically those persons who serve in a Medical Reserve Corps (MRC) unit or a Community Emergency Response Team (CERT). HB 2520 was enacted, which amended the immunity provisions of the VSGA and the ESDL to extend the liability protections available under those laws to cover persons who serve in a MRC unit or on a CERT.[2]

III. Activities of the Joint Subcommittee

A. Meeting of August 30, 2007

1. Overview

The Joint Subcommittee to Study the Feasibility of Offering Liability Protections to Health Care Providers Rendering Aid During a State or Local Emergency held its first meeting of the 2007 interim in Richmond, Virginia, on August 30, 2007. Delegate Phillip A. Hamilton was elected chairman and Senator Stephen D. Newman was elected vice-chairman. The chairman gave brief opening remarks explaining the genesis of the study resolutions, noting that they arose out of legal exercises conducted by the Attorney General's office in conjunction with the health care community. Staff then presented a brief overview of the study's directives, noting that the Joint Subcommittee was charged with examining the benefits to the Commonwealth and its citizenry of offering enhanced liability protections to health care providers who respond to declared disasters or emergencies.

2. Presentations

a. Health Care Provider Liability in Disasters

Mr. Steven D. Gravely, J.D., M.H.A., a member of the Joint Subcommittee and an attorney with Troutman Sanders, made a presentation, via teleconference, concerning health care provider liability protections in disasters and the protections currently available under Virginia law. Mr. Gravely has also been appointed as a special counsel to the Attorney General's office and assigned to work with the Virginia Department of Health on health care provider liability issues. A CD-ROM containing his earlier work in this capacity was distributed to the members of the subcommittee. He was assisted in his presentation by his associate Erin S. Whaley, J.D., M.A., who attended the subcommittee's meeting.

Mr. Gravely described a health care system that is under significant stress, where staff shortages exist and the industry has migrated to a "just in time" model of care. Mr.

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[2] Chap. 474, 2005 Acts of Assembly. Also during the 2005 Session of the General Assembly, HB 1567 was enacted. This bill amended Va. Code § 65.2-101 to provide that persons who serve in a MRC unit or on a CERT may be deemed employees of a governmental entity for workers' compensation purposes. Chap. 368, 2005 Acts of Assembly.

Gravely explained that a disaster or emergency would cause substantial disruptions to such a health care system. He stated that health care providers have three liability concerns in a disaster: (1) failure to prepare, (2) failure to respond, and (3) liability associated with "altered" standards of care. He gave examples of failures to prepare or respond, including the failure to use infection control measures in response to the SARS outbreak in Canada and the failure to evacuate in a timely manner in response to Hurricane Katrina. He noted that there were multiple suits in Canada against health care providers and the government stemming from such failures during the SARS outbreak as well as suits against health care providers in Louisiana as a result of Hurricane Katrina.

In regards to liability associated with "altered" standards of care, Mr. Gravely related that the term has no accepted definition, but has become shorthand for describing the allocation of scarce critical resources during a disaster. He further noted that making such an allocation is difficult to do in a legal vacuum. He explained that the current statutory definition of standard of care makes no provision for the circumstances under which the care was rendered, although he also noted that Virginia's Model Jury Instructions do include such a provision. He stated that there was no Virginia case law dealing with "altered" standards of care and, as a result, the discrepancy between the statutory definition and the Model Jury Instructions may lead to uncertainty among health care providers as the instructions are not mandatory.

Mr. Gravely also reviewed current Virginia law providing liability protections for health care providers, expressing that there are three primary sources of such liability protections. He stated that in recent years Virginia has focused its attention on providing protections for individual health care providers, specifically volunteers.

The first of these three laws is the Good Samaritan statute. Mr. Gravely explained that the Good Samaritan statute only applied to individuals who provide emergency care without compensation and only if such care is provided at the scene of an accident or emergency. He further explained that the Good Samaritan statute does not apply to institutional health care providers or provide liability protections for individual providers who render such care as part of their job (i.e., for compensation) or who provide care at hospitals or other nonemergency settings. The statute also does not protect providers who render preventive care during an emergency.

The second of these three laws is volunteer immunity, which is available under the Federal Volunteer Protection Act, located at 42 U.S.C. § 14501 et seq., and the VSGVA. Mr. Gravely stated that both of these acts only apply to volunteer health care providers and likewise do not apply to institutional health care providers.

The third law described by Mr. Gravely is the ESDL. Mr. Gravely explained that this law gives the Governor the power to declare a state of emergency, and that consistent with such a declaration the Governor could promulgate a rule for the allocation of scarce medical resources during the emergency. Mr. Gravely noted further that the law also expressly provides immunity under certain situations set forth in Va. Code § 44-146.23, which he described as Section A Immunity and Section C Immunity. Section A

Immunity provides liability protections for certain entities engaged in emergency services activities; however, Mr. Gravely stated that it was unclear whether the rendition of care in a hospital setting during an emergency would qualify for this protection. Section C Immunity provides liability protections for providers who gratuitously render aid during a disaster. Mr. Gravely noted that both Section A and Section C Immunity only apply after a state of emergency is declared and provide no pre-declaration protection. He also expressed his belief that basing liability protection on an emergency declaration that has yet to be drafted leaves significant uncertainty as to the scope of protection.

Mr. Gravely ended his presentation with the following three conclusions: (1) health care providers have a reasonable basis for concern about their liability for care rendered during a disaster; (2) health care providers are a vital component in an effective response framework; and (3) current Virginia law does not clearly provide liability protections for health care providers who render care during a disaster.

b. Public Health and Healthcare Emergency Preparedness and Response: Role of the Virginia Department of Health

Dr. Lisa Kaplowitz, M.D., M.S.H.A., Deputy Commissioner for Emergency Preparedness and Response, made a presentation on behalf of the Virginia Department of Health (VDH) explaining its role in emergency preparedness and response. Her presentation focused on five issues: (1) Virginia's public health emergency response; (2) hospital/health care system emergency response; (3) the public health and health system partnership; (4) the roles of health care providers; and (5) the need for liability protections for health care providers in emergencies.

In addressing these issues, Dr. Kaplowitz noted that the VDH's Emergency Preparedness and Response Programs were established in 2002 and employ an all-hazards approach, preparing for both natural disasters and terrorist-related emergencies. Since 2002, with funding provided by the Centers for Disease Control and Prevention and the United States Department of Health and Human Services, the VDH has enhanced the local capacity to respond to emergencies through the hiring of a planner and epidemiologist for each of Virginia's 35 District Health Departments, has established five regional teams to coordinate planning and response, has upgraded information and communications technologies and systems, and has enhanced public information in emergencies.

Dr. Kaplowitz noted that the initial response to an emergency is always local. The members inquired whether the Governor was required to wait for a local declaration of emergency before he would be able to issue his own declaration. Dr. Kaplowitz explained that she was unaware of any instance when the Governor thought an emergency should be declared but officials on the local level did not. Ms. Whaley stated that under the ESDL, a local declaration must exist before a declaration by the Governor. The chairman directed staff to research this issue for the next meeting.

Dr. Kaplowitz further explained that, under the coordination of the Virginia Emergency Operations Center (VEOC), the VDH is responsible for Emergency Support Function 8: The Coordination of Public Health/Health and Medical Response. The VDH's Emergency Coordination Center operates to fulfill this function on the state and local level through coordinating the Public Health response, coordinating hospital and long-term care response, and communicating with health care provider systems and linking them to the VEOC.

Dr. Kaplowitz also emphasized the importance of partnerships with private and public health care providers. She stressed that the mission of the VDH is disease control and prevention, not the provision of health care. As most health care is provided by the private sector, the VDH has partnered with the Virginia Hospital and Healthcare Association to manage and coordinate the use of federal funds for health system preparedness. Dr. Kaplowitz noted that the VDH collaborates with the health care community, including hospitals as well as individual physicians, on issues of preparedness. The VDH also helps to coordinate volunteer health care providers, such as those in MRC units, and is developing a statewide system for registering and identifying such volunteers. Through this collaboration with health care providers, Dr. Kaplowitz stated that one of the primary concerns raised by the providers is their potential liability during an emergency when the practice environment is suboptimal.

