

## The Greatest Good for the Greatest Number: Implications of Altered Standards of Care

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### I. Overview

Most experts, scholars, and healthcare providers agree that during a disaster or emergency in which there are mass casualties, healthcare facilities will not be able to provide the level of care to which they are accustomed. Instead, hospitals will be forced to implement “altered” standards of care as a way of dealing with shortages of personnel, equipment, and time. While the term “altered” standards of care has not been defined, it is a recognized concept in the emergency response and preparedness field.

The Agency for Healthcare Research and Quality (AHRQ) has issued a report entitled *Altered Standards of Care in Mass Casualty Events* in which they assume “altered” standards to mean “a shift to providing care and allocating scarce equipment, supplies, and personnel in a way that saves the largest number of lives in contrast to the traditional focus on saving individuals.<sup>1</sup> Like AHRQ, the Homeland Security Council chose not to define an “altered” standard of care in the Implementation Plan for the National Strategy for Pandemic Influenza, opting instead to conclude that “the standard of care will be met [during a pandemic] if resources are fairly distributed and are utilized to achieve the greatest benefit.”<sup>2</sup>

The Joint Commission on Accreditation of Healthcare Organizations, in its report *Healthcare at the Crossroads: Strategies for Creating and Sustaining Community-wide Emergency Preparedness Systems*, recognizes that healthcare providers should be prepared to implement systems that will allow for a “graceful degradation” of care as opposed to a catastrophic failure of services in disasters.<sup>3</sup> One aspect of a “graceful degradation” may mean that care and access to caregivers is rationed to prevent the provider from becoming completely “incapacitated and unable to deliver care of any kind.”<sup>4</sup>

There is no consensus about what is meant by “altered” standards of care. One common characteristic of any “altered” standard discussion, including the three discussed above, is the recognition that, during an emergency or disaster in which there are mass casualties, there will be a shortage of critical resources. The response to such a shortage will necessarily involve rationing. “Altered” standard of care discussions, then, are really discussions about how hospitals and other healthcare providers will allocate scarce critical resources in the face of mass casualties. It is in this context that the remainder of this paper will use the term “altered” standard of care.

American healthcare providers are unaccustomed to explicit discussions of rationing care. This makes it difficult to embrace this idea in their emergency preparedness planning. For some providers, this reluctance has turned into planning paralysis.<sup>5</sup> To help providers begin to

grapple with this complex issue, this article presents an overview of significant issues that will be implicated by the need for “altered” standards of care and one state’s mechanism for addressing these issues.

### II. Medical Malpractice Liability for Using “Altered” Standards of Care

In our litigious society, healthcare providers are understandably concerned about potential legal liability for the care they render on a daily basis. These providers understand that they have a duty to render care in accordance with the applicable standard of care. Failure to do so can result in malpractice liability. “Altered” standards of care, which by definition do not meet the traditional standard of care, implicate and exacerbate these concerns so much so that some healthcare providers have indicated that they will not provide care in a setting where “altered” standards are required.

But are these fears well founded? The fact is that there has not been significant litigation against healthcare providers in the wake of recent emergencies and disasters. Indeed, a thorough search of case law reveals no reported cases for medical malpractice cases arising out of emergency or disaster circumstances like the Oklahoma City bombing in 1995, September 11th, the series of hurricanes that devastated Florida in 2004, and most recently Hurricanes Katrina and Rita. There are anecdotal reports that malpractice claims have been filed in the wake of Hurricane Katrina, but the ultimate disposition of these cases may be years away.<sup>6</sup>

It is possible that disaster victims and their family members are not inclined to sue for care rendered because they realize that under the circumstances, medical professionals are doing the very best that they can.

While this may reassure some, most in the medical field remain wary. As a result, we must then determine whether the law will hold providers liable for implementing “altered” standards of care during a disaster. Healthcare providers are required to comply with the applicable standard of care when rendering medical services. Failure to comply with this standard is a breach of the provider’s duty to the patient and may give rise to malpractice liability. The legal “standard of care” that is applied in medical malpractice cases is a creature of state statute. That being said, most state statutes require practitioners to render care using that degree of skill and diligence used by a reasonably prudent practitioner in the same specialty under similar circumstances.<sup>7</sup>

The fact that the legal standard of care accounts for the circumstances under which the care was rendered bodes well for providers as it is the emergency or disaster *circumstances* surrounding the care rendered that gave rise to the need to employ an “altered” standard of care. Presumably, so long as providers can prove that they acted like a reasonably prudent provider in the midst of a disaster, they will not have breached their duty and will not be held liable for malpractice. To ensure that these circumstances become part of the case, providers should ensure that whenever “altered” standards of care become necessary,

the circumstances are appropriately and thoroughly documented. Documentation is difficult in the best of situations; therefore, hospitals should include in their disaster planning policies, procedures, and templates to help ensure that this documentation will be created even in the midst of the disaster.

