

PRINCIPLES AND PRACTICE OF LEGAL TRIAGE DURING PUBLIC HEALTH EMERGENCIES†

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† This article is based in part on James G. Hodge, Jr., *Legal Triage During Public Health Emergencies and Disasters*, 58 ADMIN. L. REV. 627 (2006). The authors acknowledge the editing and research assistance of Meredith Larson, J.D., M.P.H. Candidate, Georgetown and Johns Hopkins Universities, and Researcher, *Centers for Law and the Public's Health: A Collaborative at Johns Hopkins and Georgetown Universities*.

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I. INTRODUCTION

Legal preparedness is an essential component of emergency response.¹ Laws help create the infrastructure through which emergencies are detected, prevented, declared, and addressed. They authorize the performance and nonperformance of various emergency responses and determine the responsibilities of actors at every level of government. Laws determine what constitutes a public health emergency and, accordingly, set forth how response efforts should proceed.² With recent disasters such as Hurricane Katrina still fresh in mind and others like pandemic influenza looming, public health emergency legal preparedness is increasingly the focus of legislative and regulatory activities, and national discourse.³

Assessing the legal environment in declared states of emergency that impact the public's health is a complicated and difficult task. Multiple types of laws, including constitutional provisions, statutes, regulations, executive orders, judicial cases, and compacts, must be interpreted and applied in real time during emergencies.⁴ This requires competence in public health legal preparedness among legal practitioners and the public health workforce.⁵ However, it is not enough simply to understand existing emergency laws. New laws and policies are triggered, authorized, and created

1. Anthony D. Moulton et al., *What Is Public Health Legal Preparedness?*, 31 J.L. MED. & ETHICS 672, 672–83 (2003).

2. James G. Hodge, Jr., *Assessing the Legal Environment Concerning Mass Casualty Event Planning and Response*, in MASS MEDICAL CARE WITH SCARCE RESOURCES: A COMMUNITY PLANNING GUIDE 25, 27–29 (Sally J. Phillips & Ann Knebel eds. 2006), <http://www.ahrq.gov/research/mce/mceguide.pdf> [hereinafter Hodge, *Legal Environment*].

3. See generally David L. Feinberg, *Hurricane Katrina and the Public Health–Based Argument for Greater Federal Involvement in Disaster Preparedness and Response*, 13 VA. J. SOC. POL'Y & L. 596 (2006); Michael Greenberger, *Yes, Virginia: The President Can Deploy Federal Troops to Prevent the Loss of a Major American City from a Devastating Natural Catastrophe*, 26 MISS. C. L. REV. 107 (2006); Joseph G. Jarret & Michele L. Lieberman, "When the Wind Blows": *The Role of the Local Government Attorney Before, During, and in the Aftermath of a Disaster*, 36 STETSON L. REV. 293 (2007); William C. Nicholson, *Seeking Consensus on Homeland Security Standards: Adopting the National Response Plan and the National Incident Management System*, 12 WIDENER L. REV. 491 (2006).

4. See Hodge, *Legal Environment*, *supra* note 2, at 26.

5. See James G. Hodge, Jr. et al., *Assessing Competencies for Public Health Emergency Legal Preparedness*, 36 J.L. MED. & ETHICS (SPECIAL SUPPLEMENT) 28 (2008) [hereinafter Hodge et al., *Competencies*].

by the declaration of an emergency itself.⁶ Major emergencies are complicated by the inevitable convergence of actors in a multitude of areas (e.g., emergency management, public health, environment, law enforcement, security, and healthcare) at all levels of the government and the private sector.⁷

Significant legal and ethical challenges emerge from this convergence. While knowledge of pre-established principles of law and effective planning or training exercises within the public health workforce help answer many issues, other legal problems are not easily solved. No matter how thoroughly conceived or how well drafted, no set of emergency laws can anticipate with specificity the varying needs that will arise in a health-related crisis. Laws that facilitate responses to one part of an emergency may impede effective responses to another. As a result, the legal environment during health-related crises includes numerous potential obstacles and impediments to government responses that improve individual and community health.

Failing to respond to these legal challenges is not an option. During declared states of emergency, public health legal practitioners⁸ must work with non-legal actors (e.g., public health practition-

6. See James G. Hodge, Jr., *Legal Triage During Public Health Emergencies and Disasters*, 58 ADMIN. L. REV. 627, 634–38 (2006) [hereinafter Hodge, *Legal Triage*] (describing various declarations that can be issued at the state and federal levels and how those declarations change their respective legal environments).

7. See Scott E. Robinson et al., *The Development of Collaboration of Response to Hurricane Katrina in the Dallas Area*, 10 J. PUB. WORKS MGMT. & POL'Y 315, 322 (2006); Alison K Thompson et al., *Pandemic Influenza Preparedness: An Ethical Framework to Guide Decision-making*, BMC MED. ETHICS, Dec. 4, 2006, at 1.

8. We define “public health legal practitioners” to include persons at all levels of government who serve as (1) general counsels and their staff employed by public health agencies; (2) Attorneys General and their staff representing public health agencies; (3) tribal, county, and city attorneys representing public health agencies; and (4) academic attorneys who guide, train, and provide consultation to the preceding public health practitioners. See Hodge et al., *Competencies*, *supra* note 5, at 31. Public health practitioners must collaborate with additional legal actors who should be competent in public health emergency legal preparedness. These persons include (1) legislators and judges at the federal, tribal, state, and local levels; (2) general legal counsel in Attorneys’ General and corporation counsels’ offices, departments of emergency management, environment, labor, housing, and other government services; and (3) private-sector counsel representing hospitals, insurers, medical practitioners, and volunteers. Functional knowledge of public health law helps these persons use law effectively during emergencies to collaborate and coordinate responses. *Id.* This Article does not attempt to provide specific legal advice to these actors; rather, it seeks both to demonstrate the complex challenges that inevitably confront those directing law and policy responses during public health emergencies and to provide a conceptual description of a process—what we define as legal triage—for resolving those challenges.

ers, emergency care providers, healthcare workers, and volunteer health personnel) to construct a legal environment that prioritizes issues and solutions to facilitate legitimate public health responses through what we call “legal triage.”⁹ Conceptually, legal triage requires legal practitioners and others to respond to those facets of public health emergencies (1) that are not easily anticipated by existing legal structures, or (2) for which existing statutes or other laws provide only flexible guidance, but not concrete authority or direction.

Though envisioned in the design of current emergency legislation, the need to conduct legal triage is an underappreciated challenge and obligation for those formulating and applying law in real time during public health emergencies. Innovative, coordinated, and rapid responses to the shifting legal environment are as much a part of legal preparedness as what is done in advance of an emergency or thereafter. The ability to combine creativity and real-time improvisation with the fundamental skills and knowledge of public health law is quintessential to the practice of legal triage during public health emergencies.

Assessing the salience and application of legal triage requires understanding the overarching legal framework in which public health emergencies unfold. In Part II, we briefly discuss this legal framework, including major federal and state legislation, as well as a diverse body of regulatory law.¹⁰ Emergency statutes and regulations play an important role in ordering public- and private-sector responses; however, their effectiveness is premised on their ability to dramatically change the legal landscape to promote essential public health responses.¹¹ In Part III, we discuss how these sudden changes lead to gaps, holes, and challenges in emergency legal sys-

9. *See infra* note 131.

10. This legal framework has undergone dramatic changes in recent years following the terrorist attacks of September 11, 2001 and Hurricane Katrina in 2005. A number of laws at the federal level, notably the Pandemic and All-Hazards Preparedness Act, have attempted to reorganize and clarify the federal government’s roles in public health emergencies. *See generally* Pandemic and All-Hazards Preparedness Act, Pub. L. No. 109-417, 120 Stat. 2831 (2006). States have similarly revised antiquated emergency legislation in recent years, introducing new laws specifically focused on public health emergencies, and working to ameliorate legal impediments to effective emergency responses. *See infra* notes 101–113 and accompanying text (describing state legislation based on the Model State Emergency Health Powers Act). Rigid licensing and credentialing laws are an example of the latter: in non-exigent times they ensure a competent healthcare work force, but during emergencies they can restrict the supply of greatly needed out-of-state volunteer physicians. *See infra* text accompanying notes 115–122.

11. *See* Hodge, *Legal Triage*, *supra* note 6, at 628.

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tems, which necessitate legal triage. We define and illustrate the concept of legal triage amidst a diverse set of practical, ethical, and legal considerations, and propose a set of principles to help guide its practice consistent with the need to balance communal and individual interests. In Part IV, we apply legal triage in three specific legal challenges that have arisen during recent public health emergencies: allocation of scarce resources, liability protection for volunteer health practitioners, and interjurisdictional coordination of military personnel. A brief conclusion follows.

II. PUBLIC HEALTH EMERGENCIES

Responding to regional or national public health emergencies requires massive efforts from governmental and non-governmental actors. These efforts are possible only through enhanced, expedited powers and access to vast resources. Emergency statutes and regulations are designed to provide such powers and resources. In so doing, these laws can dramatically reshape the legal environment during declared states of emergency.¹² Non-emergency laws can also play important roles in the resolution of critical questions of law and policy during health catastrophes.

A. *Non-Emergency Laws*

Unless automatically suspended by the declaration of an emergency, routine statutory and regulatory provisions at all levels of government remain effective during exigencies, even though they can greatly interfere with emergency-response efforts. For example, the Privacy Rule, a federal regulation issued pursuant to the Health Insurance Portability and Accountability Act (“HIPAA”), is designed to protect individuals’ interests in health information privacy under normal circumstances. During declared emergencies, however, the Rule can restrict access to critically important, identifiable medical information for both individuals who have been dislocated during a health crisis and healthcare personnel attempting to provide care.¹³ Not surprisingly, during Hurricane Katrina, the Federal Department of Health and Human Services (“DHHS”) tem-

12. See *infra* Part II.B–C.

13. Dominic Mack et al., *Mitigating the Health Effects of Disasters for Medically Underserved Populations: Electronic Health Records, Telemedicine, Research, Screening, and Surveillance*, 18 J. HEALTH CARE FOR POOR & UNDERSERVED 432, 435–36 (2007) (discussing an initiative to create a portable electronic records system for mass evacuations that complies with the HIPAA Privacy Rule).

porarily suspended the full effect of the Privacy Rule for affected populations.¹⁴

Other forms of non-emergency law also have relevance during emergencies. Executive orders at the state and federal levels initiate and mobilize the legal machinery that arises through a declaration of emergency. Case law can influence behavior during public health emergencies.¹⁵ Contracts and memoranda of understanding are consistently used to organize and effectuate emergency responses, as evidenced by the proliferation of assistance compacts among states, local municipalities, hospitals, and others.¹⁶ All these forms of law operate against the ever-present backdrop of federal and state constitutions, which require respect for civil rights and due process even during emergencies (although under less formal constraints).¹⁷

Without detailing all of the myriad non-emergency laws that impact public health emergencies, the diversity of implicated laws illustrates the challenges facing legal practitioners attempting to assess the legal environment in declared emergencies. Laws gov-

14. See Michael O. Leavitt, Secretary of Health and Human Services, Waiver Under Section 1135 of the Social Security Act (Sept. 4, 2005), <http://www.hhs.gov/katrina/ssawaiver.html>.

15. An example of the potential for case law to affect emergency-response efforts is the recent civil and criminal cases involving Dr. Anna Maria Pou. See Susan Okie, *Dr. Pou and the Hurricane—Implications for Patient Care During Disasters*, 358 N. ENG. J. MED. 1 *passim* (2008). The State of Louisiana accused Dr. Pou of euthanizing several patients in a New Orleans hospital during and after Hurricane Katrina. *Id.* at 1. Although Dr. Pou was never formally charged, civil suits concerning her potential liability for the deaths of these patients are ongoing. *Id.* at 1–2. Even if Dr. Pou is eventually absolved of all wrongdoing, the threat of criminal and civil sanctions can deter healthcare workers and volunteers from rendering medical care during declared emergencies. See Michealle Carpenter et al., *Deploying and Using Volunteer Health Practitioners in Response to Emergencies: Proposed Uniform State Legislation Provides Liability Protections and Workers' Compensation Coverage*, 3 AM. J. DISASTER MED. 23, 24 (2008).

16. See Daniel D. Stier & Richard A. Goodman, *Mutual Aid Agreements: Essential Legal Tools for Public Health Preparedness and Response*, 97 AM. J. PUB. HEALTH (SUPPLEMENT 1) S62 (2007); Amy H. Kaji & Roger J. Lewis, *Hospital Disaster Preparedness in Los Angeles County*, 13 ACAD. EMERGENCY MED. 1198, 1201 (2006); Charles C. Branas et al., *Access to Trauma Centers in the United States*, 293 J. AM. MED. ASS'N 2626, 2631 (2005); David A. McEntire & Amy Myers, *Preparing Communities for Disasters: Issues and Processes for Government Readiness*, 13 DISASTER PREVENTION & MGMT. 140, 147 (2004).