Dr. Kaplowitz concluded her presentation by using the VDH's planning for a pandemic influenza outbreak as an example of the VDH's role in emergency preparedness as well as challenges that will be faced by health care providers during such an outbreak.

c. Medical Society of Virginia

Gerald C. Canaan, II, Esq., of Hancock, Daniel, Johnson & Nagle, P.C., briefly spoke on behalf of the Medical Society of Virginia (MSV). Mr. Canaan explained that the MSV was more focused on health care provider liability from the standpoint of the individual physicians, and not that of institutional health care providers such as hospitals. Mr. Canaan indicated that from an individual physician standpoint, the MSV does not perceive that there is a large problem with the liability protections already afforded individual physicians under current Virginia law, although he acknowledged the concerns of institutional health care providers.

Mr. Canaan represented that the primary concern of the MSV regarding health care provider liability protections is the issue of compensation. Mr. Canaan noted that current Virginia law, such as the Good Samaritan statute or the Emergency Services and Disaster Law, only provide for liability protections when the physician's services are not rendered for compensation. Mr. Canaan stressed that physicians who respond to disasters and emergencies are typically not looking for compensation; however, they would like to be able to recover their expenses without losing their liability protections. Mr. Canaan stated that physicians who accept reimbursement from charitable organizations or other entities for expenses such as travel costs or the cost of supplies may be no longer able to

invoke liability protections if such reimbursement is considered to constitute compensation.

Mr. Canaan also cited several examples of small "tweaks" that could be made to current Virginia law. First, he noted a potential discrepancy between the Good Samaritan statute, which uses the term "without compensation," and the Emergency Services and Disaster Law, which uses the term "gratuitously." Mr. Canaan also cited an omission from Va. Code § 8.01-225.01, which provides liability protections for health care providers who abandon a patient in order to respond to a man-made disaster. Mr. Canaan noted that that the protections of this statute do not apply to physicians responding to a natural disaster.

3. Other Business

The chairman opened the floor for public comments; no one took advantage of the opportunity. The chairman then asked the members for their comments. The members requested, in preparation for the next meeting, that staff research several issues: (1) how the federal government handles health care provider liability that may arise in emergency situations such as accidents on military bases that involve multiple casualties; (2) the potential criminalization of physicians' actions in response to emergencies, as illustrated by the case of Dr. Anna Pou in Louisiana; (3) the process in Virginia for the declaration of a state of emergency on the local, state, and federal levels, as well as whether different types of declarations are applicable to different types of disaster; i.e., pandemics as compared to hurricanes; (4) the liability protections available prior to the declaration of an emergency, focusing on issues such as negligent planning; and (5) whether other states offer liability protections to health care providers who render aid during emergencies. Finally, draft legislation prepared by staff was distributed to the members of the subcommittee for their review and for discussion at future meetings.

B. Meeting of September 27, 2007

1. Overview

The Joint Subcommittee held its second meeting of the 2007 interim in Richmond, Virginia, on September 27, 2007. The chairman, Delegate Phillip A. Hamilton, called the meeting to order and the members introduced themselves. Staff then presented a brief review of the Joint Subcommittee's first meeting, focusing on the presentations made to the Subcommittee at that meeting. Staff then proceeded to respond to several questions raised by the members at the first meeting.

First, staff addressed the issue of liability protections available on military bases. Staff explained that service members are precluded from bringing suits for injuries sustained while on active duty under the provisions of a United States Supreme Court case, *Feres v. United States*, 340 U.S. 135, 71 S. Ct. 153, 95 L. Ed. 152 (1950).

Staff then presented information concerning the prosecution of health care providers for decisions made during emergencies or disasters. Staff noted that concern regarding the criminalization of health care decisions resulted from the aftermath of Hurricane Katrina, where Dr. Anna Pou was accused of euthanizing patients at New Orleans' Memorial Medical Center, although a grand jury decided not to pursue criminal charges. Staff explained that the medical community, particularly the American Medical Association (AMA), is actively involved in this area. The AMA has issued policies opposing the criminalization of medical judgment and the criminalization of health care decision making. The AMA has also promulgated a Model Act to Prohibit the Criminalization of Health Care Decision Making. Staff further noted that apparently no state has adopted this Model Act.

2. Presentations

a. State of Emergency Declaration Process

Michael Cline, State Coordinator of Emergency Management for the Virginia Department of Emergency Management (VDEM), made a presentation describing the process for emergency declarations. Mr. Cline stated that the Governor is the Director of Emergency Management and has the statutory authority to declare a state of emergency. Mr. Cline explained that the typical declaration process begins with a verbal recommendation that a state of emergency be declared made by the VDEM and based on the input of the Virginia Emergency Response Team, which includes state agencies as well as representatives of the public and private sectors. In response to the oral recommendation, the Governor issues a verbal order. After input from state agencies, the VDEM, and occasionally the VDH, promulgates a written order, which is reviewed by the Attorney General's office and other agencies that may be affected by the order and then by the Secretary of Public Safety before being issued by the Governor.

Mr. Cline explained that the only exception to this process is in the event that the disaster is expected, such as in the case of a forecasted severe winter storm. In such a case, the Governor would not issue a verbal declaration of a state of emergency and only the written declaration will be issued since the declaration is being made in anticipation of the disaster. Mr. Cline further explained that some state agencies, such as the Virginia Department of Transportation, can respond to a disaster to the extent of their existing authority without a state declaration of emergency. He noted, however, that the Virginia National Guard cannot be activated without a state declaration of emergency.

Finally, Mr. Cline clarified that the declaration of a state of emergency becomes effective upon the Governor's verbal order and that there is little time lapse between the issuance of the verbal order and the subsequent written order, the longest such lapse that Mr. Cline could recall being approximately 45 minutes.

b. Virginia Healthcare and Hospital Association

Katharine M. Webb, Senior Vice-President of the Virginia Hospital and Healthcare Association (VHHA), made a presentation on the topic of providing care with limited resources. She noted that the VHHA first began to build a public/private partnership on this issue in 2001, when it established a working group of hospital leaders. Then in June of 2006, the VHHA convened a work group to begin addressing issues related to providing care in the face of normally adequate resources that are depleted by extraordinary demand during a disaster. This work group's membership included various hospital systems as well as other interested organizations and state representation from the VDH and the General Assembly.

Ms. Webb explained that the focus of the work group was on the ability of hospitals to continue to provide care during extraordinary events when faced with limited resources. The work group began its efforts by researching the appropriate laws in order to understand, correct, and validate the concerns of health care providers. After this research was completed, the work group developed a Critical Resource Shortage Planning Guide. Ms. Webb stated that this guide focuses on the allocation of scarce resources during an emergency situation and establishes a process for hospitals to follow in planning for the provision of care in the face of scarce resources. The guide rests on four assumptions: (1) that hospitals will be responsible for making decisions regarding resource shortages at the institution and health system level; (2) that hospitals will need to allocate resources during a shortage in a way that does the greatest good for the greatest number; (3) that resource shortage plans should fall within the hospital's existing incident command system; and (4) that the guide only applies during emergencies and disasters.

