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On October 23, 2009, President Obama declared a national emergency[1] in response to the 2009 influenza A(H1N1) pandemic. The president's declaration followed the US Department of Health and Human Services' (HHS) prior declaration of a public health emergency in April 2009.[2] Together, these declarations changed the legal landscape for influenza A(H1N1) response efforts domestically. HHS Secretary Kathleen Sebelius, for example, was authorized to waive or conditionally set aside or modify certain federal program requirements and disable federal law requiring hospitals to screen patients seeking emergency services on site. These federal responses and several state-based emergency declarations are intended to help clinicians handle surges of patients with flu symptoms and other conditions.

Through what the Institute of Medicine (IOM) has recently framed "crisis standards of care,"[3] health care practitioners (eg, physicians, nurses, counselors) adapt medical standards of care to screen and treat increasing numbers of patients and manage limited resources during severe public health emergencies. Changing medical standards, however, leads to some uncertainty in practice and corresponding unpredictability in how legal decision makers may judge the performance of health care practitioners in crises.[4]

Emergency laws provide liability protections for some health care practitioners and many volunteers.[5] Yet, for many clinicians and health care entities lacking immunity during emergencies, questions of liability are pervasive. These clinicians and entities may be unsure about how legal decision makers may judge their actions if patients are harmed stemming from adjustments to the medical standard of care in emergencies. Medical malpractice claims have typically not proliferated in emergencies. However, fears of liability may deter clinicians and hospitals from affirmative responses to protect patients and the public's health—especially given highly publicized cases such as those involving physicians' actions during Hurricane Katrina.[6] To assist medical and judicial responders, we propose a new framework for assessing legal standards of care in emergencies that seeks to balance practitioner, patient, and community needs.

Existing Legal Standards of Care

Nationally, clinicians are obligated to conform to medical standards of care in the provision of health services. Medical standards of care reflect the types and levels of medical care and practices appropriate for each profession.[3] In nonemergencies, these standards are based largely on professional requirements and norms; are established by professional societies, government agencies, accrediting organizations, and other entities; and vary among types of facilities (eg, hospitals, assisted living facilities, clinics).[7] In emergencies, medical standards of care can fluctuate to allow for rapid changes in practices as circumstances evolve.

When determining liability, legal decision makers assess a clinician's practices against the prevalent legal standard of care. As with medical standards, there is no single legal standard of care nationally. Most state courts use the national standard of care as the legal barometer of care that a clinician should provide. At the state level, the legal standard of care is based on what a reasonable and prudent practitioner of the same specialty nationally would do under similar circumstances. Some state courts will also consider a practitioner's access to available resources (eg, medical equipment, facilities, specialists) in determining whether appropriate care was given under this standard. A minority of states refer to the locality rule, which assesses what a reasonable practitioner in the same or similar locality would do under the circumstances.[8] Under any of these approaches, a practitioner who deviates from the legal standard of care may face medical malpractice liability for resulting patient harms.[5]

Legal Standard of Care in Public Health Emergencies

In any state, assessing legal standards of care is intrinsically patient-centered, subject to considerable discretion by adjudicators, and highly variable. In nonemergencies, practitioners may find it challenging to adhere to legal standards of care. While the specter of liability may motivate clinicians to practice the best medicine, uncertainty concerning legal standards of care contributes to defensive prac-

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tices that usurp limited resources to protect against liability claims.[9] In emergencies, this challenge escalates. When personnel and other resources are stretched thin, clinicians may be unwilling to adjust their medical practices if courts, arbitrators, and medical malpractice insurers are unwilling to recognize these adjustments in assessing disaster-related claims.

Under current approaches, malpractice claims are assessed as to whether a practitioner acted consistently with how a similarly situated, reasonable practitioner (either nationally or locally) would have treated patients during an emergency.[5] Defining what a reasonable practitioner would do in an emergency is difficult when access to and use of resources differ even within the same locality. Principles of medical triage do not lend to easy determinations of what care is reasonably due and owed when resources are scarce and no patient may receive optimal care. Maintaining comprehensive medical records supporting treatment decisions is arduous. Simply establishing when and for how long a practitioner is responsible for individuals or groups of patients in an emergency is problematic.

There is a better way to adjudge the liability of physicians and other clinicians in emergencies other than applying the same legal formula altered to reflect the crisis situation. To ensure fair, equitable, and consistent provision of limited resources in catastrophic emergencies, practitioners must provide patient care consistent with broader interests of protecting the public's health. Legal standards of care must also shift. Patient liability claims arising from crisis care should not be assessed solely on what a reasonable practitioner would do in similar circumstances. These claims should be examined based on how a practitioner acts consistent with the need to protect community health in accordance with established national and state crisis standards of care plans or real-time emergency practices.

Decisions to restrict, limit, or deny care to specific patients may be warranted by communal needs arising from the emergency—even when these decisions may directly affect patient outcomes. For example, critical decisions underlie whether specific patients facing respiratory failure may access ventilators when supplies are scarce.[10] Unless public health needs and ethical concerns are assessed in setting legal standards of care in allocating ventilators, any practitioner who denies a patient access may arguably be subject to liability. Explicit recognition of how treatment and allocation decisions reflect the interests of protecting patient and public health in setting the legal standard of care precludes practitioners from having to choose between patient health and their own liability.

This approach, which builds on the IOM's crisis standards of care recommendations,[3] seeks to directly incorporate public health interests in setting legal standards of care in disaster situations. It is intended to reflect the careful balance practitioners attempt to achieve in fairly, equitably, and consistently deciding which patients to treat in emergencies and how to treat them. Some may argue that this approach may further insulate medical practitioners from liability claims. No one wants to leave patients harmed through medical mistakes without recourse. However, patient harms stemming from fair treatment and allocation of limited resources are a natural reality in emergencies. These harms should not result in successful liability claims when practitioners meet crisis standards of care. Adjusting legal standards of care to explicitly recognize communal objectives in providing health care in crises empowers physicians and other health care practitioners to use best practices to maximize patient and public health outcomes. Without comprehensive national liability protections for practitioners during catastrophic health emergencies, legislators and courts should support the essential role of health practitioners in providing crisis standards of care that combine public health objectives and effective patient care.

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