17. Cf. Rebecca M. Kahan, *Constitutional Stretch, Snap-Back, & Sag: Why Blaisdell Was a Harsher Blow to Liberty Than Korematsu*, 99 NW. U. L. REV. 1279, 1280–81 (2005) (arguing that even though government powers might expand during emergencies at the expense of constitutional mandates, constitutional mandates should not remain permanently degraded).

erning subjects as diverse as medical licensing, workers' compensation, the environment, privacy, discrimination, health-care access, tort liability, and criminal liability can significantly promote or impede response efforts. Legal practitioners and others who focus only on emergency-specific laws during actual emergencies may fail to appreciate the ongoing role of non-emergency laws during crises.

B. Federal Emergency Laws

As events over the last decade have demonstrated, state and local resources can be easily overwhelmed when health-related catastrophes strike.¹⁸ In such instances, the need for interjurisdictional coordination and assistance is dire. While state and local governments are closer to the front lines of emergency response and expected to respond in organized ways,¹⁹ the federal government is positioned to coordinate and supplement response efforts for regional and national emergencies. Accordingly, an array of federal emergency laws shapes the legal environment during public health emergencies.

A number of federal laws address specific issues that can arise during public health crises.²⁰ The Federal Public Health Security

18. During Hurricane Katrina, local and state emergency-response resources and general local government management resources were compromised when they were needed most.

In fact, the New Orleans Mayor's Office operated out of a Hyatt Hotel for several days after Hurricane Katrina's landfall, unable to establish reliable communications with anyone outside the hotel for nearly forty-eight hours. This meant that the Mayor was neither able to effectively command the local efforts, nor was he able to guide the State and Federal support for two days following the storm. . . . The complete devastation of the communications infrastructure left responders without a reliable network to use for coordinating emergency-response operations. Flooding blocked access to the police and fire dispatch centers in New Orleans; neither 911 service nor public-safety radio communications functioned sufficiently . . . local emergency response officials found it difficult or impossible to establish functioning incident command structures in these conditions. Such structures would have better enabled local response officials to direct operations, manage assets, obtain situational awareness, and generate requests for assistance to State authorities. Without an incident command structure, it was difficult for local leaders to guide the local response efforts, much less command them.

THE WHITE HOUSE, *THE FEDERAL RESPONSE TO HURRICANE KATRINA: LESSONS LEARNED* 37 (2006), available at <http://www.whitehouse.gov/reports/katrina-lessons-learned.pdf> [hereinafter *HURRICANE KATRINA: LESSONS LEARNED*].

19. See Moulton et al., *supra* note 1.

20. There are important distinctions between the terms disaster, emergency, and public health emergency as they are employed as terms of art in the prevailing

and Bioterrorism Preparedness and Response Act of 2002²¹ authorizes the implementation of the National Disaster Medical System (“NDMS”). NDMS is a program that provides and coordinates the rapid deployment of specialized response teams composed of members from various levels of government and the private sector, which can operate self-sufficiently for up to seventy-two hours before reinforcements arrive.²² The Project BioShield Act of 2004²³ establishes the Strategic National Stockpiles (“SNS”)²⁴ of countermeasure drugs and vaccines. The Public Health Threats and Emergencies Act of 2000²⁵ and the Homeland Security Act of 2002²⁶ specify responsibilities of national security–based agencies during exigencies.²⁷ The Food, Drug, and Cosmetic Act²⁸ has been amended to authorize the emergency use of regulated drug products still undergoing testing.²⁹ These amendments allow the FDA to approve potential uses of new or existing drugs that are not fully tested consistent with existing regulatory processes, provided there

statutory frameworks discussed below. To avoid confusion, whenever possible we have tried to use health crisis, incident of exigency, or catastrophe to refer to those instances when an event has occurred that has significantly threatened the public’s health.

21. Pub. L. No. 107-188, 116 Stat. 594 (2002).

22. SARAH A. LISTER, CONGRESSIONAL RESEARCH SERVICE, CRS REPORT FOR CONGRESS: AN OVERVIEW OF THE U.S. PUBLIC HEALTH SYSTEM IN THE CONTEXT OF EMERGENCY PREPAREDNESS 4 (2007), available at <http://www.fas.org/sgp/crs/homsec/RL31719.pdf>.

23. Pub. L. No. 108-276, 118 Stat. 835 (2004).

24. See generally Ctrs. for Disease Control and Prevention, Strategic National Stockpile, <http://www.bt.cdc.gov/stockpile/> (last visited Oct. 9, 2008) (providing background information on the SNS).

25. Pub. L. No. 106-505, 114 Stat. 2314 (2000).

26. Pub. L. No. 107-296, 116 Stat. 2135 (2002).

27. The Homeland Security Act of 2002 created the Department of Homeland Security (“DHS”) with specialized Under Secretaries for Information Analysis and Infrastructure Protection, Science and Technology, Border and Transportation Security, and Emergency Preparedness and Response. See *id.* § 103. The Under Secretary for Emergency Preparedness and Response was subsequently transferred back to DHHS via the Pandemic and All-Hazards Preparedness Act. See *infra* text accompanying notes 77–82.

28. 21 U.S.C.A. §§ 301–399 (West 2008).

29. See 21 U.S.C. § 360bbb-3(a)(1) (2000) (“[T]he Secretary may authorize the introduction . . . of a drug, device, or biological product intended for use in an actual or potential emergency”); § 360bbb-3(a)(2) (“[The Secretary] may authorize an emergency use of a product that . . . is not approved, licensed, or cleared for commercial distribution under a provision of law referred to in such paragraph (referred to in this section as an ‘unapproved product’); or . . . is approved, licensed, or cleared under such a provision, but which use is not under such provision an approved, licensed, or cleared use of the product (referred to in this section as an ‘unapproved use of an approved product’).”).

is a strong public health justification that these drugs may be effective as treatment or prophylaxis.³⁰ Likewise, recently amended provisions of the Social Security Act authorize the emergency waiver of certain requirements of the Emergency Medical Treatment and Labor Act (“EMTALA”),³¹ which would normally require all persons seeking emergency care to be treated by hospitals receiving federal funds, and authorize the waiver of eligibility requirements for Medicaid and Medicare.³²

Most emergency powers at the federal level are concentrated in the Robert T. Stafford Disaster Relief and Emergency Assistance Act (“Stafford Act”),³³ the Public Health Service Act,³⁴ and the Pandemic and All-Hazards Preparedness Act (“PAHPA”).³⁵ In the event of a health crisis, the inception of federal emergency power begins with the declaration of a defined state of exigency. Federal law authorizes three types of emergency declarations: (1) a declaration of general emergency, (2) a declaration of disaster, and (3) a declaration of public health emergency. The first two declarations, which are authorized by the Stafford Act,³⁶ must be issued by the President.³⁷ The declaration of a public health emergency is issued by the Secretary of Health and Human Services pursuant to the Public Health Service Act.³⁸ These declarations grant executive and administrative officials various powers to marshal and distribute resources and spur federal agencies, like the Department of Homeland Security (“DHS”) or DHHS’s Office of the Assistant Secretary of Preparedness and Response (“ASPR”), to actively coordinate interstate efforts. Yet these declarations differ in their effects on the legal environment.

In general, the President can declare a state of emergency under the Stafford Act only after a state governor requests federal assistance “to save lives and to protect property and public health and safety, or to lessen or avert the threat of a catastrophe.”³⁹ What constitutes an emergency is broad and may apply to a wide range of

30. See OFFICE OF COUNTERTERRORISM POLICY AND PLANNING, U.S. Food & Drug Admin., Guidance: Emergency Use Authorization of Medical Products (2007), <http://www.fda.gov/oc/guidance/emergencyuse.html>.

31. 42 U.S.C.A. § 1320b-5 (West 2008).

32. *Id.*; § 1320b-2.

33. 42 U.S.C.A. §§ 5121–5205 (West 2008).

34. 42 U.S.C. § 201 (2000).

35. Pub. L. No. 109-417, 120 Stat. 2831 (2006).

36. See *infra* notes 39–46, 50–55.

37. 42 U.S.C.A. § 5170 (West 2008).

38. See 42 U.S.C.A. § 247d (West 2008).

39. 42 U.S.C.A. § 5122(1) (West 2008).

incidents.⁴⁰ According to the Federal Emergency Management Agency (“FEMA”), the federal government declared states of emergency as a result of thirteen different events in 2007.⁴¹ Of these, nine involved severe winter storms or snow.⁴² The other four declarations were issued in response to wildfires in California, drought in the Federated States of Micronesia, a bridge collapse in Minnesota, and a hurricane in Texas.⁴³ When incidents involve federal property or responsibility, like the bombing of the Alfred P. Murrah Federal Building in Oklahoma City in 1995,⁴⁴ the President can declare an emergency pursuant to the Stafford Act even without a gubernatorial request.⁴⁵ Stafford Act emergency declarations provide the President with expansive power to authorize temporary housing, to provide financial assistance for individuals,⁴⁶ and to issue new rules and regulations.⁴⁷ It also allows the President to appoint a federal coordinating officer⁴⁸ who has broad discretion in carrying out his mandate.⁴⁹

The President can declare a state of disaster pursuant to the Stafford Act upon the request of a governor during a more extreme crisis involving any of the following:

40. A more recent and perhaps unusual example of a Stafford Act emergency declaration was President Clinton’s declaration of a state of emergency in 2000 in New York and New Jersey to contain West Nile Virus. SARAH A. LISTER, CONGRESSIONAL RESEARCH SERVICE, CRS REPORT FOR CONGRESS: THE PUBLIC HEALTH AND MEDICAL RESPONSE TO DISASTERS: FEDERAL AUTHORITY AND FUNDING 4 (2007), *available at* <http://fas.org/sgp/crs/misc/RL33579.pdf> [hereinafter FED. AUTH. & FUNDING].

41. *See* FEMA, 2007 Federal Disaster Declarations, <http://www.fema.gov/news/disasters.fema?year=2007#sev2> (last visited Aug. 31, 2008).

42. *See id.*

43. *See id.*

44. *See generally* Oklahoma City National Memorial & Museum—Official Website, <http://www.oklahomacitynationalmemorial.org/> (last visited Aug. 31, 2008).

45. 42 U.S.C.A. § 5191(b) (West 2008) (stating that the President can declare an emergency, absent a governor’s request, when “the emergency involves a subject area for which, under the Constitution or laws of the United States, the United States exercises exclusive or preeminent responsibility and authority”).

46. *Id.* § 5174 (stating that the President may provide financial or other assistance under this section to those displaced from their homes in the event of a declared emergency).

47. *Id.* § 5164 (describing the broad power of the President to “prescribe such rules and regulations as may be necessary and proper to carry out the provisions of [the] Act”).

48. *Id.* § 5143(a) (requiring the appointment of a federal coordinating officer to operate in the affected area).

49. *Id.* § 5143(b) (granting the federal coordinating officer discretion to employ the powers “as he may deem necessary to assist local citizens and public officials in promptly obtaining assistance to which they are entitled”).

any natural catastrophe (including any hurricane, tornado, storm, high water, wind driven water, tidal wave, tsunami, earthquake, volcanic eruption, landslide, mudslide, snowstorm, or drought), or, regardless of cause, any fire, flood, or explosion, in any part of the United States, which in the determination of the President causes damage of sufficient severity and magnitude to warrant major disaster assistance . . . to supplement the efforts and available resources of States, local governments, and disaster relief organizations in alleviating the damage, loss, hardship, or suffering caused thereby.⁵⁰

Almost all of the Stafford Act disasters declared since January 1, 2008 have been in response to severe storms.⁵¹ When issued, a declaration of disaster grants expansive powers to the President and other federal officials. Federal agencies may help support local and state response efforts, but can also directly coordinate the response efforts of federal agencies, private organizations, and state and local governments.⁵² Accelerated federal assistance can also be provided even in the absence of a specific request.⁵³ Federal officials can modify federal assistance requirements such as Medicaid eligibility requirements.⁵⁴ The President can even deploy resources and personnel from the Department of Defense.⁵⁵

In contrast with Stafford Act declarations, the Public Health Services Act⁵⁶ authorizes DHHS's Secretary to declare a federal public health emergency.⁵⁷ The term "public health emergency" is not specifically defined in the Act. Rather, DHHS's Secretary has wide discretion to determine when "a disease or disorder presents a public health emergency; or . . . a public health emergency, including significant outbreaks of infectious diseases or bioterrorist attacks, otherwise exists."⁵⁸ Upon declaring a public health emergency, the Secretary is authorized to respond appropriately,

50. *Id.* § 5122(2).