In addition to the development of the guide, Ms. Webb expressed her belief that legislation is still necessary in order to protect health care providers as care rendered during a disaster will be different than what would be provided under normal circumstances. Ms. Webb listed five legislative principles needed for comprehensive protection of health care providers: (1) protections embrace an all-hazards approach and apply to both natural and man-made disasters; (2) protections apply to all health care providers, including hospitals; (3) protections are not limited to volunteers; (4) protections apply both pre- and post-declaration of a state of emergency; and (5) protections apply to all care provided during the emergency or disaster.

c. Liability Insurance and Liability Protections

J. Christopher LaGow, J.D., who represents the Property Casualty Insurers Association of America, briefly spoke on the relation of liability protections and insurance. Mr. LaGow expressed his support for liability protections, such as the Good Samaritan statute, as they further the public policy of encouraging the provision of emergency care. However, Mr. LaGow indicated that there is a lack of any quality studies regarding the impact of such protections on paid claims or insurance premiums. In response to questioning from the members, Mr. LaGow did state that he believed that the degree of contingency planning a hospital did in preparation for disasters may be a

factor in determining its premiums. He also stated that he believed that such risk management considerations are already taking place. This position was contradicted by Subcommittee member Steven Gravely, who stated that no insurance carrier has incorporated disaster management in making its risk assessment.

d. Health Care Provider Liability Protections in Other Jurisdictions

Staff then made a brief presentation regarding health care liability protections in other states. Staff noted that almost every state has its own version of a Good Samaritan statute as well as civil defense/emergency services laws. Staff observed that other states' Good Samaritan statutes are relatively similar to Virginia's and likewise provide that care must be rendered without compensation at the scene of an accident or emergency before the liability protections may be invoked. Staff also noted that at least six states--California, Indiana, Louisiana, Maryland, Michigan, and Minnesota--have civil defense/emergency services laws that expressly afford liability protections for health care providers. All except one of these statutes require that a declared state of emergency exist before they will apply. Indiana also requires that a declaration of emergency exist, but provides that the statute's liability protections cover the provision of health care that occurred prior to the declaration.

3. Public Comment

The Chairman requested that Steve Pearson, who represents the Virginia Trial Lawyers Association, speak during the public comment period. Mr. Pearson expressed his belief that the issue of health care provider liability being addressed by the subcommittee already fits into the current legal framework in Virginia involving the standard of care. Mr. Pearson stated that issues such as the provision of health care in the face of resource shortages or by providers outside the scope of their expertise would all come before the jury as part of the question of whether the standard of care used was appropriate. Mr. Pearson also emphasized his opposition to broad grants of immunity, including immunity that would apply during time periods prior to the declaration of a state of emergency.

In response to questioning from the Joint Subcommittee members, Mr. Pearson acknowledged differences between the statutory standard of care and Model Jury Instructions' standard of care. He did not, however, believe that there is any need to conform the statutory definition to the Model Jury Instructions and expressed his opinion that there is no history of any problems with juries in Virginia understanding that when they consider the standard of care, they must consider the circumstances in which such care was provided, as it is their duty to consider relevant evidence.

Mr. Pearson also addressed questions from the members concerning claims brought against health care providers for failing to plan for emergencies, such as some of the claims filed in the wake of Hurricane Katrina or the SARS outbreak in Canada. While he could not speak as to specific differences between the laws of Virginia,

Louisiana, and Canada, Mr. Pearson stated that the laws of Virginia would lead to predictable, reasonable results in such cases. He also stated it would be difficult to prevent people from engaging in such litigation, as people would try to find ways around any limitation on their ability to succeed on a particular claim.

In conclusion, Mr. Pearson reiterated his belief that current Virginia law affords sufficient liability protections to health care providers to ensure an effective emergency response. He also stated that increased education for the medical community regarding current Virginia law would help ease the medical community's concerns about their potential liability.

Three other people made comments to the subcommittee. First, Beverly Soble of the Virginia Health Care Association expressed her preference that the subcommittee extend any liability protections it may choose to recommend to all health care providers, including nursing homes and assisted living facilities. She expressed her opinion that such facilities would likely assist with any surge in the provision of health care associated with an emergency.

Second, Scott Johnson, who represents the Medical Society of Virginia, stated his preference that the protections already afforded to health care providers in Va. Code § 8.01-225.01 be extended to include natural disasters, in addition to the man-made disasters that are already covered by that statute. He further expressed his support that any recommendation of the subcommittee include liability protections that cover both pre- and post-declaration of emergency time periods. Finally, Mr. Johnson advocated several changes to Virginia's Good Samaritan statute, including that persons rendering services under that statute be permitted to be reimbursed for their actual expenses and expanding that statute's scope so the protections are not limited to care provided at the scene of an emergency.

Finally, Dr. Lisa Kaplowitz, Deputy Commissioner for Emergency Preparedness and Response for the VDH, stated that physicians who would be willing to respond to a disaster are worried about the risk that they may be subjecting themselves to by doing so. Dr. Kaplowitz said that such concerns could be ameliorated if the physicians were aware that they were afforded greater liability protections. She expressed her skepticism that greater physician education concerning the currently available liability protections would be sufficient.

4. Member Discussion and Recommendations

The members then proceeded to discuss several legislative alternatives that had been prepared by staff. As a way of framing their discussion, the Chairman utilized the legislative principles contained in Ms. Webb's presentation on behalf of the VHHA.

The first principle put to the Joint Subcommittee was who should be covered. It was decided by the Joint Subcommittee that any liability protections should extend to all health care providers, and not be limited to institutional providers, such as hospitals.

The second principle was whether to adopt an all-hazards approach. The Joint Subcommittee determined that any liability protections should cover both natural and man-made disasters. In furtherance of this decision, the Joint Subcommittee decided that, if possible, the current definitions of these types of disasters contained in the Virginia Code should be condensed into one single definition of "disaster." Alternatively, Delegate Hull also requested that an amendment to the term "natural disaster" be made to clarify that disease outbreaks would be covered.

The third principle considered by the Joint Subcommittee was the issue of volunteers. The Joint Subcommittee decided that volunteer health care providers be allowed to recover their actual expenses incurred during the rendition of care.

The fourth principle that the Joint Subcommittee addressed was when the liability protections should apply. The Joint Subcommittee determined that the protections should apply both before and after the declaration of a state of emergency.

The fifth and final principle was the application of any liability protections to all care provided during a disaster or emergency. The Joint Subcommittee decided that no dual standard of care should apply during an emergency or disaster.

The Joint Subcommittee also approved the fifth legislative draft prepared by staff, which amended the exceptions to the definition of a patient found in Va. Code § 8.01-581.1 to add a reference to Va. Code § 44-146.23, the liability provision of the ESDL, in addition to the already existing reference to the Good Samaritan statute.

The Joint Subcommittee also decided to attempt to broaden the Good Samaritan statute to expand its application from care rendered at the scene of the accident or emergency to care rendered in response to an accident or emergency.

In preparation for the Joint Subcommittee's next meeting, the Chairman directed staff to draft legislation consistent with the Joint Subcommittee's decisions on these legislative principles and its other decisions. The Chairman also directed staff to research the existing liability protections for emergency medical technicians and whether they would be covered by the draft legislation.

C. Meeting of October 16, 2007

1. Member Discussion and Recommendations

The Joint Subcommittee held its third and final meeting of the 2007 interim in Richmond, Virginia, on October 16, 2007. The Joint Subcommittee's final meeting focused primarily on a review of draft legislation prepared by staff in accordance with the legislative principles endorsed by the Subcommittee at its previous meeting. The Chairman called the meeting to order and proceeded to enumerate these legislative principles as follows: (1) liability protections should extend to all health care providers;

(2) liability protections should cover both natural and man-made disasters, the definitions of these types of disasters should be condensed into one single definition of "disaster," and it should be clarified that certain disease outbreaks would be considered to be disasters; (3) liability protections should apply both before and after the declaration of a state of emergency; (4) liability protections should apply to all care provided during a disaster or emergency, regardless of the possible scarcity of resources; (5) volunteer health care providers should be allowed to recover their actual expenses incurred during the rendition of care; (6) the Good Samaritan statute should include care rendered in response to an accident or emergency but not necessarily rendered at the scene of the accident or emergency; and (7) a reference to the liability provision of the ESDL, Va. Code § 44-146.23, should be added to the exceptions to the definition of a patient in Va. Code § 8.01-581.1.