Because in most medical malpractice cases lay juries cannot be expected to know how “reasonably prudent” doctors would have treated the plaintiff, expert testimony is required to educate and assist the jury in its decision-making.<sup>8</sup> When the conduct in question is clearly negligent, as in a case where a defendant doctor leaves a hypodermic needle in the plaintiff’s neck at the close of surgery and it is not discovered until months later, courts may not require expert testimony to establish a standard of care.<sup>9</sup> In most cases, however, expert testimony is typically presented by the plaintiff to establish the appropriate standard of care, a deviation from that standard, and that such deviation was the proximate cause of the plaintiff’s injury and damages.<sup>10</sup> The defendant, of course, presents his own experts to rebut those experts presented by the plaintiff.

As in the typical malpractice case, in an “altered” standard of care malpractice case, the parties will be required to present expert testimony. This requirement may present a significant problem for both the plaintiff and the defendant, as there are no real experts because “altered” standards of care are used infrequently, if at all. To the extent “altered” standards of care are formally created and promulgat-

ed, however, those who take part in the creation of the standard will likely become the experts. This is a significant issue to keep in mind when choosing the individuals who will craft “altered” standards.

### III. Emergency Services and Disaster Law Protections

There are various tools that are currently available and that hospitals can use to assuage liability concerns connected to the use of “altered” standards of care. In addition to the use of policies, procedures, and templates discussed above, a declaration of emergency under a state’s Emergency Services and Disaster Law may provide protection for healthcare providers who must employ an “altered” standard of care in the face of an emergency or disaster.

Emergency Services and Disaster Laws typically set forth the statutory framework for the Governor and the executive heads or governing bodies of the political subdivisions of the state to deal with emergency situations caused by major, natural, or man-made disasters or a local emergency. Among their stated purposes, these laws confer upon the state’s Governor specific emergency powers, including the ability to proclaim and publish rules, regulations, and orders as are needed to respond to the emergency. In some states, this power to proclaim rules also includes the power to waive state law and control, restrict, or allocate resources as part of the state’s emergency response. A state’s emergency response to a mass casualty disaster will surely include the provision of healthcare services. Because “altered”

standards of care are designed to allocate scarce medical resources, it may be reasonable to think that the Governor could proclaim an “altered” standard of care through an emergency declaration.

The content of such a declaration will be uncertain until it is actually issued in the midst of an emergency. There is infinite variation on how these declarations could be worded, ranging from a generic statement that, as a result of the emergency conditions and resulting scarcity of resources, “altered” standards of care will be implemented in affected jurisdictions to a much more specific articulation of actual “altered” standards of care. This variability in the content of emergency declarations gives little comfort to healthcare providers.

The key point is that the specific content of the Governor’s emergency declaration will determine its legal significance. General statements about “emergency conditions” may be too broad to have any significant legal effect. Emergency declarations that are very specific and impose “altered” standards could be beneficial for the following reasons:

- It would definitively establish an “altered” standard of care for healthcare providers within the area of the declared emergency, negating the need for expert testimony on this subject during a malpractice case. Experts would still be needed to opine on whether the physician’s actions complied with the “altered” standard established by the declaration.
- It may cloak healthcare providers complying with the “altered” standard with a

shield of immunity. Under many Emergency Services and Disaster Laws, those complying with the law, emergency declarations, or engaged in emergency services activities will be immune from liability for injury to persons or property that results from such activities. Healthcare providers within the affected areas who comply with the “altered” standard of care issued by the Governor through a declaration of emergency would presumably be able to take advantage of this type of immunity.

- It would ensure that healthcare providers across affected areas were all providing the same care to similar patients. Since theoretically no patient will receive less care than any other patient, it may be difficult for individual patients to prove negligence.

Healthcare providers should begin discussing solutions to the “altered” standard of care issue, including embarking on discussions with the Governor’s office as to the exact content of such a declaration and creating template declarations that can be quickly completed in the midst of an emergency.

### IV. Scope of Practice

One key component of a standard of care is personnel—who will provide the needed care? During an emergency or disaster, there will be a shortage of personnel at all levels. As a result, physician assistants may be required to perform procedures that are usually only done by physicians. Nurses may have to perform tasks traditionally

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within the bailiwick of physician assistants. Licensed practical nurses may perform as registered nurses. Having these healthcare providers perform tasks historically outside the scope of their practice may be necessary to be a part of any “altered” standard of care, but it still presents a host of concerns.

Liability is of course a concern for these health professionals. The protection tools previously discussed can also be used to protect all types of healthcare providers who are forced to practice under an “altered” standard of care. In addition to this concern, healthcare providers who render care outside the scope of their practice can be subject to disciplinary proceedings through their respective Boards. To avoid this situation, the Governor may waive the statutory and regulatory requirements related to the licensure of health professionals during a state of emergency or declared disaster. Along these same lines, the health boards may be able to use emergency procedures to expand the scope of practice to encompass new tasks necessitated by the “altered” standards of care. If any of these courses of action will be undertaken during an emergency or disaster situation, it is important that the details be discussed now, before the “altered” standard of care is necessary.