51. *See* FEMA, 2008 Federal Disaster Declarations, <http://www.fema.gov/news/disasters.fema?year=2008> (last visited Aug. 31, 2008).

52. 42 U.S.C.A. § 5170a.

53. *Id.*

54. *Id.* § 5141 (stating that "any Federal agency charged with the administration of a Federal assistance program may . . . modify or waive, for a major disaster, such administrative conditions for assistance as would otherwise prevent the giving of assistance under such programs").

55. *Id.* § 5170b(c)(1) (allowing a governor to request assistance from the Department of Defense).

56. 42 U.S.C. § 201 (2000).

57. *See* 42 U.S.C.A. § 247d (West 2008).

58. *Id.* § 247d(a).

including making or entering grants or contracts, providing awards for expenses, and conducting and supporting investigations into the cause, treatment, or prevention of a disease or disorder.⁵⁹ DHHS's Secretary can also access the Public Health Emergency Fund,⁶⁰ waive certain Medicare and Medicaid requirements,⁶¹ and authorize emergency use of medicinal products still undergoing testing.⁶²

The emergency powers that flow from the Stafford and Public Health Service Acts are designed to allow for dynamic responses to health crises. While these powers have been carefully conceived with respect to how they enhance response capabilities, they are not necessarily well integrated.⁶³ Consequently, the potential for confusion and redundancy arises when Stafford Act declarations and a public health emergency declaration overlap. Congress recognized and attempted to resolve this problem with the passage of the Homeland Security Act in 2002.⁶⁴ It centralized federal emergency management functions in a new, single federal agency, DHS.⁶⁵ Pursuant to the Homeland Security Presidential Directive of February 2003, DHS was vested with responsibility to organize federal response capabilities through the formulation of the National Response Plan ("NRP"). The NRP provides an "all-hazards plan"⁶⁶ for managing domestic incidents across all levels of government

59. *See id.*

60. *See id.* § 247d(b).

61. 42 U.S.C.A. § 1320b-5 (West 2008).

62. *See supra* note 30 and accompanying text.

63. The systematic integration of multiple, hierarchical levels of emergency-response agencies, each of which may respond to or be authorized by different state, local, or federal authorities, presents a complex problem for disaster response and may prevent effective handling of large-scale emergencies. *See* Erik Auf der Heide, *Disaster Planning, Part II: Disaster Problems, Issues, and Challenges Identified in the Research Literature*, 14 EMERGENCY MED. CLINICS N. AM. 453, 454 (1996) ("When—as often is the case—these units have different operating procedures, levels of training and equipment, and incompatible radio frequencies and terminology, the situation can become a logistical nightmare. The end-result is that these response organizations may end up operating as best they can individually, but with little overall direction, coordination, or control."); Arnold M. Howitt & Herman B. Leonard, *Katrina and the Core Challenges of Disaster Response*, 30 FLETCHER F. WORLD AFF. 215, 219–20 (2006).

64. Pub. L. No. 107-296, 116 Stat. 2135 (2002).

65. *See* U.S. DEP'T OF HOMELAND SEC., NATIONAL RESPONSE PLAN 9 (2004), <http://www.scd.state.hi.us/documents/nrp.pdf> [hereinafter NAT'L RESPONSE PLAN].

66. An "all-hazards plan" refers to an emergency management framework designed to respond to the types of emergencies most likely to occur but applicable to a wide variety of disasters. *See* WILLIAM L. WAUGH, JR., TERRORISM AND THE ALL-

through prevention, preparedness, response, and recovery activities.⁶⁷ The plan is triggered by a declaration of an “Incident of National Significance”⁶⁸ stemming from actual or anticipated threats or acts of terrorism, major disasters, and other emergencies.⁶⁹

Despite reorganization of federal emergency powers after September 11, 2001, the newly organized system fared poorly during the Gulf Coast Hurricanes of 2005.⁷⁰ During the response to Hurricane Katrina, states of emergency and major disaster were declared pursuant to the Stafford Act on August 27 and August 29, 2005, respectively.⁷¹ Additionally, the Secretary of DHHS declared a public health emergency for Louisiana on August 29.⁷² The next day, August 30, DHS Secretary Michael Chertoff declared that an Incident of National Significance had occurred,⁷³ adding another level

HAZARDS MODEL 1 (2004), <http://training.fema.gov/EMIWeb/downloads/Waugh%20-%20Terrorism%20and%20Planning.doc>.

67. Office of the Press Secretary, The White House, Homeland Security Presidential Directive/HSPD-5 (Feb. 28, 2003), <http://www.whitehouse.gov/news/releases/2003/02/20030228-9.html>; NAT'L RESPONSE PLAN, *supra* note 65, at iii. R

68. “Incidents of National Significance are those high-impact events that require a coordinated and effective response by an appropriate combination of Federal, State, local, tribal, private-sector, and non-governmental entities in order to save lives, minimize damage, and provide the basis for long-term community recovery and mitigation activities.” NAT'L RESPONSE PLAN, *supra* note 65, at 3. R

69. The NRP was recently superseded by the National Response Framework (“NRF”) in March 2008. *See* U.S. DEP'T OF HOMELAND SEC., NATIONAL RESPONSE FRAMEWORK i (2003), <http://www.fema.gov/pdf/emergency/nrf/nrf-core.pdf>. Confusion regarding the implementation of the NRP was a major problem during Hurricane Katrina and remained unresolved in its aftermath. *See* HURRICANE KATRINA: LESSONS LEARNED, *supra* note 18, at 14 (stating that the triggering mechanisms for the implementation of the NRP were unclear). R

70. *See* HURRICANE KATRINA: LESSONS LEARNED, *supra* note 18, at 47 (describing the inability of federal agencies to establish coordinated interagency cooperation). R

71. *Id.* at 27; DANIEL A. FARBER & JIM CHEN, DISASTERS AND THE LAW: KATRINA AND BEYOND 31 (2006).

72. FED. AUTH. & FUNDING, *supra* note 40, at 6 n.14 (“Louisiana received an emergency declaration on August 27, 2006, prior to landfall, which was superceded [*sic*] by a major disaster declaration on August 29, 2006, the day of landfall. The Secretary of HHS also determined that a public health emergency existed in Louisiana, effective August 29, 2006. To further complicate matters, at least two types of assistance to Louisiana citizens—Medicaid and Crisis Counseling Program grants—were based on their evacuation status *from* Stafford major disaster areas, and were available to them in host areas (including other states), some of which did not themselves have major disaster declarations.”). R

73. Michael Chertoff did not declare an incident of national significance until August 30, one day after the hurricane’s landfall. HURRICANE KATRINA: LESSONS LEARNED, *supra* note 18, at 41. R

of complexity by initiating the “relatively new” NRP.⁷⁴ This redundancy of declarations engendered confusion and undermined organizational accountability. In many instances, officials from assisting agencies were unable or unsure of how to deploy their resources because of non-centralized coordination and an absence of the communications needed to foster interagency collaboration.⁷⁵ Similar confusion undermined the assistance efforts of private-sector actors as well.⁷⁶

The public fallout from Hurricane Katrina led to the federal enactment of PAHPA on December 19, 2006.⁷⁷ The principal objective of PAHPA is to improve the effectiveness of response efforts through enhanced organization and more systematic preparedness efforts.⁷⁸ The Act centralizes federal responsibilities and encourages state-based preparedness capacities for public health emergencies. In particular, it resolves the question of “who is in charge”⁷⁹ by identifying DHHS as the lead agency for federal public health and medical responses to public health emergencies.⁸⁰ PAHPA also addresses (1) the need to meet patient surge capacity⁸¹ through the use of volunteer health personnel,⁸² (2) various shortcomings in

74. *See id.* at 53 (“The NRP was relatively new to many at the Federal, State, and local levels before the events of Hurricane Katrina. This lack of understanding of the ‘National’ plan not surprisingly resulted in ineffective coordination of the Federal, State, and local response.”).

75. *See, e.g., id.* at 45 (“Ineffective communications between FEMA and other Federal departments and agencies prevented available Federal resources from being effectively used for response operations.”).

76. *Id.* (“The private sector too met roadblocks in its efforts to coordinate with the Federal government during the response. For example, the American Bus Association spent an entire day trying to find a point of contact at FEMA to coordinate bus deployment without success.”).

77. Pandemic and All-Hazards Preparedness Act, Pub. L. No. 109-417, 120 Stat. 2831 (2006).

78. *See* James G. Hodge, Jr. et al., *The Pandemic and All-Hazards Preparedness Act: Improving Public Health Emergency Response*, 297 J. AM. MED. ASS’N 1708, 1708 (2007).

79. *Id.*

80. Pandemic and All-Hazards Preparedness Act § 101.

81. Patient surge capacity describes the ability of local emergency facilities to accommodate larger-than-normal numbers of casualties in the event of a disaster. *See* John L. Hick et al., *Health Care Facility and Community Strategies for Patient Care Surge Capacity*, 44 ANNALS EMERGENCY MED. 253, 254 (2004).

82. *Cf.* U.S. DEP’T OF HEALTH & HUMAN SERVS., EMERGENCY SYSTEM FOR ADVANCE REGISTRATION OF VOLUNTEER HEALTH PROFESSIONALS (ESAR-VHP)—LEGAL AND REGULATORY ISSUES 8 (Draft report 2006), <http://www.publichealthlaw.net/Research/PDF/ESAR%20VHP%20Report.pdf> [hereinafter ESAR-VHP Draft Report].

national surveillance methods,⁸³ and (3) the development of vaccines and other scarce public health resources.⁸⁴ Future public health emergencies such as an influenza pandemic or incidents of bioterrorism will determine how well the powers vested in DHHS facilitate the resolution of public health challenges during disasters and other public health crises.

C. *State Emergency Laws*

Despite wide variation in state laws governing emergencies, disasters, and public health emergencies, many commonalities exist in legal approaches to addressing catastrophes, due in part to extensive prior and existing efforts to increase uniformity.⁸⁵ As with the federal government, state laws allow certain officials, typically the state's governor, to declare a state of health-related emergency.⁸⁶ However, these declarations differ in significant ways, particularly in how the exigency is defined. Some states may authorize the declaration of specific exigencies, which include "state of war emergency,"⁸⁷ "major emergency,"⁸⁸ "civil preparedness emergency,"⁸⁹ "manmade emergency,"⁹⁰ "natural emergency,"⁹¹ "tech-

83. *See* Pandemic and All-Hazards Preparedness Act § 201(H).

84. *See id.* § 204.

85. *See, e.g.*, UNIFORM EMERGENCY VOLUNTEER HEALTH PRACTITIONERS ACT (Nat'l Conference of Comm'rs on Unif. State Laws 2007), http://www.law.upenn.edu/bll/archives/ulc/uiehsa/2007act_final.pdf; MODEL STATE PUBLIC HEALTH ACT (Pub. Health Statute Modernization Nat'l Excellence Collaborative 2003), <http://www.hss.state.ak.us/dph/improving/turningpoint/PDFs/MSPHAweb.pdf>; MODEL STATE EMERGENCY HEALTH POWERS ACT (Ctr. for Law & the Pub.'s Health at Georgetown & Johns Hopkins Univs., unpublished draft for discussion Dec. 21, 2001), <http://www.publichealthlaw.net/MSEHPA/MSEHPA2.pdf>.

86. *See, e.g.*, KY. REV. STAT. ANN. § 39A.100(1) (West 2008) ("In the event of the occurrence or threatened or impending occurrence of any of the situations or events contemplated by [sections defining emergency in Kentucky], the Governor may declare, in writing, that a state of emergency exists.").

87. ARIZ. REV. STAT. ANN. § 26-301(15) (LexisNexis 2008) ("[T]he condition which exists immediately whenever this nation is attacked or upon receipt by this state of a warning from the federal government indicating that such an attack is imminent.").

88. ARK. CODE ANN. § 12-75-103(13) (West 2008) ("[A] condition which requires the activation of emergency response at the state or local levels, either in anticipation of a severe disaster such as an imminent enemy attack, potential civil disturbance, forecast major natural or human-caused disaster, or actual onset of conditions requiring the use of such forces which exceed the day-to-day response and activities of such forces and requires the coordinating of a complement of local, state, federal, or volunteer organizations.").

89. CONN. GEN. STAT. ANN. § 28-1(7) (West 2008) ("[A]n emergency declared by the Governor under the provisions of this chapter in the event of serious disas-

nological emergency,”⁹² “catastrophe,”⁹³ and “energy emergency.”⁹⁴ In addition, every state also authorizes the declaration of either a “general emergency,” a “disaster,” or both. Currently, thirty-eight states and the District of Columbia legislatively authorize declarations of “emergency.”⁹⁵ Typically, a general emergency

ter or of enemy attack, sabotage or other hostile action within the state or a neighboring state, or in the event of the imminence thereof.”).