Staff then reviewed the draft legislation they had prepared, noting for the members how the provisions of the draft correspond to the legislative principles endorsed by the Joint Subcommittee. Additionally, in response to the question posed at the previous meeting, staff informed the Joint Subcommittee that certain emergency medical technicians (i.e., those who receive a fee for services) would be covered by the liability protections contained in the draft legislation, while those who work without compensation are already covered by the Good Samaritan statute.

The members of the Joint Subcommittee then discussed the draft legislation. Steve Pearson, representing the Virginia Trial Lawyers Association, Scott Johnson, representing the Medical Society of Virginia, and Susan Ward, Vice-President and General Counsel of the VHHA, also spoke to the draft legislation. Mr. Pearson also distributed two alternate versions of draft legislation that he prepared.

The Joint Subcommittee unanimously adopted several changes to the draft legislation. The majority of these changes were aimed at refining the language in the legislative draft concerning when the liability protections would apply and what conduct would be covered by the protections. However, there was one substantial change made to the legislative draft, which resulted from the Chairman's observance of the precise language of the study resolutions. The Chairman noted that the study resolutions dealt with the issue of liability protections for health care providers during a declared disaster or emergency. The members discussed whether the portions of the legislative draft involving the Good Samaritan statute and other statutes related to the Good Samaritan statute were beyond the scope of the study resolutions. The Joint Subcommittee unanimously agreed that they were and directed that they be removed from the draft legislation. With these changes, the draft legislation was unanimously adopted by the members of the Joint Subcommittee as suggested legislation for the 2008 Session of the General Assembly.

IV. Final Recommendations of the Joint Subcommittee

The Joint Subcommittee recommended draft legislation for the 2008 Session of the General Assembly that would make several changes to Virginia's laws concerning

liability protections for health care providers who respond to declared emergencies or disasters. The proposed legislation, located at Appendix C, does the following:

1. Adds a new Code section at § 8.01-225.01 that provides immunity from civil liability for injury or wrongful death that arises from the delivery or withholding of health care by a health care provider who, in the absence of gross negligence or willful misconduct, responds to a disaster. The immunity only applies when a state or local emergency has been or is subsequently declared in response to the disaster to which the health care provider responded. The failure of a health care provider to deliver care at the same level or manner as would be provided under non-disaster circumstances, where the failure results from a lack of necessary resources, is not a breach of any duty owed by the provider. As used in this section, the term "disaster" includes the terms "disaster," "emergency," and "major disaster" as those terms are defined in Va. Code § 44-146.16.

2. Combines the definitions of the terms "man-made disaster" and "natural disaster" located in Va. Code § 44-146.16 into one inclusive term "disaster" and makes corresponding changes where needed throughout the Code.

3. Adds the term "communicable disease of public health threat" to the definition of "disaster" in Va. Code § 44-146.16. This term is defined under current law in Va. Code § 44-146.16.

4. Expands the immunity afforded to health care providers who abandon patients in order to deliver health care to persons injured in a man-made disaster under Va. Code § 8.01-225.01 to include persons injured in a "disaster," "emergency," or "major disaster" as those terms are defined in Va. Code § 44-146.16.

5. Amends the liability protections afforded under the ESDL, Va. Code § 44-146.23, to persons who hold a license or certificate evidencing their professional or mechanical skills, including health care providers, and who, without compensation, render aid involving that skill during a disaster, to be reimbursed for the actual and necessary expenses incurred during the rendition of aid.

6. Adds a reference to the immunity provision of the ESDL, Va. Code § 44-146.23, to the exceptions to the definition of the term "patient" in Va. Code § 8.01-581.1 in addition to the already existing reference to the Good Samaritan statute.

7. Makes technical amendments to Va. Code § 44-146.16.

Respectfully submitted,

The Honorable Phillip A. Hamilton, Chairman
The Honorable Stephen D. Newman, Vice-Chairman
The Honorable John M. O'Bannon, III
The Honorable Benjamin L. Cline
The Honorable Robert D. Hull
The Honorable Mark D. Sickles
The Honorable Frank M. Ruff, Jr.
The Honorable Ken Cuccinelli, II
Dr. P.M. Colopy, M.D.
Dr. Mark J. Dietz, M.D., M.B.A.
Steven D. Gravely, J.D., M.H.A.
The Honorable Robert F. McDonnell
The Honorable Marilyn B. Tavenner

SENATE JOINT RESOLUTION NO. 390

Establishing a joint subcommittee to study the feasibility of offering liability protections to health care providers rendering aid during a state or local emergency. Report.

Agreed to by the Senate, February 24, 2007
Agreed to by the House of Delegates, February 24, 2007

WHEREAS, health care providers responding during a disaster or a declared emergency may not have access to the same level of resources that are ordinarily available; and

WHEREAS, during an emergency, health care providers must make decisions as to the level of care they can render based upon what resources are available; and

WHEREAS, health care providers may need to render care during an emergency that is outside their scope of practice; and

WHEREAS, a disaster may be declared at the state or local level; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That a joint subcommittee be established to study the feasibility of offering liability protections to health care providers rendering aid during a state or local emergency. The joint subcommittee shall have a total membership of 13 members that shall consist of eight legislative members, three nonlegislative citizen members, and two ex officio members. Members shall be appointed as follows: three members of the Senate to be appointed by the Senate Committee on Rules; five members of the House of Delegates to be appointed by the Speaker of the House of Delegates in accordance with the principles of proportional representation contained in the Rules of the House of Delegates; one nonlegislative citizen member who shall be a licensed physician to be appointed by the Senate Committee on Rules; and two nonlegislative citizen members, one of whom shall be an attorney specializing in health care law and one of whom shall be a representative of the Virginia Hospital and Healthcare Association, to be appointed by the Speaker of the House of Delegates. The Secretary of Health and Human Resources or her designee and the Attorney General of Virginia or his designee shall serve ex officio with voting privileges. Nonlegislative citizen members of the joint subcommittee shall be citizens of the Commonwealth of Virginia. Unless otherwise approved in writing by the chairman of the joint subcommittee and the respective clerk, nonlegislative citizen members shall only be reimbursed for travel originating and ending within the Commonwealth of Virginia for the purpose of attending meetings. If a companion joint resolution of the other chamber is agreed to, written authorization of both clerks shall be required. The joint subcommittee shall elect a chairman and vice chairman from among its membership, who shall be members of the General Assembly.

In conducting its study, the joint subcommittee shall examine the estimated benefits to the citizens of the Commonwealth of enhanced liability protections for health care providers as well as determining how many other states provide these kinds of liability protections.

Administrative staff support shall be provided by the Office of the Clerk of the Senate. Legal, research, policy analysis, and other services as requested by the joint subcommittee shall be provided by the Division of Legislative Services. All agencies of the Commonwealth shall provide assistance to the joint subcommittee for this study, upon request.

The joint subcommittee shall be limited to four meetings for the 2007 interim, and the direct costs of this study shall not exceed $8,800 without approval as set out in this resolution. Approval for unbudgeted nonmember-related expenses shall require the written authorization of the chairman of the joint subcommittee and the respective Clerk. If a companion joint resolution of the other chamber is agreed to, written authorization of both Clerks shall be required.

No recommendation of the joint subcommittee shall be adopted if a majority of the Senate members or a majority of the House members appointed to the joint subcommittee (i) vote against the recommendation and (ii) vote for the recommendation to fail notwithstanding the majority vote of the joint subcommittee.

The joint subcommittee shall complete its meetings by November 30, 2007, and the chairman shall submit to the Division of Legislative Automated Systems an executive summary of its findings and recommendations no later than the first day of the 2008 Regular Session of the General Assembly. The executive summary shall state whether the joint subcommittee intends to submit to the General Assembly and the Governor a report of its findings and recommendations for publication as a House or Senate document. The executive summary and report shall be submitted as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents and reports and shall be posted on the General Assembly's website.