### **V. Reimbursement**

Hospitals are understandably concerned about liability for healthcare providers practicing outside of their traditional scope of practice, but they are also concerned about the resulting reimbursement issues. For some procedures, hospitals can obtain reimbursement from insurers,

including Medicare and Medicaid, only if a physician performed the procedure. Where this is not feasible in the midst of a disaster and a nurse or physician assistant performs the task instead, the hospital may not be reimbursed. If this happens for the duration of the disaster, the hospital could find itself in serious financial trouble. Resolution of this issue will likely require federal intervention.

Hospitals also understand that documentation of care rendered is critical when seeking payment from insurers. Proper documentation is difficult to maintain during the best of times in a hospital. It will be infinitely more difficult to maintain this during an emergency or disaster. Understandably, healthcare providers will be focused on delivering the best care to the greatest number of individuals, not with thoroughly documenting this care in the chart. Indeed, events may be unfolding so rapidly that a traditional “chart” does not even exist at the time the care is rendered. It is crucial that hospitals institute policies, procedures, and practices that will help providers document care while not detracting from their ability to render it.

### **VI. Determining the Content of an “Altered” Standard of Care—Virginia’s Approach**

While it is commonly recognized within the healthcare industry that “altered” standards of care will have to be employed during a disaster, the exact nature of those standards is far from understood. Each disaster situation is unique, as is each healthcare community. This makes it

difficult to formulate “altered” standards of care in advance.<sup>11</sup> Instead, some are suggesting that it will be most beneficial to design a *process* for identifying the content of such standards. That process can then be utilized to develop “altered” standards as the need arises.

This is the exact approach that the Virginia Department of Health (VDH), in conjunction with the Virginia Hospital and Healthcare Association (VHHA), has chosen to take. Recognizing that issues surrounding “altered” standards of care were a significant concern for Virginia healthcare facilities, VDH used a portion of its Health Resources Services Administration emergency preparedness funds to engage Troutman Sanders to address these issues.

Troutman Sanders, in partnership with VDH and VHHA, formed an “altered” standard of care work group composed of individuals from across the state who represent various healthcare institutions, clinician groups, emergency planning bodies, and the state government. The collaborative product of this work group, developed over a period of several months, is a “Critical Resource Shortage Planning Guide” that healthcare facilities can use to help them begin thinking about “altered” standard issues now, before a disaster strikes.

The Planning Guide explicitly recognizes that healthcare facilities have varying capabilities and resources, which materially affect how best to respond to disasters. It provides a common process that facilities can follow to begin to identify which resource shortages are most like-

ly to occur, when a resource shortage has occurred, which principles should inform allocation decisions and how those principles can be translated and reflected in the care rendered during a disaster. This proactive planning is likely to be a key element of a successful defense against any potential malpractice action.

### **VII. Conclusion**

During a mass casualty disaster, there will be a shortage of resources that are necessary to provide the medical care to which most are accustomed. To deal with these shortages, providers will have to allocate resources in some systematic manner. While these shortages are relatively foreseeable, many providers have not started planning for this eventuality because of the numerous, complex issues that are an inextricably linked to “altered” standards of care. These issues, including liability, scope of practice, and reimbursement, must be addressed in each state to allow providers to move forward with their important emergency preparedness activities.

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*Endnotes*

<sup>1</sup> *Altered Standards of Care in Mass Casualty Events*. Prepared by Health Systems Research Inc. under Contract No. 290-04-0010. AHRQ Publication No. 05-0043. Rockville, MD: Agency for Healthcare Research and Quality. April 2005. (AHRQ Report)

<sup>2</sup> *National Strategy for Pandemic Influenza: Implementation Plan*. Homeland Security Council (May 2006) at 110.

<sup>3</sup> Available at [www.astho.org/pubs/Emergencypreparedness3-12-03.pdf](http://www.astho.org/pubs/Emergencypreparedness3-12-03.pdf) (page 26).

<sup>4</sup> *Id.*

<sup>5</sup> AHRQ Report at 23.

<sup>6</sup> Certainly, there has been post-Katrina litigation including health-care facilities. At least one civil claim has been filed seeking to recover for a healthcare facility's failure to maintain electrical power. [*Estate of John Dunn v. Tenet Mid-City Medical, LLC*, No. 2006-2341 (La. filed March 21, 2006)] Additionally, the Louisiana state criminal prosecutor's allegations of provider misconduct have been well publicized. [Associated Press, "Doctor, 2 nurses held in Katrina deaths," 2006 Jul 18, <http://msnbc.msn.com/id/13916867/from/ET/> (last visited Oct 20, 2006).] None of those cases, however, are based upon traditional medical malpractice theories.

<sup>7</sup> See Virginia Code § 8.01-581.20.

<sup>8</sup> See *Beverly Enterprises-Virginia, Inc. t/a, ETC. v. Nichols*, 247 Va. 264, 267, 441 S.E.2d 1, 3 (1994).

<sup>9</sup> See *Dickerson v. Fatehi*, 253 Va. 324, 484 S.E.2d 880 (1997).

<sup>10</sup> See *Bryan v. Burt*, 254 Va. 28, 486 S.E.2d 536 (1997).

<sup>11</sup> Hick JL, O'Laughlin, DT. "Concept of Operations for Triage of Mechanical Ventilation in an Epidemic." *Acad Emerg Med*. 2006 Feb; 13(2): 195-8.

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