90. FLA. STAT. ANN. § 252.34(6) (West 2008) (“[A]n emergency caused by an action against persons or society, including, but not limited to, enemy attack, sabotage, terrorism, civil unrest, or other action impairing the orderly administration of government.”).

91. *Id.* § 252.34(7) (“[A]n emergency caused by a natural event, including, but not limited to, a hurricane, a storm, a flood, severe wave action, a drought, or an earthquake.”).

92. *Id.* § 252.34(9) (“[A]n emergency caused by a technological failure or accident, including, but not limited to, an explosion, transportation accident, radiological accident, or chemical or other hazardous material incident.”).

93. KY. REV. STAT. ANN. § 39A.020(2) (West 2008) (“[A] disaster or series of concurrent disasters which adversely affect the entire Commonwealth of Kentucky or a major geographical portion thereof.”).

94. TEX. GOV'T CODE ANN. § 418.004(3) (Vernon 2008) (“[A] temporary statewide, regional, or local shortage of petroleum, natural gas, or liquid fuel energy supplies that makes emergency measures necessary to reduce demand or allocate supply.”).

95. ESAR-VHP Draft Report, *supra* note 82, at 79–89. The states and District include: Alabama, ALA.CODE § 31-9-3 (LexisNexis 2008); Alaska, ALASKA STAT. § 26.23.900 (2008); Arizona, ARIZ. REV. STAT. ANN. § 26-301 (2008); Arkansas, ARK. CODE ANN. § 12-75-103 (West 2008); California, CAL. GOV'T CODE § 8558 (West 2008); Connecticut, CONN. GEN. STAT. ANN. § 28-1 (West 2008); Delaware, DEL. CODE ANN. tit. 20, § 3102 (2008); the District of Columbia, D.C. CODE ANN. § 7-2301(3) (LexisNexis 2008); Florida, FLA. STAT. ANN. § 252.34 (West 2008); Georgia, GA. CODE ANN. § 38-3-3 (West 2008); Idaho, IDAHO CODE ANN. § 46-1002 (2008); Illinois, 20 ILL. COMP. STAT. ANN. 3305/4 (West 2008); Kentucky, KY. REV. STAT. ANN. § 39A.020 (West 2008); Louisiana, LA. REV. STAT. ANN. § 29:723 (2008); Maryland, MD. CODE ANN., PUB. SAFETY § 14-301 (West 2008); Massachusetts, MASS. GEN. LAWS ANN. ch. 17 § 2A (West 2008); Michigan, MICH. COMP. LAWS ANN. § 30.402(h) (West 2008); Minnesota, MINN. STAT. ANN. § 12.03(3) (West 2008); Mississippi, MISS. CODE ANN. § 33-15-305(d) (West 2008); Missouri, MO. ANN. STAT. § 44.010(6) (West 2008); Montana, MONT. CODE ANN. § 10-3-103(6) (2008); Nebraska, NEB. REV. STAT. ANN. § 81-829.39(3) (LexisNexis 2008); Nevada, NEV. REV. STAT. ANN. § 414.0345 (West 2008); New Hampshire, N.H. REV. STAT. ANN. § 21-P:35 (LexisNexis 2008); New Jersey, N.J. STAT. ANN. § App. A:9-33.1(4) (West 2008); New York, NY EXEC. LAW § 20(2) (McKinney 2008); North Dakota, N.D. CENT. CODE § 37-17.1-04(3) (2008); Ohio, OHIO REV. CODE ANN. § 5502.21(F) (West 2008); Oklahoma, OKLA. STAT. ANN. tit. 63, § 683.3(3) (West 2008); Oregon, OR. REV. STAT. ANN. § 401.025(4) (West 2008); Pennsylvania, *see* 35 PA. STAT. ANN. § 7102 (West 2008); South Carolina, S.C. CODE ANN. § 25-1-430(b) (2008); South Dakota, S.D. CODIFIED LAWS § 33-15-1(3) (2008); Tennessee, TENN. CODE ANN. § 58-2-101(6) (West 2008); Utah, UTAH CODE ANN. § 53-2-102(10) (West 2008); Vermont, VT. STAT. ANN. tit. 20, § 102 (2008); Virginia, VA. CODE ANN. § 44-146.16

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is defined under a broad standard that includes any event or occurrence that immediately threatens the public's health or safety. Missouri, for example, defines an emergency as "the actual occurrence of a natural or man-made disaster of major proportions within [the] state when the safety and welfare of the inhabitants of [the] state are jeopardized."⁹⁶ The statutes of forty-one states currently authorize declarations of "disaster."⁹⁷ The definition of a disaster often focuses on the nature of the incident underlying the emergency (e.g., natural disaster, fire, civil disorder). Missouri defines a disaster as an event that results from "terrorism, including bioterrorism, or from fire, wind, flood, earthquake, or other natural or man-made causes."⁹⁸

Since September 11, 2001, a prominent trend among states has been legislatively to define and authorize the declaration of a "pub-

(West 2008); Washington, WASH. REV. CODE ANN. § 38.52.010 (West 2008); and Wisconsin, WIS. STAT. ANN. § 166.03(1)(b)(1) (West 2008).

96. MO. ANN. STAT. § 44.010(6) (West 2008).

97. The states include: Alaska, ALASKA STAT. § 26.23.900 (2008); Arkansas, ARK. CODE ANN. § 12-75-103 (West 2008); Colorado, COLO. REV. STAT. ANN. § 24-32-2103(1.5) (West 2008); Connecticut, CONN. GEN. STAT. ANN. § 28-1(2) (West 2008); Delaware, DEL. CODE ANN. tit. 20, § 3102 (2008); Florida, FLA. STAT. ANN. § 252.34 (West 2008); Georgia, GA. CODE ANN. § 38-3-3 (West 2008); Idaho, IDAHO CODE ANN. § 46-1002 (2008); Illinois, 20 ILL. COMP. STAT. ANN. 3305/4 (West 2008); Indiana, IND. CODE ANN. § 10-14-3-1 (West 2008); Iowa, IOWA CODE ANN. § 29C.2(1) (West 2008); Kansas, KAN. STAT. ANN. § 48-904(d) (2008); Kentucky, KY. REV. STAT. ANN. § 39A.020(7) (West 2008); Louisiana, LA. REV. STAT. ANN. § 29:723(1) (2008); Maine, ME. REV. STAT. ANN. tit. 37-B, § 703(2) (2008); Michigan, MICH. COMP. LAWS ANN. § 30.402(p) (West 2008); Minnesota, MINN. STAT. ANN. § 12.03(2) (West 2008); Mississippi, MISS. CODE ANN. § 33-15-305(b) (West 2008); Missouri, MO. ANN. STAT. § 44.010(4) (West 2008); Montana, MONT. CODE ANN. § 10-3-103(3) (2008); Nebraska, NEB. REV. STAT. § 81-829.39(2) (LexisNexis 2008); Nevada, NEV. REV. STAT. ANN. § 414.0335 (West 2008); New Jersey, N.J. STAT. ANN. § App. A:9-33.1(1) (West 2008); New Mexico, N.M. STAT. ANN. § 12-11-3(B) (West 2008); New York, NY EXEC. LAW § 20(2)(a) (McKinney 2008); North Carolina, N.C. GEN. STAT. ANN. § 166A-4(1a) (West 2008); North Dakota, N.D. CENT. CODE § 37-17.1-04(1) (2008); Ohio, OHIO REV. CODE ANN. § 5502.21(E) (West 2008); Oklahoma, OKLA. STAT. ANN. tit. 63, § 683.3(7)-(8) (West 2008); Oregon, OR. REV. STAT. ANN. § 401.025(16) (West 2008); Pennsylvania, 35 PA. STAT. ANN. § 7102 (West 2008); Rhode Island, R.I. GEN. LAWS § 30-15-3(1) (2008); South Dakota, S.D. CODIFIED LAWS § 33-15-1(2) (2008); Tennessee, TENN. CODE ANN. § 58-2-101(4) (West 2008); Texas, TEX. GOV'T CODE ANN. § 418.004(1) (Vernon 2008); Utah, UTAH CODE ANN. § 53-2-402(2)(a) (West 2008); Vermont, VT. STAT. ANN. tit. 20, § 102(c)(1) (2008); Virginia, VA. CODE ANN. § 44-146.16 (West 2008); Washington, WASH. REV. CODE ANN. § 38.52.010(6)(a) (West 2008); West Virginia, W. VA. CODE ANN. § 15-5-2(h) (West 2008); Wisconsin, WIS. STAT. ANN. § 166.03(1)(b)(1) (West 2008); and Wyoming, WYO. STAT. ANN. § 19-13-102(ii) (2008).

98. MO. ANN. STAT. § 44.010(4) (West 2008).

lic health emergency.”⁹⁹ As of April 1, 2008, twenty-eight states have done so.¹⁰⁰ In many instances, provisions authorizing the declaration of public health emergencies have developed as part of a larger effort by states to reform their emergency powers consistent with the guidance provided in the Model State Emergency Health Powers Act (“MSEHPA”). MSEHPA was drafted by the *Centers for Law and the Public’s Health* in response to calls for legislative reforms following the anthrax exposures in the Fall of 2001.¹⁰¹ MSEHPA offers model statutory language that incorporates a series of flexible measures to facilitate emergency responses under a high threshold definition of what constitutes a public health emergency.¹⁰² “Public health emergency” is defined in MSEHPA as:

99. Lawrence O. Gostin et al., *The Model State Emergency Health Powers Act: Planning for and Response to Bioterrorism and Naturally Occurring Infectious Diseases*, 288 J. AM. MED. ASS’N 622, 622–23, 625 (2002) (noting that bills based on the Model State Emergency Health Powers Act (“MSEHPA”) have been introduced in thirty-four states and discussing how the MSEHPA authorizes the declaration of a public health emergency).

100. ESAR-VHP Draft Report, *supra* note 82, at 74–78. The states and District include: Alabama, ALA. CODE § 31-9-3(4) (LexisNexis 2008); Alaska, ALASKA STAT. § 18.05.070(2) (2008); Arizona, ARIZ. REV. STAT. ANN. § 36-787 (2008); California, CAL. GOV’T CODE § 8558 (West 2008); Connecticut, CONN. GEN. STAT. ANN. § 19a-131 (West 2008); Delaware, DEL. CODE ANN. tit. 20, § 3132 (2008); the District of Columbia, D.C. CODE ANN. § 7-2304.01 (LexisNexis 2008); Florida, FLA. STAT. ANN. § 381.00315(1)(b) (West 2008); Georgia, GA. CODE ANN. § 38-3-3(6) (West 2008); Illinois, 20 ILL. COMP. STAT. 3305/4 (West 2008); Iowa, IOWA CODE ANN. § 135.140(6) (West 2008); Louisiana, LA. REV. STAT. ANN. § 29:762(12) (2008); Maine, ME. REV. STAT. ANN. tit. 22, § 801 (2008); Maryland, MD CODE ANN., PUB. SAFETY, § 14-3A-01 (West 2008); Massachusetts, MASS. GEN. LAWS ANN. ch. 17, § 2A (West 2008); New Jersey, N.J. STAT. ANN. § 26:13-2 (West 2008); New Mexico, N.M. STAT. ANN. § 12-10A-3(G) (West 2008); North Carolina, N.C. GEN. STAT. ANN. § 130A-475 (West 2008); Oklahoma, OKLA. STAT. ANN. tit. 63, § 6104 (West 2008); Oregon, OR. REV. STAT. ANN. § 433.441 (West 2008); South Carolina, S.C. CODE ANN. § 44-4130(P) (2008); South Dakota, S.D. CODIFIED LAWS § 34-22-41 (2008); Texas, TEX. HEALTH & SAFETY CODE ANN. § 81.003 (Vernon 2008); Utah, UTAH CODE ANN. § 26-23b-102(6) (West 2008); Virginia, *cf.* VA. CODE ANN. § 44-146.16 (West 2008) (“public health threat”); Washington, WASH. REV. CODE ANN. § 70.119A.020 (West 2008); Wisconsin, WIS. STAT. ANN. § 166.02 (West 2008); and Wyoming, WYO. STAT. ANN. § 35-4-115 (2008).

101. MODEL STATE EMERGENCY HEALTH POWERS ACT (Ctr. for Law & the Pub.’s Health at Georgetown & Johns Hopkins Univs., unpublished draft for discussion Dec. 21, 2001), <http://www.publichealthlaw.net/MSEHPA/MSEHPA2.pdf>.