Implementation of this resolution is subject to subsequent approval and certification by the Joint Rules Committee. The Committee may approve or disapprove expenditures for this study, extend or

delay the period for the conduct of the study, or authorize additional meetings during the 2007 interim.

HOUSE JOINT RESOLUTION NO. 701

Establishing a joint subcommittee to study the feasibility of offering liability protections to health care providers rendering aid during a state or local emergency. Report.

Agreed to by the House of Delegates, February 23, 2007
Agreed to by the Senate, February 23, 2007

WHEREAS, health care providers responding during a disaster or a declared emergency may not have access to the same level of resources that are ordinarily available; and

WHEREAS, during an emergency, health care providers must make decisions as to the level of care they can render based upon what resources are available; and

WHEREAS, health care providers may need to render care during an emergency that is outside their scope of practice; and

WHEREAS, a disaster may be declared at the state or local level; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That a joint subcommittee be established to study the feasibility of offering liability protections to health care providers rendering aid during a state or local emergency. The joint subcommittee shall have a total membership of 13 members that shall consist of eight legislative members, three nonlegislative citizen members, and two ex officio members. Members shall be appointed as follows: five members of the House of Delegates to be appointed by the Speaker of the House of Delegates in accordance with the principles of proportional representation contained in the Rules of the House of Delegates; three members of the Senate to be appointed by the Senate Committee on Rules; two nonlegislative citizen members, one of whom shall be an attorney specializing in health care law and one of whom shall be a representative of the Virginia Hospital and Healthcare Association, to be appointed by the Speaker of the House of Delegates; and one nonlegislative citizen member who shall be a licensed physician to be appointed by the Senate Committee on Rules. The Secretary of Health and Human Resources or her designee and the Attorney General of Virginia or his designee shall serve ex officio with voting privileges. Nonlegislative citizen members of the joint subcommittee shall be citizens of the Commonwealth of Virginia. Unless otherwise approved in writing by the chairman of the joint subcommittee and the respective clerk, nonlegislative citizen members shall only be reimbursed for travel originating and ending within the Commonwealth of Virginia for the purpose of attending meetings. If a companion joint resolution of the other chamber is agreed to, written authorization of both clerks shall be required. The joint subcommittee shall elect a chairman and vice chairman from among its membership, who shall be members of the General Assembly.

In conducting its study, the joint subcommittee shall examine the estimated benefits to the citizens of the Commonwealth of enhanced liability protections for health care providers as well as determining how many other states provide these kinds of liability protections.

Administrative staff support shall be provided by the Office of the Clerk of the House of Delegates. Legal, research, policy analysis, and other services as requested by the joint subcommittee shall be provided by the Division of Legislative Services. All agencies of the Commonwealth shall provide assistance to the joint subcommittee for this study, upon request.

The joint subcommittee shall be limited to four meetings for the 2007 interim, and the direct costs of this study shall not exceed $8,800 without approval as set out in this resolution. Approval for unbudgeted nonmember-related expenses shall require the written authorization of the chairman of the joint subcommittee and the respective Clerk. If a companion joint resolution of the other chamber is agreed to, written authorization of both Clerks shall be required.

No recommendation of the joint subcommittee shall be adopted if a majority of the House members or a majority of the Senate members appointed to the joint subcommittee (i) vote against the recommendation and (ii) vote for the recommendation to fail notwithstanding the majority vote of the joint subcommittee.

The joint subcommittee shall complete its meetings by November 30, 2007, and the chairman shall submit to the Division of Legislative Automated Systems an executive summary of its findings and recommendations no later than the first day of the 2008 Regular Session of the General Assembly. The executive summary shall state whether the joint subcommittee intends to submit to the General Assembly and the Governor a report of its findings and recommendations for publication as a House or Senate document. The executive summary and report shall be submitted as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents and reports and shall be posted on the General Assembly's website.

Implementation of this resolution is subject to subsequent approval and certification by the Joint

Rules Committee. The Committee may approve or disapprove expenditures for this study, extend or delay the period for the conduct of the study, or authorize additional meetings during the 2007 interim.

SENATE BILL NO. __________ HOUSE BILL NO. __________

A BILL to amend and reenact §§ 8.01-225.01, 8.01-581.1, 38.2-324, 44-146.16, 44-146.17, 44-146.18:1, 44-146.23, and 59.1-526 of the Code of Virginia and to amend the Code of Virginia by adding a section numbered 8.01-225.02, relating to health care provider liability protections.

Be it enacted by the General Assembly of Virginia:

1. That §§ 8.01-225.01, 8.01-581.1, 38.2-324, 44-146.16, 44-146.17, 44-146.18:1, 44-146.23, and 59.1-526 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding a section numbered 8.01-225.02 as follows:

§ 8.01-225.01. Certain immunity for health care providers during disasters under specific circumstances.

A. In the absence of gross negligence or willful misconduct, any health care provider who responds to ~~a man-made~~ disaster by delivering health care to persons injured in such ~~man-made~~ disaster shall be immune from civil liability for any injury or wrongful death arising from abandonment by such health care provider of any person to whom such health care provider owes a duty to provide health care when (i) a state or local emergency has been or is subsequently declared; and (ii) the provider was unable to provide the requisite health care to the person to whom he owed such duty of care as a result of the provider's voluntary or mandatory response to the relevant ~~man-made~~ disaster.

B. In the absence of gross negligence or willful misconduct, any hospital or other entity credentialing health care providers to deliver health care in response to ~~a man-made~~ disaster shall be immune from civil liability for any cause of action arising out of such credentialing or granting of practice privileges if (i) a state or local emergency has been or is subsequently declared; and (ii) the hospital has followed procedures for such credentialing and granting of practice privileges that are consistent with the Joint Commission on Accreditation of Healthcare Organizations' standards for granting emergency practice privileges.

C. For the purposes of this section:

"Disaster" means any "disaster," "emergency," or "major disaster" as those terms are used and defined in § 44-146.16; and

"Health care provider" means those professions defined as such in § 8.01-581.1~~; and~~.

~~"Man-made disaster" means the circumstances described in § 44-146.16.~~

D. The immunity provided by this section shall be in addition to, and shall not be in lieu of, any immunities provided in other state or federal law, including, but not limited to, §§ 8.01-225 and 44-146.23.

§ 8.01-225.02. Certain immunity for health care providers during disasters.

A. In the absence of gross negligence or willful misconduct, any health care provider who responds to a disaster shall be immune from civil liability for any injury or wrongful death of any person arising from the delivery or withholding of health care when a state or local emergency has been or is subsequently declared in response to such disaster. The failure of a health care provider in response to a disaster to deliver the same level or manner of health care that would be delivered under nondisaster circumstances, where such failure results from a lack of any resource necessary for the delivery of such health care, shall not be a breach of any duty by such provider.

B. For purposes of this section:

"Disaster" means any "disaster," "emergency," or "major disaster" as those terms are used and defined in § 44-146.16; and

"Health care provider" has the same definition as provided in § 8.01-581.1.

§ 8.01-581.1. Definitions.

As used in this chapter:

"Health care" means any act, or treatment performed or furnished, or which should have been performed or furnished, by any health care provider for, to, or on behalf of a patient during the patient's medical diagnosis, care, treatment or confinement.

"Health care provider" means (i) a person, corporation, facility or institution licensed by this Commonwealth to provide health care or professional services as a physician or hospital, dentist, pharmacist, registered nurse or licensed practical nurse or a person who holds a multistate privilege to

52 practice such nursing under the Nurse Licensure Compact, optometrist, podiatrist, chiropractor, physical
53 therapist, physical therapy assistant, clinical psychologist, clinical social worker, professional counselor,
54 licensed marriage and family therapist, licensed dental hygienist, health maintenance organization, or
55 emergency medical care attendant or technician who provides services on a fee basis; (ii) a professional
56 corporation, all of whose shareholders or members are so licensed; (iii) a partnership, all of whose
57 partners are so licensed; (iv) a nursing home as defined in § 54.1-3100 except those nursing institutions
58 conducted by and for those who rely upon treatment by spiritual means alone through prayer in
59 accordance with a recognized church or religious denomination; (v) a professional limited liability
60 company comprised of members as described in subdivision A 2 of § 13.1-1102; (vi) a corporation,
61 partnership, limited liability company or any other entity, except a state-operated facility, which
62 employs or engages a licensed health care provider and which primarily renders health care services; or
63 (vii) a director, officer, employee, independent contractor, or agent of the persons or entities referenced
64 herein, acting within the course and scope of his employment or engagement as related to health care or
65 professional services.

66 "Health maintenance organization" means any person licensed pursuant to Chapter 43 (§ 38.2-
67 4300 et seq.) of Title 38.2 who undertakes to provide or arrange for one or more health care plans.

68 "Hospital" means a public or private institution licensed pursuant to Chapter 5 (§ 32.1-123 et
69 seq.) of Title 32.1 or Article 2 (§ 37.2-403 et seq.) of Chapter 4 of Title 37.2.

70 "Impartial attorney" means an attorney who has not represented (i) the claimant, his family, his
71 partners, co-proprietors or his other business interests; or (ii) the health care provider, his family, his
72 partners, co-proprietors or his other business interests.

73 "Impartial health care provider" means a health care provider who (i) has not examined, treated
74 or been consulted regarding the claimant or his family; (ii) does not anticipate examining, treating, or
75 being consulted regarding the claimant or his family; or (iii) has not been an employee, partner or co-
76 proprietor of the health care provider against whom the claim is asserted.

77 "Malpractice" means any tort action or breach of contract action for personal injuries or wrongful
78 death, based on health care or professional services rendered, or which should have been rendered, by a
79 health care provider, to a patient.

80 "Patient" means any natural person who receives or should have received health care from a
81 licensed health care provider except those persons who are given health care in an emergency situation
82 which exempts the health care provider from liability for his emergency services in accordance with §
83 8.01-225 or 44-146.23.

84 "Physician" means a person licensed to practice medicine or osteopathy in this Commonwealth
85 pursuant to Chapter 29 (§ 54.1-2900 et seq.) of Title 54.1.

86 § 38.2-324. Disclosure of property damage information.

87 Nothing in this title shall prohibit an insurer or its agent from disclosing information obtained
88 from policyholders or other persons regarding claims or reports of property damage resulting from a
89 natural disaster, as defined in clause (ii) of the definition of "disaster" in § 44-146.16, to the Director of
90 the Department of Emergency Management or his designees or other state officials, to federal officials,
91 or to local government officials of the locality where the damage occurred; provided that the disclosures
92 (i) do not identify persons whose property is damaged or the address thereof and (ii) include only
93 aggregated data that relates to the assessment of damage from a natural disaster, including, but not
94 limited to, the number of claims, estimates of the dollar amount of damage, and types of damage, for a
95 specified geographic area, such as a census tract or zip code area.

96 § 44-146.16. Definitions.

97 As used in this chapter unless the context requires a different meaning:

98 "Communicable disease of public health threat" means an illness of public health significance, as
99 determined by the State Health Commissioner in accordance with regulations of the Board of Health,
100 caused by a specific or suspected infectious agent that may be reasonably expected or is known to be
101 readily transmitted directly or indirectly from one individual to another and has been found to create a
102 risk of death or significant injury or impairment; this definition shall not, however, be construed to
103 include human immunodeficiency viruses or tuberculosis, unless used as a bioterrorism weapon.

104 "Individual" shall include any companion animal. Further, whenever "person or persons" is used in
105 Article 3.02 (§ 32.1-48.05 et seq.) of Chapter 2 of Title 32.1, it shall be deemed, when the context
106 requires it, to include any individual;

107 "Disaster" means (i) any man-made disaster including any condition following an attack by any
108 enemy or foreign nation upon the United States resulting in substantial damage of property or injury to
109 persons in the United States and may be by use of bombs, missiles, shell fire, nuclear, radiological,
110 chemical, or biological means or other weapons or by overt paramilitary actions; terrorism, foreign and
111 domestic; also any industrial, nuclear, or transportation accident, explosion, conflagration, power failure,
112 resources shortage, or other condition such as sabotage, oil spills, and other injurious environmental
113 contaminations that threaten or cause damage to property, human suffering, hardship, or loss of life; and
114 (ii) any natural disaster including any hurricane, tornado, storm, flood, high water, wind-driven water,
115 tidal wave, earthquake, drought, fire, communicable disease of public health threat, or other natural
116 catastrophe resulting in damage, hardship, suffering, or possible loss of life;

117 "Discharge" means spillage, leakage, pumping, pouring, seepage, emitting, dumping, emptying,
118 injecting, escaping, leaching, fire, explosion, or other releases;

119 "Emergency" means any occurrence, or threat thereof, whether natural or man-made, which
120 results or may result in substantial injury or harm to the population or substantial damage to or loss of
121 property or natural resources and may involve governmental action beyond that authorized or
122 contemplated by existing law because governmental inaction for the period required to amend the law to
123 meet the exigency would work immediate and irrevocable harm upon the citizens or the environment of
124 the Commonwealth or some clearly defined portion or portions thereof;

125 "Emergency services" means the preparation for and the carrying out of functions, other than
126 functions for which military forces are primarily responsible, to prevent, minimize and repair injury and
127 damage resulting from ~~natural or man made~~ disasters, together with all other activities necessary or
128 incidental to the preparation for and carrying out of the foregoing functions. These functions include,
129 without limitation, fire-fighting services, police services, medical and health services, rescue,
130 engineering, warning services, communications, radiological, chemical and other special weapons

131 defense, evacuation of persons from stricken areas, emergency welfare services, emergency
132 transportation, emergency resource management, existing or properly assigned functions of plant
133 protection, temporary restoration of public utility services, and other functions related to civilian
134 protection. These functions also include the administration of approved state and federal disaster
135 recovery and assistance programs;

136 "Hazard mitigation" means any action taken to reduce or eliminate the long-term risk to human
137 life and property from natural hazards;

138 "Hazardous substances" means all materials or substances which now or hereafter are designated,
139 defined, or characterized as hazardous by law or regulation of the Commonwealth or regulation of the
140 United States government;

141 "Interjurisdictional agency for emergency management" is any organization established between
142 contiguous political subdivisions to facilitate the cooperation and protection of the subdivisions in the
143 work of disaster prevention, preparedness, response, and recovery;

144 "Local emergency" means the condition declared by the local governing body when in its
145 judgment the threat or actual occurrence of an emergency or disaster is or threatens to be of sufficient
146 severity and magnitude to warrant coordinated local government action to prevent or alleviate the
147 damage, loss, hardship or suffering threatened or caused thereby; provided, however, that a local
148 emergency arising wholly or substantially out of a resource shortage may be declared only by the
149 Governor, upon petition of the local governing body, when he deems the threat or actual occurrence of
150 such an emergency or disaster to be of sufficient severity and magnitude to warrant coordinated local
151 government action to prevent or alleviate the damage, loss, hardship or suffering threatened or caused
152 thereby; provided, however, nothing in this chapter shall be construed as prohibiting a local governing
153 body from the prudent management of its water supply to prevent or manage a water shortage;

154 "Local emergency management organization" means an organization created in accordance with
155 the provisions of this chapter by local authority to perform local emergency service functions;

156 "Major disaster" means any natural catastrophe, including any: hurricane, tornado, storm, high
157 water, wind-driven water, tidal wave, tsunami, earthquake, volcanic eruption, landslide, mudslide,