102. In the time between its completion on December 21, 2001 and July 15, 2006, MSEHPA was introduced in whole or in part through bills or resolutions in forty-four states and the District of Columbia. Of these, thirty-seven states and the District of Columbia have passed bills or resolutions that include provisions from or closely related to the MSEHPA. Ctr. for Law & the Pub.’s Health at Georgetown

An occurrence or imminent threat of an illness or health condition that is (1) believed to be caused by . . . bioterrorism, the appearance of a novel or previously controlled or eradicated infectious agent or biological toxin; and (2) poses a high probability of . . . a large number of deaths in the affected population; a large number of serious or long-term disabilities in the affected population; or widespread exposure to an infectious or toxic agent that poses a significant risk of substantial future harm to a large number of people in the affected population.¹⁰³

Once a state of emergency, disaster, or public health emergency is declared under MSEHPA, the governor, public health authorities, and emergency management agencies are granted additional powers and duties. By design, these declarations seek to change, modify, or suspend existing laws and regulations that may interfere with or curtail emergency responses. During a public health emergency declared pursuant to MSEHPA, (1) the government is vested with new and expedited powers, such as the ability of a state's governor to suspend the operation of existing laws that may interfere with effective emergency responses;¹⁰⁴ (2) individuals are entitled to enhanced public health services, such as expedited access to medicines, vaccines, or other resources;¹⁰⁵ (3) responders may be authorized to act in ways that differ from non-emergency situations, including by practicing medicine with out-of-state licenses;¹⁰⁶ and, (4) volunteers and other emergency responders are protected from some forms of civil liability.¹⁰⁷ Underlying these provisions is the flexibility needed to support governmental actors and others acting responsibly and efficiently to protect the public's health.

An unintended consequence of the passage of public health emergency statutes across many states is the potential for states simultaneously to declare a public health emergency in addition to a general emergency or disaster. Thus, the potential for dual decla-

& Johns Hopkins Univs., MSEHPA State Legislative Activity (July, 2006), <http://www.publichealthlaw.net/MSEHPA/MSEHPA%20Leg%20Activity.pdf>.

103. MODEL STATE EMERGENCY HEALTH POWERS ACT § 104(m) (Ctr. for Law & the Pub.'s Health at Georgetown & Johns Hopkins Univs., unpublished draft for discussion Dec. 21, 2001), <http://www.publichealthlaw.net/MSEHPA/MSEHPA2.pdf>.

104. *Id.* § 403(a).

105. *Id.* § 505(d).

106. *Id.* § 608.

107. *Id.* § 804(b).

rations exists not only at the federal level, as discussed above,¹⁰⁸ but also at the state level. Twenty-seven states and the District of Columbia define “general emergency” or “disaster,” and “public health emergency.”¹⁰⁹ The potential to issue dual declarations at the state level exists because the statutory constructs of emergencies, disasters, and public health emergencies are not mutually exclusive. In fact, they often share common components. In Delaware, for example, a *disaster* can be declared when any of a number of man-made or natural events causes “substantial damage to property or the environment, and/or hardship, suffering, injury or possible loss of life;”¹¹⁰ an *emergency* can be declared in any situation that requires government efforts to save lives, to protect property, public health and safety, or to decrease the threat of a disaster;¹¹¹ and a *public health emergency* can be declared when an event occurs that involves bioterrorism, an infectious agent, or the release of a chemical that poses a high probability of numerous deaths, disabilities, or widespread exposure to a dangerous agent.¹¹² An influenza pandemic could, for example, trigger all three declarations simultaneously in Delaware and other states.¹¹³

108. See *supra* notes 70–76.

109. See *supra* notes 95, 96, and 100.

110. A disaster is

a catastrophic condition caused by a man-made event (including, but not limited to, industrial, nuclear or transportation accident, explosion, conflagration, power failure, act of domestic terrorism, natural resource shortage or other condition resulting from man-made causes, such as hazardous materials spills and other injurious environmental contamination), natural event (including, but not limited to, any hurricane, tornado, storm, flood, high water, wind-driven water, tidal wave, earthquake, landslide, mud slide, snowstorm, drought, fire or explosion) or war-caused event (following an attack upon the United States caused by use of bombs, missiles, shellfire or nuclear, radiological, chemical or biological means, or other weapons, or overt paramilitary actions, or other conditions such as sabotage) which results in substantial damage to property or the environment, and/or hardship, suffering, injury or possible loss of life.

DEL. CODE ANN. tit. 20, § 3102(1) (2007).

111. See *id.* § 3102(2) (defining “emergency” as “any situation which requires efforts and capabilities to save lives or to protect property, public health and safety, or to lessen or avert the threat of a disaster in Delaware”).

112. *Id.* § 3132(11).

113. For example, during Hurricane Katrina, the State of Louisiana initially declared a state of emergency on Friday, August 26, 2005 and then declared a state of public health emergency a week later on Friday, September 2 as flooding in New Orleans created a public health catastrophe beyond the initial damage caused by the hurricane itself.

As with dual federal declarations, the legal landscape for emergency responses and protections changes depending on the type of declaration issued. Duplicate state-emergency declarations add redundancy, complexity, and confusion to already muddied channels of communication, control, and accountability. Different state or local agencies may be legislatively or administratively responsible for coordinating simultaneous responses depending on the type of emergency declared. Thus, these statutory enactments can lead to confusion because they may vest similar authorities in divergent governmental agents, fail to set priorities for action when more than one governmental entity is authorized to respond, or grant conflicting powers.

D. Effects of Changing Legal Norms During Declared Emergencies

Public health catastrophes challenge the infrastructure of society and necessitate emergency responses that are supported by a legal landscape that facilitates the protection of the public's health. Declarations of emergency, disaster, and public health emergency are intended to empower the government to act expeditiously with new, expanded authority. However, such declarations also raise legal issues to the extent that they trigger new and sometimes amorphous powers, suspend the applicability of existing laws that may impede governmental responses, and alter the authority and risks of public and private actors.

We argue that legal voids result during declared emergencies because the normally prevailing legal structure, which is carefully calibrated to guide legal actions in non-emergencies, is effectively suspended to allow for flexible emergency responses. Emergency laws like PAHPA, the Stafford Act, and various state statutes require the creation of a new legal environment in real time: one that prioritizes legal responses to promote various public health objectives as they arise. When properly couched with sufficient protections for individual liberties, the effect of MSEHPA¹¹⁴ and most modern emergency laws is to offer broad, discretionary power to government agents and their private-sector partners to respond to exigencies in ways that are efficient, effective, ethical, and legal.

Medical licensing provides an illustrative example of this shift in the legal environment. During non-exigent circumstances, each state's laws feature a carefully formulated policy for educating, testing, and licensing medical personnel.¹¹⁵ Medical licensure is con-

114. See *supra* notes 101–07.

115. See ESAR-VHP Draft Report, *supra* note 82, at 125–44.

tingent on multiple factors that are designed to protect patients by assuring that only highly qualified, vetted individuals are authorized to practice medicine, nursing, and other health professions.¹¹⁶ To meet patient surge capacity during public health emergencies, however, traditional medical licensure provisions may be set aside to allow for immediate licensure reciprocity for out-of-state medical personnel.¹¹⁷ While the potential for harm to the public from unscrupulous actors posing as out-of-state licensed medical practitioners exists, the need for immediate health services justifies rapid assessments of medical personnel to assure that qualified personnel are quickly ready to serve.¹¹⁸

Although flexibility and discretion are important elements of legal responses to public health emergencies, they carry significant risks. Flexibility, though necessary during an emergency, can enable inadvertent misuses and deliberate abuses of extraordinary governmental powers. These concerns are amplified by the scale and the extreme nature of the governmental measures needed to respond to health crises. For example, in the event of a biological attack or the outbreak of a highly contagious disease, it is anticipated that specific social-distancing measures (e.g., quarantine, iso-

116. William C. McGaghie, *The Evaluation of Competence: Validity Issues in Health Professions*, 3 EVALUATION & HEALTH PROFS. 289, 292–300 (1980) (discussing the history and operation of certifying and licensing health professionals).

117. See *supra* note 106 and accompanying text; see also Emergency Management Assistance Compact, Pub. L. No. 104-321, § 1, 110 Stat. 3877, 3877–82 (1996) (providing an example of an agreement among states that provides for mutual assistance in responding to and training for emergency situations). Article V of EMAC provides for licensure reciprocity:

Whenever any person holds a license, certificate, or other permit issued by any state party to the compact evidencing the meeting of qualifications for professional, mechanical, or other skills, and when such assistance is requested by the receiving party state, such person shall be deemed licensed, certified, or permitted by the state requesting assistance to render aid involving such skill to meet a declared emergency or disaster, subject to such limitations and conditions as the Governor of the requesting state may prescribe by executive order or otherwise.

§ 1, 110 Stat. at 3880.

118. James G. Hodge, Jr., Raymond P. Pepe & William H. Henning, *Voluntarism in the Wake of Hurricane Katrina: The Uniform Emergency Volunteer Health Practitioners Act*, 1 DISASTER MED. & PUB. HEALTH PREPAREDNESS 44, 44–45 (2007) (noting the influx of volunteer health professionals to hurricane-impacted areas, the need for volunteers, and the difficulty in assessing the legality of deploying and using volunteers).

lation, curfews, closure of schools or public places)¹¹⁹ may be used by government to limit population exposures to infectious agents. Implementing social-distancing measures, however, implicates fundamental individual rights to associate, assemble, and travel.¹²⁰ The potential for discrimination in these and other measures is daunting.¹²¹ Even when rights are respected, these and other efforts may produce unexpected and unintended problems.¹²² Balancing these concerns with those regarding response efforts requires effective, real-time emergency legal decision making.

119. See Robert J. Glass et al., *Targeted Social Distancing Design for Pandemic Influenza*, 12 EMERGING INFECTIOUS DISEASES 1671, 1675–80 (2006), available at <http://www.cdc.gov/ncidod/EID/vol12no11/pdfs/06-0255.pdf>.

120. Quarantine and isolation inherently challenge fundamental civil liberties. See, e.g., Joseph Barbera et al., *Large-Scale Quarantine Following Biological Terrorism in the United States: Scientific Examination, Logistic and Legal Limits, and Possible Consequences*, 286 J. AM. MED. ASS'N 2711, 2713 (2001); Wendy E. Parmet et al., *Individual Rights Versus the Public's Health—100 Years After Jacobson v. Massachusetts*, 352 NEW ENG. J. MED. 652, 654 (2005) (noting that drastic public health measures like forced vaccination, isolation, and quarantine implicate fundamental liberty concerns that are in tension with constitutionally mandated limits on state power).

121. The potential misuse of quarantine powers has been demonstrated in quarantine of ethnic minorities, see, e.g., Felice Batlan, *Law in the Time of Cholera: Disease, State Power, and Quarantines Past And Future*, 80 TEMPLE L. REV. 53, 53–122 (2007) (noting the historical use and abuse of quarantine powers in the United States and abroad and describing how quarantine powers have at times been employed in racially discriminatory manners against ethnic minorities), and the proposed quarantine of homosexuals and others with HIV/AIDS, see Wendy Parmet, *AIDS and Quarantine: The Revival of an Archaic Doctrine*, 14 HOFSTRA L. REV. 53, 53–90 (1985) (discussing the proposed use of quarantine powers against those with HIV/AIDS in the early years of the AIDS epidemic).

122. See Lawrence Gostin, *Public Health Strategies for Pandemic Influenza: Ethics and the Law*, 295 J. AM. MED. ASS'N 1700, 1702–03 (2006) (discussing the legal and ethical implications of social distancing); John P. Middaugh, *Pandemic Influenza Preparedness and Community Resiliency*, 299 J. AM. MED. ASS'N 566, 567 (2008) (discussing other potential unintended consequences of quarantine and noting that social-distancing programs can have an unexpected negative impact on social resiliency and community cohesion); Sarah H. Sutton & Alison Thompson, *"I'm Sorry but You Can't Leave": Patients, Physicians, and Quarantine*, 8 VIRTUAL MENTOR 201 (2006), available at <http://virtualmentor.ama-assn.org/2006/04/pdf/ccas2-0604.pdf>; JAMES G. HODGE, JR. ET AL., LEGAL PREPAREDNESS FOR SCHOOL CLOSURES IN RESPONSE TO PANDEMIC INFLUENZA AND OTHER EMERGENCIES (2008), available at <http://www2a.cdc.gov/phlp/docs/Legal%20Preparedness%20for%20School%20Closures%20in%20Response%20to%20Pandemic%20Influenza.pdf>.