158 snowstorm or drought, or regardless of cause, any fire, flood, or explosion, in any part of the United
159 States, which, in the determination of the President of the United States is, or thereafter determined to
160 be, of sufficient severity and magnitude to warrant major disaster assistance under the ~~Strafford~~ Stafford
161 Act (P.L. ~~43-288~~ 93-288 as amended) to supplement the efforts and available resources of states, local
162 governments, and disaster relief organizations in alleviating the damage, loss, hardship, or suffering
163 caused thereby and is so declared by him;

164 ~~"Man-made disaster" means any condition following an attack by any enemy or foreign nation~~
165 ~~upon the United States resulting in substantial damage of property or injury to persons in the United~~
166 ~~States and may be by use of bombs, missiles, shell fire, nuclear, radiological, chemical or biological~~
167 ~~means or other weapons or by overt paramilitary actions; terrorism, foreign and domestic; also any~~
168 ~~industrial, nuclear or transportation accident, explosion, conflagration, power failure, resources shortage~~
169 ~~or other condition such as sabotage, oil spills and other injurious environmental contaminations that~~
170 ~~threaten or cause damage to property, human suffering, hardship or loss of life;~~

171 ~~"Natural disaster" means any hurricane, tornado, storm, flood, high water, wind-driven water,~~
172 ~~tidal wave, earthquake, drought, fire or other natural catastrophe resulting in damage, hardship, suffering~~
173 ~~or possible loss of life;~~

174 "Political subdivision" means any city or county in the Commonwealth and for the purposes of
175 this chapter, the Town of Chincoteague and any town of more than 5,000 population that chooses to
176 have an emergency management program separate from that of the county in which such town is
177 located;

178 "Resource shortage" means the absence, unavailability or reduced supply of any raw or
179 processed natural resource, or any commodities, goods or services of any kind that bear a substantial
180 relationship to the health, safety, welfare and economic well-being of the citizens of the Commonwealth;

181 "State of emergency" means the condition declared by the Governor when in his judgment, the
182 threat or actual occurrence of an emergency or a disaster in any part of the Commonwealth is of
183 sufficient severity and magnitude to warrant disaster assistance by the Commonwealth to supplement the
184 efforts and available resources of the several localities, and relief organizations in preventing or

185 alleviating the damage, loss, hardship, or suffering threatened or caused thereby and is so declared by
186 him.

187 § 44-146.17. Powers and duties of Governor.

188 The Governor shall be Director of Emergency Management. He shall take such action from time
189 to time as is necessary for the adequate promotion and coordination of state and local emergency
190 services activities relating to the safety and welfare of the Commonwealth in time of ~~natural or man-~~
191 ~~made~~ disasters.

192 The Governor shall have, in addition to his powers hereinafter or elsewhere prescribed by law,
193 the following powers and duties:

194 (1) To proclaim and publish such rules and regulations and to issue such orders as may, in his
195 judgment, be necessary to accomplish the purposes of this chapter including, but not limited to such
196 measures as are in his judgment required to control, restrict, allocate or regulate the use, sale, production
197 and distribution of food, fuel, clothing and other commodities, materials, goods, services and resources
198 under any state or federal emergency services programs.

199 He may adopt and implement the Commonwealth of Virginia Emergency Operations Plan,
200 which provides for state-level emergency operations in response to any type of disaster or large-scale
201 emergency affecting Virginia and that provides the needed framework within which more detailed
202 emergency plans and procedures can be developed and maintained by state agencies, local governments
203 and other organizations.

204 He may direct and compel evacuation of all or part of the populace from any stricken or
205 threatened area if this action is deemed necessary for the preservation of life, implement emergency
206 mitigation, preparedness, response or recovery actions; prescribe routes, modes of transportation and
207 destination in connection with evacuation; and control ingress and egress at an emergency area,
208 including the movement of persons within the area and the occupancy of premises therein.

209 Executive orders, to include those declaring a state of emergency and directing evacuation, shall
210 have the force and effect of law and the violation thereof shall be punishable as a Class 1 misdemeanor
211 in every case where the executive order declares that its violation shall have such force and effect.

212 Such executive orders declaring a state of emergency may address exceptional circumstances
213 that exist relating to an order of quarantine or an order of isolation concerning a communicable disease
214 of public health threat that is issued by the State Health Commissioner for an affected area of the
215 Commonwealth pursuant to Article 3.02 (§ 32.1-48.05 et seq.) of Chapter 2 of Title 32.1.

216 Except as to emergency plans issued to prescribe actions to be taken in the event of disasters and
217 emergencies, no rule, regulation, or order issued under this section shall have any effect beyond June 30
218 next following the next adjournment of the regular session of the General Assembly but the same or a
219 similar rule, regulation, or order may thereafter be issued again if not contrary to law;

220 (2) To appoint a State Coordinator of Emergency Management and authorize the appointment or
221 employment of other personnel as is necessary to carry out the provisions of this chapter, and to remove,
222 in his discretion, any and all persons serving hereunder;

223 (3) To procure supplies and equipment, to institute training and public information programs
224 relative to emergency management and to take other preparatory steps including the partial or full
225 mobilization of emergency management organizations in advance of actual disaster, to insure the
226 furnishing of adequately trained and equipped forces in time of need;

227 (4) To make such studies and surveys of industries, resources, and facilities in the
228 Commonwealth as may be necessary to ascertain the capabilities of the Commonwealth and to plan for
229 the most efficient emergency use thereof;

230 (5) On behalf of the Commonwealth enter into mutual aid arrangements with other states and to
231 coordinate mutual aid plans between political subdivisions of the Commonwealth. After a state of
232 emergency is declared in another state and the Governor receives a written request for assistance from
233 the executive authority of that state, the Governor may authorize the use in the other state of personnel,
234 equipment, supplies, and materials of the Commonwealth, or of a political subdivision, with the consent
235 of the chief executive officer or governing body of the political subdivision;

236 (6) To delegate any administrative authority vested in him under this chapter, and to provide for
237 the further delegation of any such authority, as needed;

238 (7) Whenever, in the opinion of the Governor, the safety and welfare of the people of the
239 Commonwealth require the exercise of emergency measures due to a threatened or actual disaster, he
240 may declare a state of emergency to exist;

241 (8) To request a major disaster declaration from the President, thereby certifying the need for
242 federal disaster assistance and ensuring the expenditure of a reasonable amount of funds of the
243 Commonwealth, its local governments, or other agencies for alleviating the damage, loss, hardship, or
244 suffering resulting from the disaster;

245 (9) To provide incident command system guidelines for state agencies and local emergency
246 response organizations; and

247 (10) Whenever, in the opinion of the Governor or his designee, an employee of a state or local
248 public safety agency responding to a ~~man made or natural~~ disaster has suffered an extreme personal or
249 family hardship in the affected area, such as the destruction of a personal residence or the existence of
250 living conditions that imperil the health and safety of an immediate family member of the employee, the
251 Governor may direct the Comptroller of the Commonwealth to issue warrants not to exceed $2,500 per
252 month, for up to three calendar months, to the employee to assist the employee with the hardship.

253 § 44-146.18:1. Virginia Disaster Response Funds disbursements; reimbursements.

254 There is hereby created a nonlapsing revolving fund which shall be maintained as a separate
255 special fund account within the state treasury, and administered by the Coordinator of Emergency
256 Management, consistent with the purposes of this chapter. All expenses, costs, and judgments recovered
257 pursuant to this section, and all moneys received as reimbursement in accordance with applicable
258 provisions of federal law, shall be paid into the fund. Additionally, an annual appropriation to the fund
259 from the general fund or other unrestricted nongeneral fund, in an amount determined by the Governor,
260 may be authorized to carry out the purposes of this chapter. All recoveries from occurrences prior to
261 March 10, 1983, and otherwise qualifying under this section, received subsequent to March 10, 1983,
262 shall be paid into the fund. No moneys shall be credited to the balance in the fund until they have been
263 received by the fund. An accounting of moneys received and disbursed shall be kept and furnished to the
264 Governor or the General Assembly upon request.

265 Disbursements from the fund may be made for the following purposes and no others:

266 1. For costs and expenses, including, but not limited to personnel, administrative, and equipment 267 costs and expenses directly incurred by the Department of Emergency Management or by any other state 268 agency or political subdivision or other entity, acting at the direction of the Coordinator of Emergency 269 Management, in and for preventing or alleviating damage, loss, hardship, or suffering caused by 270 emergencies, resource shortages, or ~~natural or man-made~~ disasters; and

271 2. For procurement, maintenance, and replenishment of materials, equipment, and supplies, in 272 such quantities and at such location as the Coordinator of Emergency Management may deem necessary 273 to protect the public peace, health, and safety and to preserve the lives and property and economic well-274 being of the people of the Commonwealth; and

275 3. For costs and expenses incurred by the Department of Emergency Management or by any 276 other state agency or political subdivision or other entity, acting at the direction of the Coordinator of 277 Emergency Management, in the recovery from the effects of a disaster or in the restoration of public 278 property or facilities.

279 The Coordinator of Emergency Management shall promptly seek reimbursement from any 280 person causing or contributing to an emergency or disaster for all sums disbursed from the fund for the 281 protection, relief and recovery from loss or damage caused by such person. In the event a request for 282 reimbursement is not paid within ~~sixty~~ 60 days of receipt of a written demand, the claim shall be 283 referred to the Attorney General for collection. The Coordinator of Emergency Management shall be 284 allowed to recover all legal and court costs and other expenses incident to such actions for collection. 285 The Coordinator is authorized to recover any sums incurred by any other state agency or political 286 subdivision acting at the direction of the Coordinator as provided in this paragraph.

287 § 44-146.23. Immunity from liability.

288 A. Neither the Commonwealth, nor any political subdivision thereof, nor federal agencies, nor 289 other public or private agencies, nor, except in cases of willful misconduct, public or private employees, 290 nor representatives of any of them, engaged in any emergency services activities, while complying with 291 or attempting to comply with this chapter or any rule, regulation, or executive order promulgated

292 pursuant to the provisions of this chapter, shall be liable for the death of, or any injury to, persons or
293 damage to property as a result of such activities. The provisions of this section shall not affect the right
294 of any person to receive benefits to which he would otherwise be entitled under this chapter, or under
295 the Workers' Compensation Act (§ 65.2-100 et seq.), or under any pension law, nor the right of any such
296 person to receive any benefits or compensation under any act of Congress. For the purposes of the
297 immunity conferred by this subsection, representatives of public or private employees shall include, but
298 shall not be limited to, volunteers in state and local services who are persons who serve in a Medical
299 Reserve Corps (MRC) unit or on a Community Emergency Response Team (CERT).

300 B. Any person owning or controlling real estate or other premises who voluntarily and without
301 compensation grants a license or privilege, or otherwise permits the designation or use of the whole or
302 any part or parts of such real estate or premises for the purpose of sheltering persons, of emergency
303 access or of other uses relating to emergency services shall, together with his successors in interest, if
304 any, not be liable for negligently causing the death of, or injury to any person on or about such real
305 estate or premises or for loss of or damage to the property of any person on or about such real estate or
306 premises during such actual or impending disaster.

307 C. If any person holds a license, certificate, or other permit issued by any state, or political
308 subdivision thereof, evidencing the meeting of qualifications for professional, mechanical, or other
309 skills, the person, without compensation other than reimbursement for actual and necessary expenses,
310 may ~~gratuitously~~ render aid involving that skill in the Commonwealth during a disaster, and such person
311 shall not be liable for negligently causing the death of, or injury to, any person or for the loss of, or
312 damage to, the property of any person resulting from such ~~gratuitous~~ service.

313 D. No person, firm or corporation which gratuitously services or repairs any electronic devices or
314 equipment under the provisions of this section after having been approved for the purposes by the State
315 Coordinator shall be liable for negligently causing the death of, or injury to, any person or for the loss
316 of, or damage to, the property of any person resulting from any defect or imperfection in any such
317 device or equipment so gratuitously serviced or repaired.

318 E. Notwithstanding any law to the contrary, no individual, partnership, corporation, association,
319 or other legal entity shall be liable in civil damages as a result of acts taken voluntarily and without
320 compensation in the course of rendering care, assistance, or advice with respect to an incident creating a
321 danger to person, property, or the environment as a result of an actual or threatened discharge of a
322 hazardous substance, or in preventing, cleaning up, treating, or disposing of or attempting to prevent,
323 clean up, treat, or dispose of any such discharge, provided that such acts are taken under the direction of
324 state or local authorities responding to the incident. This section shall not preclude liability for civil
325 damages as a result of gross negligence, recklessness or willful misconduct. The provisions of this
326 section shall not affect the right of any person to receive benefits to which he would otherwise be
327 entitled under this chapter, or under the Workers' Compensation Act (§ 65.2-100 et seq.), or under any
328 pension law, nor the right of any such person to receive any benefits or compensation under any act of
329 Congress. The immunity provided by the provisions of this paragraph shall be in addition to, not in lieu
330 of, any immunities provided by § 8.01-225.

331 § 59.1-526. Definitions.

332 As used in this chapter:

333 "Disaster" means any "~~natural~~ disaster," ~~"man-made disaster,"~~ "emergency," or "major disaster,"
334 as those terms are used and defined in § 44-146.16, that results in the declaration of a state of emergency
335 by the Governor or the President of the United States.

336 "Goods," "services," and "supplier" have the same meanings as are set forth for those terms in §
337 59.1-198.

338 "Necessary goods and services" means any necessary good or service for which consumer
339 demand does, or is likely to, increase as a consequence of the disaster, and includes, but is not limited to,
340 water, ice, consumer food items or supplies, property or services for emergency cleanup, emergency
341 supplies, communication supplies and services, medical supplies and services, home heating fuel,
342 building materials and services, tree removal supplies and services, freight, storage services, housing,
343 lodging, transportation, and motor fuels.

344 "Time of disaster" means the shorter of (i) the period of time when a state of emergency declared
345 by the Governor or the President of the United States as the result of a ~~natural~~ disaster, ~~manmade~~
346 ~~disaster,~~ emergency, or major disaster, as those terms are used and defined in § 44-146.16, is in effect or
347 (ii) 30 days after the occurrence of the ~~natural~~ disaster, ~~manmade disaster,~~ emergency, or major disaster
348 that resulted in the declaration of the state of emergency; however, if the state of emergency is extended
349 or renewed within 30 days after such an occurrence, then such period shall be extended to include the 30
350 days following the date the state of emergency was extended or renewed.

351 #

SUMMARY

Health care provider liability protections. Provides that, in the absence of gross negligence or willful misconduct, health care providers who respond to a disaster are immune from civil liability for any injury or wrongful death arising from the delivery or withholding of health care. This immunity only applies if a state or local emergency has been or is subsequently declared in response to such a disaster. This bill further provides that the failure of a health care provider to deliver the same level or manner of care that would be delivered under nondisaster circumstances does not constitute a breach of duty by such provider where the failure results from a lack of necessary resources. The bill also allows persons who hold licenses or certificates evidencing their professional or mechanical skills who render aid involving that skill during a disaster to receive reimbursement for their actual and necessary expenses. The bill also combines the definitions of the terms "man-made disaster" and "natural disaster" as contained in the Commonwealth of Virginia Emergency Services and Disaster Law of 2000 into the term "disaster" and adds the term "communicable disease of public health threat" to the definition. The bill also expands when immunity attaches for health care providers who abandon patients in order to respond to a disaster to include disasters, emergencies, and major disasters. This bill also makes technical amendments.