III. LEGAL TRIAGE

Emergencies that significantly impact the public's health raise multifarious legal questions relating to the authority, responsibility, accountability, and liability of emergency responders, and the allocation of scarce resources. As noted above, addressing these questions is difficult because they arise in times of exigency, when the legal environment itself is changing. Emergency preparedness laws have been reformed over the past decade to reflect modern principles of public health emergency preparedness and response focused on flexibility, responsiveness, and management.¹²³ These laws allow, or even require, governmental agents to act responsibly to protect the public's health from serious actual or imminent threats.¹²⁴ However, the same laws are intentionally ambiguous in their attempts to offer multiple, flexible options without commanding specific applications.¹²⁵

These qualities of emergency-preparedness laws encourage innovative, non-traditional responses but can also contribute to confusion during emergencies. Public health legal practitioners¹²⁶ may not fully appreciate or understand how the legal environment has changed or is changing as a result of the declaration of a state of emergency. Alternatively, they may not be able to fully assess and apply legal authorities because of the circumstances of the exigency.¹²⁷ Consequently, emergency managers, public health practitioners, healthcare workers, volunteers, and others may not be able to fully determine the legality of their actions during emergencies.¹²⁸ Some responders may act without significant regard for any legal ramifications; others may choose not to act at all because of this legal uncertainty.¹²⁹ Neither of these consequences is acceptable because each has the potential to "stymie [important] public health interventions."¹³⁰

123. See *infra* Part II.B–C.

124. See MODEL STATE EMERGENCY HEALTH POWERS ACT (Ctr. for Law & the Pub.'s Health at Georgetown & Johns Hopkins Univ., unpublished draft for discussion Dec. 21, 2001), <http://www.publichealthlaw.net/MSEHPA/MSEHPA2.pdf>.

125. See Hodge, *Legal Triage*, *supra* note 6, at 627–29.

126. See *supra* note 8 and accompanying text.

127. See Hodge, *Legal Triage*, *supra* note 6, at 630.

128. See Hodge et al., *Competencies*, *supra* note 5, at 31.

129. See *infra* notes 172–77 (discussing ways that legal concerns significantly impact the decisions of emergency responders).

130. Hodge, *Legal Triage*, *supra* note 6, at 630–31.

Just as physicians and other healthcare providers must make critical decisions concerning the treatment of patients via medical triage during public health emergencies, public health legal practitioners must be able to resolve relevant legal issues in real time during those emergencies. We define the concept of *legal triage*¹³¹ as those efforts by public health legal practitioners during declared emergencies “to prioritize legal issues and solutions in real time that facilitate legitimate public health responses.”¹³² Through legal triage, legal practitioners must effectively construct a legal environment to help fill the legal void that arises from the declaration of a state of emergency. Undertaking legal triage is neither easy nor clear. It is, however, essential to effective execution of public health efforts during emergencies and disasters.

Legal triage requires legal practitioners to engage in a series of critical tasks and responsibilities. They must appreciate how changes facilitated by emergency laws temporarily alter, suspend, or obviate typical legal interventions. Emergency declarations implicate significant changes in substantive and procedural rules that practitioners must be able to implement. For example, MSEHPA sets forth distinct due process protections for individuals or groups who may be quarantined or isolated during declared public health emergencies.¹³³ These protections reflect constitutional due process norms, but are structured with sufficient flexibility to be practicable during times of emergency. Applying them, though, requires advance knowledge and real-time legal-practice skills to ensure due process protections are provided.

The legal environment during emergencies is always in flux, necessitating constant review. This requires regular communications with law and policymakers at all levels of government, along with private-sector actors, to ensure the legality of specific actions. Public health legal practitioners have to gather reliable, accurate information from public health practitioners or others in the field to understand prevalent public health needs of populations affected by an emergency. This information can be used to prioritize legal issues that may facilitate or impede public health efforts in

131. Our definition incorporates a general meaning of “triage” as “a process in which things are ranked in terms of importance or priority.” AMERICAN HERITAGE DICTIONARY OF THE ENGLISH LANGUAGE (4th ed. 2000).

132. See Hodge, *Legal Triage*, *supra* note 6, at 631.

133. MODEL STATE EMERGENCY HEALTH POWERS ACT § 604 (Ctr. for Law & the Pub.’s Health at Georgetown & Johns Hopkins Univ., unpublished draft for discussion Dec. 21, 2001), <http://www.publichealthlaw.net/MSEHPA/MSEHPA2.pdf>.

advance or as they arise. Public health practitioners, healthcare workers, and others may face a plethora of legal issues, both actual and perceived. The capacity to classify quickly and respond to these issues in real time is at the core of legal triage.

The ultimate objective of legal triage is to find legally viable answers to identifiable dilemmas. In fashioning remedies to address potential legal obstacles, public health legal practitioners must promote the common goal of protecting the public's health by reducing morbidity and mortality. Conflicting legal obligations or rights that are motivated by other interests, such as the protection of business interests or the preservation of property, should not be ignored, but rather accommodated within the contexts of the exigencies. To be sure, critical choices underlie many questions in legal triage. Responses that promote the public's health must be effectively communicated in ways that are easily absorbed and implemented by recipients, even as circumstances change during an emergency. Legal triage practitioners should regularly revisit the utility and efficacy of legal opinions related to improving public health outcomes.¹³⁴

A central challenge of legal triage is how to interpret and craft laws to help protect the public's health while respecting individual rights. Balancing individual and communal needs requires decision makers to make tradeoffs that are both legally and ethically defensible. Making such tradeoffs during emergencies is precarious. Crumbling infrastructures and rising morbidity and mortality may derail societal norms observed in non-emergency situations.¹³⁵ Amidst chaos, when traditional rules of society are suspended, governmental and private-sector actors may assert competing—and perhaps, at times, even divergent—needs and goals. Individuals may simultaneously demand governmental benefits, such as antiviral medications and vaccines, and disdain governmental restrictions, such as quarantine, isolation, and curfews. Certain principles are critical to ensuring that emergency-response efforts are maximally efficient and just,¹³⁶ as discussed in the following subsections.

A. *Preservation of Constitutional Norms*

Public health emergencies may allow government officials to act quickly and non-traditionally to protect the public's health, but

134. *See id.*

135. *See infra* notes 217–19 and accompanying text (discussing civil unrest, looting, and police dereliction during Hurricane Katrina).

136. *See* Hodge et al, *Competencies*, *supra* note 5.

constitutional norms impose limits. Principles of justice, due process, privacy, and equal protection, among others, continue to apply during emergencies even though their applications and effects may be altered. Government must respect due process protections when it seeks to compel individual action (such as through quarantine or isolation requirements) during public health emergencies. However, assuring due process rights during public health emergencies may differ in application from non-emergency scenarios. For example, individuals must have access to impartial tribunals when their fundamental rights are at stake, but that access may be limited to electronic communication and provided after an emergency isolation order has been issued, or be made available to groups of similarly situated persons rather than to citizens individually. Notice of an isolation order may be delivered through non-traditional means, and the opportunity to appeal may be delayed slightly depending on allocation of limited resources. These concessions may diminish individual expectations of procedural due process, but they are constitutionally sound during emergencies. Failure to provide any procedural due process during emergencies, however, would be constitutionally invalid.¹³⁷

B. Primacy of Statutory Enactments

Emergency statutes provide essential guidance to which legal practitioners and the public tend to defer because they reflect legislative direction and provide the necessary flexibility to facilitate various responses. Practitioners of legal triage can be confident that actions supported by legislative bodies during emergencies may be relied upon by executive agencies, courts, and other decision makers. To the extent that public health legal practitioners find legal support in specific directives issued by legislatures, adherence and acceptance are more predictable than potential responses lacking legislative direction. As noted above,¹³⁸ during a public health

137. Although less robust due process protections are available for civil detention orders and other civil restraints on liberty (i.e., government quarantine orders during emergencies) than for criminal detentions, *see, e.g., Morales v. Turman*, 562 F.2d 993, 998 (5th Cir. 1977) (“A state should not be required to provide the procedural safeguards of a criminal trial when imposing a quarantine to protect the public against a highly communicable disease.”), the Supreme Court has held that government actors must provide some form of procedural due process in all circumstances of civil restraint, *Addington v. Texas*, 441 U.S. 418, 425 (1978) (“This Court repeatedly has recognized that civil commitment for any purpose constitutes a significant deprivation of liberty that requires due process protection.”).

138. *See supra* Part II.C.

emergency, laws in many states either explicitly waive formal in-state licensure requirements for out-of-state licensed health professionals or recognize a professional's out-of-state license as a provisional in-state license for the duration of the emergency declaration. The effect of these clear, statutory provisions is to provide significant assurances for out-of-state volunteer health professionals that their medical services can be provided without fear of sanction.¹³⁹ Comparable efforts to provide such licensure reciprocity through hastily assembled legal opinions or executive orders have less utility and force because they may result in costly delays in effectuating emergency responses and may not be viewed as carrying the same weight as legislative directives.¹⁴⁰

C. Suspension of Conflicting Legal Authorities

A facet of many state emergency statutes, as noted above,¹⁴¹ is the ability of the government (typically through the governor) to suspend any law or policy that may interfere or conflict with public health responses.¹⁴² State emergency laws clearly cannot obviate constitutional norms or federal legal provisions.¹⁴³ However, to the degree that state or local laws impede emergency responses, they may be temporarily suspended for the duration of the emergency. Public health legal practitioners may argue for temporary suspension of various legal requirements (e.g., fiscal processes, labor practices, procurement policies) that may inhibit rapid governmental or private-sector responses to public health emergencies.¹⁴⁴ Of course, there are inherent risks in allowing expansive disregard of existing laws. Potential governmental abuses or misinterpretations may lead to individual harms for which neither public nor private sectors are fully accountable at the time. Yet such harms may be

139. Hodge, Pepe & Henning, *supra* note 118, at 44, 46.

140. *Id.*

141. *See supra* Part II.D.

142. *See supra* Part II.C.

143. This follows from the Supremacy Clause of the United States Constitution. *See* U.S. CONST. art. VI, § 2.

144. MODEL STATE EMERGENCY HEALTH POWERS ACT § 403(a)(1) (Ctr. for Law & the Pub.'s Health at Georgetown & Johns Hopkins Univs., unpublished draft for discussion Dec. 21, 2001), <http://www.publichealthlaw.net/MSEHPA/MSEHPA2.pdf> ("During a state of public health emergency, the Governor may suspend the provisions of any regulatory statute prescribing procedures for conducting State business, or the orders, rules and regulations of any State agency, to the extent that strict compliance with the same would prevent, hinder, or delay necessary action (including emergency purchases) by the public health authority to respond to the public health emergency, or increase the health threat to the population.").

appropriately redressed post-emergency. Concerns about these issues should not derail essential public health responses, provided the harms are not of the same types as those which the government seeks to remedy.

D. Recognition of Public Health Ethics

Despite the primacy and flexibility of law during emergencies, practitioners of legal triage must also be guided by principles of public health ethics in addressing those issues for which the law may require normatively questionable actions. Laws during emergencies, just as during non-emergencies, provide imperfect guidance for public- or private-sector roles and responsibilities when devoid of ethical support. In public health emergencies, core principles of public health ethics that focus on the preservation of community health through respect for persons and principles of social justice can support legal decisions.¹⁴⁵

E. Adoption of an Interdisciplinary Approach

Public health crises require collaboration among practitioners of various disciplines including law, public health, medicine, environment, and law enforcement.¹⁴⁶ Legal triage recognizes the need for significant input, in real time, from multidisciplinary actors who may not have an extensive history of working together. Legal practitioners must be willing to grapple with public health, medical, and ethical dimensions of emerging issues in emergencies. A panoply of emergency public health powers (e.g., testing, treatment, vaccination, quarantine, and isolation)¹⁴⁷ may be authorized to address specific threats to the public's health. Legal practitioners should ascertain which of these powers may help public health officials curb morbidity and mortality based on available data and

145. Nancy E. Kass, *An Ethics Framework for Public Health and Avian Influenza Pandemic Preparedness*, 78 *YALE J. BIOLOGY & MED.*, 235, 235–46 (2005) (noting that a framework based on public health ethics is better suited to decision making during public health crises—such as an influenza pandemic—than a traditional bioethics framework).

146. See generally William L. Waugh Jr. & Gregory Streib, *Collaboration and Leadership for Effective Emergency Management*, 66 *PUB. ADMIN. REV. (SUPPLEMENT)* 131 (2006) (discussing the critical role of multidisciplinary intersectoral collaboration and mechanisms for improving such collaboration).

147. MODEL STATE EMERGENCY HEALTH POWERS ACT §§ 602-603 (Ctr. for Law & the Pub.'s Health at Georgetown & Johns Hopkins Univs., unpublished draft for discussion Dec. 21, 2001), <http://www.publichealthlaw.net/MSEHPA/MSEHPA2.pdf> (authorizing vaccination, testing and treatment); see also *id.* §§ 604–605 (authorizing isolation and quarantine).

guidance. They should then seek to balance these powers with the need to respect civil liberties to the greatest extent possible. For example, during an emergency involving a contagious disease, government may be empowered to offer testing and vaccination for at-risk individuals or to conduct mass quarantine and isolation efforts among exposed or infected persons, respectively. If public health data derived from response efforts suggest that each of these interventions is equally efficacious in controlling the spread of disease, all other issues aside, public health legal practitioners ought to support optional testing and vaccination programs first because those programs are less restrictive.

F. Efficiency in Decision Making

To effectuate legal triage, public health legal practitioners must be prepared to synthesize an array of facts and circumstances to quickly determine how the law may support or impede various objectives. When the opportunity costs of inaction are high, practitioners of legal triage need to be comfortable making decisions quickly and with less certainty of their accuracy than in non-exigent circumstances. The potential for insufficient legal responses is dangerous, but the failure to act due to cumbersome legal deliberations could present a more serious deficiency. The challenge of legal triage is to produce good judgments in little time based on incomplete situational knowledge and to be comfortable with residual uncertainty.

IV.

LEGAL TRIAGE IN KEY CONTEXTS

For some, legal triage may represent a radical idea. Legal practitioners are taught to learn, interpret, and apply the law, but not always actively to manipulate it. Yet this skill is at the core of legal triage. In this Part, we attempt to illustrate the need for legal triage in three key contexts: (A) the allocation of scarce resources, (B) volunteer liability protections, and (C) interjurisdictional coordination. Each of these issues implicates different legal principles and is apt to resonate differently among legal and public health practitioners. The allocation of scarce resources raises fundamental ethical quandaries for those practicing legal triage during public health emergencies. Constructing adequate liability protections for volunteer health practitioners helps assure that they are not deterred from participating in response efforts but must be balanced against the costs of upsetting the traditional mechanisms of compensating those that are harmed through negligent and reckless care. In-

terjurisdictional coordination is a lynchpin to successful governmental response efforts to major emergencies, but such coordination is pervaded by complex doctrinal legal issues such as federalism and state sovereignty.

A. *Allocation of Scarce Resources*

The dilemma of how to allocate scarce resources when delivering healthcare or public health benefits is not unique to emergencies.¹⁴⁸ Healthcare and public health resources are always limited.¹⁴⁹ As a consequence, allocation decisions are made every day as to whether and how much healthcare service individuals will receive.¹⁵⁰ These decisions are reached through legal and policy choices at every level of government, as well as by following institutional guidelines among healthcare providers and insurers, and through “bedside” decisions by healthcare workers.¹⁵¹ During non-exigent circumstances, allocation decisions are driven by established legal principles and policy based on societal expectations and ethical norms. During an emergency, these practices and norms can become confused and untenable. In such instances, legal triage is needed to address the unique and challenging legal and ethical issues that arise.

The events that transpired during and after Hurricane Katrina are a tragic but powerful example of the difficulty in allocating health-related resources during public health crises.¹⁵² As flood waters rose, hospitals faced numerous obstacles including shortages of

148. Catherine M. DesRoches, Robert J. Blendon & John M. Benson, *Americans' Responses to the 2004 Influenza Vaccine Shortage*, 24 HEALTH AFF. 822, 822 (2005) (discussing the shortage of influenza vaccines in the United States in 2004 that resulted from the temporary closure of a pharmaceutical factory in England).

149. See, e.g., Wendy K Mariner, *Rationing Health Care and the Need for Credible Scarcity: Why Americans Can't Say No*, 85 AM. J. PUB. HEALTH 1439, 1439–44 (describing scarcity of medical and health resources in the United States and how those resources are rationed among the populace).

150. *Id.* at 1440–42.

151. *Id.*

152. The areas that were most severely impacted by Hurricane Katrina already had poor access to healthcare. ROBIN RUDOWITZ, DIANE ROWLAND & ADELE SHARTZER, *Health Care in New Orleans Before and After Hurricane Katrina*, 25 HEALTH AFF. 393, 394–95 (2006) (noting the high rates of poverty and low rates of healthcare coverage in New Orleans). As a result of the flooding, the existing infrastructure for providing healthcare during the hurricane was severely compromised. See *infra* notes 179, 180 and accompanying text (discussing the shortages of electricity, medical supplies, and personnel in the aftermath of the storm).

care providers, medications, basic supplies, space, and utilities.¹⁵³ In combination, these obstacles presented an incredibly difficult practice environment that necessitated critical decisions regarding how to distribute limited personnel and supplies. Emergency laws have the potential to support the allocation of scarce resources by (1) authorizing expedited uses of public health powers by public- and private-sector actors; (2) requiring cooperation between public- and private-sector actors to protect the public's health; (3) temporarily suspending statutes or regulations that may interfere with emergency medical responses (e.g., the EMTALA);¹⁵⁴ (4) allowing sharing of resources across local or state boundaries (e.g., the Emergency Management Assistance Compact ("EMAC"));¹⁵⁵ (5) helping government entities quickly procure essential supplies or services to meet surge capacity;¹⁵⁶ and (6) clarifying specific options and priorities for resource allocations when supplies are scarce (e.g., vaccine-distribution requirements).¹⁵⁷ However, emergency laws can also undermine efficient allocation decisions by discounting or overriding ethical input in the face of exigent circumstances or in favor of political objectives, or by shifting control of resources from private to public sectors.

As the World Health Organization ("WHO") suggests, allocating resources via legal triage during emergencies should be grounded in principles of justice and fairness.¹⁵⁸ Yet the question remains: how can adherence to notions of fairness be assured in exigencies?¹⁵⁹ WHO, many of its member states, and numerous

153. SARAH A. LISTER, CONGRESSIONAL RESEARCH SERVICES, 2005 GULF COAST HURRICANES: THE PUBLIC HEALTH AND MEDICAL RESPONSE 11 (2006), <http://digital.library.unt.edu/govdocs/crs/permalink/meta-crs-9707:1>.

154. See Michael O. Leavitt, Secretary of Health and Human Services, Waiver Under Section 1135 of the Social Security Act (Sept. 4, 2005), <http://www.hhs.gov/katrina/ssawaiver.html>.

155. Emergency Management Assistance Compact, Pub. L. No. 104-321, 110 Stat. 3877 (1996). EMAC is an agreement between states that provides for mutual assistance in responding to and training for emergency situations. See *id.* EMAC can only be activated in response to a government-declared emergency or the commencement of organized drills or training exercises. See *id.*

156. See ESAR-VHP Draft Report, *supra* note 82.

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157. See U.S. GEN. ACCOUNTING OFFICE, FLU VACCINE: STEPS ARE NEEDED TO BETTER PREPARE FOR POSSIBLE FUTURE SHORTAGES (2001), <http://www.gao.gov/new.items/d01786t.pdf>.

158. See WORLD HEALTH ORG., ETHICAL CONSIDERATIONS IN DEVELOPING A PUBLIC HEALTH RESPONSE TO PANDEMIC INFLUENZA 3-7 (2007), http://www.who.int/csr/resources/publications/WHO_CDS_EPR_GIP_2007_2c.pdf.

159. See Thompson et al., *supra* note 7, at 2 ("[P]andemic planning needs to take ethical considerations seriously . . .").

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public- and private-sector entities have issued guidance on allocating scarce resources.¹⁶⁰ Ethical models for emergency-resource distributions have been widely proposed.¹⁶¹ Though beneficial, these models do not fully account for the role of law during emergencies. Allocation decisions must be infused with legal and ethical principles in real time during emergencies to provide procedural mechanisms that ensure fairness.¹⁶² These legal and ethical principals are critical to well-managed, efficacious, and socially just allocation decisions.

Decision makers must strive to maintain transparency in decision-making processes. Openness and public accessibility are legal and ethical hallmarks reflected in principles of procedural justice.¹⁶³ In emergencies and non-emergencies alike, these hallmarks underlie any process designed to inspire confidence in decision making. Allowing persons, particularly those deprived of essential goods or services or otherwise impacted by the decisions, to access decision-making processes is essential. Commitment to transparency ensures accountability concerning the specific duties and liabilities of persons making allocation decisions. Decision makers must act quickly while providing the public with some assurance that choices are being made responsibly.

160. See WORLD HEALTH ORG., *Global Influenza Preparedness Plan* (2005), http://www.who.int/csr/resources/publications/influenza/GIP_2005_5Eweb.pdf; SWITZ. FED. OFFICE OF PUB. HEALTH, SWISS INFLUENZA PANDEMIC PLAN (2006), <http://www.bag.admin.ch/influenza/01120/01134/03058/index.html?lang=en>; AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, MASS MEDICAL CARE WITH SCARCE RESOURCES: A COMMUNITY PLANNING GUIDE (2007), <http://www.ahrq.gov/research/mce/mceguide.pdf>; Richard Coker & Sandra Mounier-Jack, *Pandemic Influenza Preparedness in the Asia-Pacific Region*, 368 LANCET 886, 886–89 (2006).

161. See, e.g., Lawrence O. Gostin, *Medical Countermeasures for Pandemic Influenza: Ethics and the Law*, 229 J. AM. MED. ASS'N 554, 555 (2006); John L Hick et al., *Clinical Review: Allocating Ventilators During Large-scale Disasters—Problems, Planning, and Process*, 11 CRITICAL CARE 217 (2007); Thompson et al., *supra* note 7; NYS WORKGROUP ON VENTILATOR ALLOCATION IN AN INFLUENZA PANDEMIC, NEW YORK STATE DEPARTMENT OF HEALTH ALLOCATION OF VENTILATORS IN AN INFLUENZA PANDEMIC: PLANNING DOCUMENT (Unpublished draft for public comment 2007), http://www.health.state.ny.us/diseases/communicable/influenza/pandemic/ventilators/docs/ventilator_guidance.pdf.

162. See Johns Hopkins Ctr. for Pub. Health Preparedness et al., *Principles of Law and Ethics to Guide Allocation Decisions Involving Scarce Resources During Public Health Emergencies* (Oct. 9, 2006), <http://www.publichealthlaw.net/Resources/ResourcesPDFs/Summit%20Allocation%20Principles.pdf>.

163. See Asha V. Devereaux et al., *Definitive Care for the Critically Ill During a Disaster: A Framework for Allocation of Scarce Resources in Mass Critical Care: From a Task Force for Mass Critical Care Summit Meeting, January 26 27, 2007, Chicago, IL*, 133 CHEST (SUPPLEMENT) 51S, 62S (2008); Kass, *supra* note 145, at 248.

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Allocation decisions must focus on initiatives that are well tailored to accomplishing essential emergency public health services. For example, if epidemiologic evidence suggests that allocation of a limited vaccine to a specific at-risk group may significantly reduce morbidity and mortality across populations, such a finding must be strongly considered. In assessing allocation options, policy leaders must identify public health priorities based on available, scientifically sound evidence. At a minimum, governmental acts must be rationally related to legitimate objectives.¹⁶⁴ Correspondingly, supporting public-sector decisions with sound evidence helps empower decision makers to reject potential political interests that are contrary to good public health practice. As part of assuring transparency, public participation should be invited through education and outreach before, during, and after emergencies. Members of the public are entitled to know how allocation decisions are made. Effective outreach to vulnerable populations benefits the community and leads to better choices by decision makers.

Finally, to ensure a socially just allocation of resources, legal practitioners must establish, adhere to, and communicate applicable standards of care. In non-emergencies, standards of care help actors distinguish between acceptable and unacceptable behavior.¹⁶⁵ During emergencies, standards of care may deviate greatly from non-emergency expectations.¹⁶⁶ Allocation decisions must be made with an appreciation for the prevailing standard of care to avoid inequities and prevent potentially wasteful uses of resources. Public health legal practitioners must consider the communal needs of various individuals and groups regardless of their human condition. A person's race, ethnicity, nationality, religious beliefs, sexual orientation, residency status, ability to pay, and other such characteristics are unsuitable grounds for allocating resources in a way that provides or denies access to limited medical or public health services, medicines, or supplies.

164. *Cf. Fed. Commc'ns Comm'n v. Beach Commc'ns, Inc.*, 508 U.S. 307, 313 (1993) ("In areas of social and economic policy, a statutory classification that neither proceeds along suspect lines nor infringes fundamental constitutional rights must be upheld against equal protection challenge if there is any reasonably conceivable state of facts that could provide a rational basis for the classification.").

165. See AGENCY FOR HEALTHCARE RESEARCH & QUALITY, U.S. DEP'T OF HEALTH & HUMAN SERVS., ALTERED STANDARDS OF CARE IN MASS CASUALTY EVENTS 7 (2005), available at <http://www.ahrq.gov/research/altstand/altstand.pdf> ("Standards of health and medical care, broadly defined, address not only what care is given, but to whom, when, by whom, and under what circumstances or in what places.").

166. See Hodge, Pepe & Henning, *supra* note 118, at 44–49.

B. Volunteer Liability Protections

Meeting patient surge capacity¹⁶⁷ during emergencies invariably requires the efforts of existing healthcare personnel¹⁶⁸ as well as volunteer health practitioners (“VHPs”) and entities that support their deployment and use.¹⁶⁹ Yet assuring the availability of VHPs (e.g., physicians, nurses, pharmacists, public health workers, lab technicians, emergency medical technicians, and psychologists) during emergencies requires legal tradeoffs.¹⁷⁰ Persons receiving healthcare and services are normally entitled to reasonable compensation for their injuries and losses that are caused by negligent or wrongful acts of healthcare personnel.¹⁷¹ However, VHPs and the entities that rely on them need to be able to provide services during emergencies without excessive concern for post-emergency liability for non-criminal mistakes or harms that may arise.

Balancing these competing interests is perplexing during public health emergencies that pose immediate and disabling threats to communal health. Congress has proposed legislation to provide strong liability protection for VHPs nationally,¹⁷² but these bills have not passed.¹⁷³ What remains is a default patchwork of varying liability protections for VHPs across the states. While American healthcare practitioners are remarkably likely to volunteer when na-

167. Surge capacity is “the number of critical casualties arriving per unit of time that can be managed without compromising the level of care.” Asher Hirshberg, et al., *Does Casualty Load Affect Trauma Care in Urban Bombing Incidents? A Quantitative Analysis*, 58 J. TRAUMA 686, 691 (2005).

168. Carl H. Coleman & Andreas Reis, *Potential Penalties for Health Care Professionals Who Refuse to Work During a Pandemic*, 299 J. AM. MED. ASS’N 1471, 1472 (2008) (stating that the need to maintain staffing during public health emergencies has prompted some states to create penalties including fines and imprisonment for healthcare professionals who refuse to work during public health emergencies).

169. See James G. Hodge, Jr. et al., *The Legal Framework for Meeting Surge Capacity Through the Use of Volunteer Health Professionals During Public Health Emergencies and Other Disasters*, 22 J. CONTEMP. HEALTH L. & POL’Y 5, 8 (2005) (“Larger scale emergencies, however, demand participation of significant numbers of capable VHPs to provide health care and services to potentially thousands of victims.”).

170. See James G. Hodge, Jr., et al., *Volunteer Health Professionals and Emergencies: Assessing and Transforming the Legal Environment*, 3 BIOSECURITY & BIOTERRORISM 216, 221 (2005) (arguing that liability protections for VHPs should be balanced against the rights to compensation of people who are harmed in the course of VHPs’ care).

171. See DAN B. DOBBS, *THE LAW OF TORTS* 631–33 (2000).

172. E.g., National Trauma Center Stabilization Act of 2007, S. 2319, 110th Cong. (2007); Hurricane Katrina Emergency Health Workforce Act of 2005, S. 1638, 109th Cong. (2005).

173. Hodge, Pepe & Henning, *supra* note 118, at 49.

tional or regional crises arise,¹⁷⁴ a significant number are deterred from doing so because of liability concerns.¹⁷⁵ In an October 2006 study conducted by the Community Health Planning and Policy Development Section of the American Public Health Association, nearly seventy percent of healthcare practitioners surveyed stated that immunity from civil liability is important in deciding whether to volunteer during emergencies.¹⁷⁶ Lacking qualified volunteers, countless persons may go without adequate health services as hospitals, clinics, and other health facilities fail to meet surge capacity. Collectively, the impact on the public's health and potential for significant societal costs can be severe.¹⁷⁷

During Hurricanes Katrina and Rita in 2005, regional hospitals faced problems resulting from flood water,¹⁷⁸ scarcity of medical resources and basic supplies, and depleted medical staffs.¹⁷⁹ With rising numbers of patients and dwindling numbers of trained healthcare workers to treat them, hospitals had to rely on VHPs to meet surge capacity.¹⁸⁰ Thousands of trained, vetted VHPs were

174. See Stephen E. Flynn, *America the Resilient: Defying Terrorism and Mitigating Natural Disasters*, FOREIGN AFFS., Mar.–Apr. 2008, at 2–8 (2008), available at <http://www.foreignaffairs.org/20080301faessay87201/stephen-e-flynn/america-the-resilient.html>.

175. Cf. ESAR-VHP Draft Report, *supra* note 82, at 43 (“Civil liability is one of the most pervasive issues affecting the modern health care delivery system.”). Negligence theories, rooted in the failure of the VHP to adhere to a particular standard of care when providing healthcare services, are most commonly the basis for civil liability claims. See *id.* at 42. In addition to the direct liability of VHPs for their own actions, their employers may be held vicariously liable for their actions. *Id.* at 41; see also DOBBS, *supra* note 171, at 667–71. In addition to negligence, VHPs could be subject to civil liability for failing to secure a patient’s informed consent before providing medical services. See DOBBS, *supra* note 171, at 652–58. Liability for negligent infliction of emotional distress may also result if the actions taken by a practitioner foreseeably cause a patient or a bystander substantial emotional suffering with concordant physical injuries. See BARRY FURROW, HEALTH LAW 282–84 (2000).

176. See Carpenter et al., *supra* note 15, at 24.

177. Hodge, Pepe & Henning, *supra* note 118, at 44–45.

178. *Evacuations Resume at Flooded Hospital*, CNN, Sept. 2, 2005, <http://www.cnn.com/2005/HEALTH/09/02/katrina.hospitals/index.html>.

179. See Matthew Herper, *One Hospital’s Fight Against Katrina’s Wrath*, MSNBC, Sept. 2, 2005, <http://www.msnbc.msn.com/id/9176916/>; Susanna Schrobsdorff, ‘A Horrible Dream’: *The Inside Story of How the Staff of One New Orleans-area Hospital Heroically Saved Their Patients and Themselves*, NEWSWEEK, Sept. 7, 2005, available at <http://tania.blythe-systems.com/pipermail/nytr/Week-of-Mon-20050829/022741.html>.

180. See James G. Hodge, *Legal Issues Concerning Volunteer Health Professionals and the Hurricane-Related Emergencies in the Gulf Coast Region*, 121 PUB. HEALTH REPS. 205, 205 (2006) [hereinafter Hodge, *Legal Issues*] (noting that numerous volunteer

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deployed through public-sector programs at the national, regional, state, and local levels. These included Disaster Medical Assistance Teams (“DMATs”),¹⁸¹ federal agents through DHHS,¹⁸² and local Medical Reserve Corps (“MRC”) units.¹⁸³ Private-sector organizations such as the American Red Cross¹⁸⁴ also helped coordinate health volunteers for emergency responses. State emergency systems for the advance registration of volunteer health professionals (“ESAR-VHP”) led to the deployment of over 8,300 volunteers to affected regions.¹⁸⁵

Yet many of these VHPs faced considerable uncertainties as to their liability exposure depending on the source of their existing employment, their mode of deployment, and existing federal or state emergency laws.¹⁸⁶ VHPs who are government employees, uncompensated for their work, or helping during a declared emergency may be immune from civil liability through multiple legal sources, including (1) governmental provisions via sovereign immunity, if the volunteer is a government employee or agent;¹⁸⁷ (2) volunteer protection acts (“VPAs”);¹⁸⁸ (3) Good Samaritan statutes;¹⁸⁹ (4) emergency statutes (e.g., the Uniform Emergency Volunteer

medical and health personnel registered to assist with the aftermath of Hurricane Katrina).

181. See HURRICANE KATRINA: LESSONS LEARNED, *supra* note 18, at 27.

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182. See U.S. Dep’t of Health & Human Servs., Health Care Professionals and Relief Personnel Worker Page, <https://volunteer.ccrf.hhs.gov/> (last visited Aug. 31, 2008).

183. See Robert Tosatto, Commander, Med. Reserve Corps, Address at the Emergency System for Advance Registration of Volunteer Health Professionals Focus Group Meeting: Medical Reserve Corps and Volunteer Recruitment (Aug. 12, 2005).

184. See NAT’L RESPONSE PLAN, *supra* note 65, at 70.

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185. *Responsible Resource Management at the Nation’s Health Access Agency: Hearing Before the Fed. Financial Management, Government Information and International Security Subcomm. of the S. Comm. on Homeland Security & Governmental Affairs*, 109th Cong. 10 (2006) (statement of Joyce Somsak, Associate Administrator, Healthcare Systems Bureau, Health Resources and Services Administration, United States Department of Health and Human Services).

186. See Hodge, Pepe & Henning, *supra* note 118, at 46–47.

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187. See ESAR-VHP Draft Report, *supra* note 82, at 45–46.

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188. The Federal Volunteer Protection Act of 1997 states that volunteers for nonprofit organizations or governmental entities shall not be liable for harm caused by their acts or omissions on behalf of the organization or entity. 42 U.S.C. § 14503 (2000). Inconsistent state laws are preempted by the federal VPA, although more protective state laws remain in effect. § 14502. Examples of state VPAs include those of Alabama and Mississippi, which provide volunteers with immunity for injuries resulting from good-faith acts associated with the performance of their volunteer duties. See ALA. CODE § 6-5-336(d) (LexisNexis 2008); Miss. CODE ANN. § 95-9-1(3) (West 2008).

Health Practitioners Act);¹⁹⁰ and (5) mutual aid compacts (e.g., the Emergency Management Assistance Compact (“EMAC”)).¹⁹¹

These legal protections may shield VHPs from liability, but they must be expeditiously defined, applied, and communicated through legal triage during emergencies. For example, during a federally declared emergency, federal agencies and employees are immune from civil liability for any discretionary actions undertaken in the course of providing emergency assistance.¹⁹² However, these protections do not extend to volunteers unless those volunteers are “federalized,” or recognized temporarily as federal agents.¹⁹³ The routes to federalizing volunteers during Hurricanes Katrina and Rita were not clearly defined or communicated to prospective volunteers. Federal legal teams had to scramble to provide liability protections through various negotiations with public- and private-sector entities. In the interim, deployments of some volunteers were delayed,¹⁹⁴ which may have contributed to preventable morbidity and mortality among affected populations. Consequently, legal practitioners need to be cognizant of liability concerns among prospective VHPs and tailor efforts, via legal triage, to facilitate an environment that supports VHPs’ availability through affirmative liability protections.

189. Good Samaritan statutes may apply different levels of legal protections to volunteers with different professional qualifications. For example, Massachusetts law provides physicians and nurses with legal protection for emergency care provided in good faith and without a fee. MASS. GEN. LAWS ANN. ch. 112, § 12B (West 2008). However, people trained in CPR, AEDs, or basic cardiac life support only receive protection for uncompensated emergency CPR or defibrillation other than in the course of regular business activity. *Id.* § 12V. Other states provide broad protection to any person that gratuitously provides emergency care outside of a hospital. *See, e.g.*, MINN. STAT. ANN. § 604A.01(2) (West 2008); OHIO REV. CODE ANN. § 2305.23 (West 2008).

190. *See* UNIFORM EMERGENCY VOLUNTEER HEALTH PRACTITIONERS ACT § 11 (Nat’l Conference of Comm’rs on Unif. State Laws 2007), http://www.law.upenn.edu/bll/archives/ulc/uehsa/2007act_final.pdf (providing two alternative provisions for limiting civil liability of VHPs).

191. Emergency Management Assistance Compact, Pub. L. No. 104-321, 110 Stat. 3877, 3880 (1996) (“Officers or employees of a party state rendering aid in another state pursuant to this compact shall be considered agents of the requesting state for tort liability and immunity purposes,” and thus protected from civil liability so long as he or she acts in good faith and without “willful misconduct, gross negligence, or recklessness.”).

192. 42 U.S.C. § 5148 (2000).

193. *See* 45 C.F.R. § 57.5 (2005).

194. *See* Hodge, *Legal Issues*, *supra* note 180, at 206.

C. *Coordination of Interjurisdictional Emergency-response Efforts*

One of the most daunting challenges during health catastrophes is coordinating interjurisdictional response efforts. Organizing and effectuating assistance across governments raises complex logistical and legal issues, especially concerning the utilization of federal, state, and local personnel. These considerations are particularly acute when the United States Military is deployed to assist in disaster-response efforts. The military is trained and poised to address the incidences of disasters and public health crises. It has vast logistical and physical resources, as well as a supporting command structure that is conducive to rapid interventions during exigent circumstances.¹⁹⁵ During Hurricane Katrina, federal military personnel provided critical, real-time services.¹⁹⁶ However, the federal deployment of military personnel for domestic matters has the potential to intrude on traditional sovereign interests of the states and ingrained principles of federalism.¹⁹⁷ These concerns are compounded by uncertain legal authority as to how and when such military assistance can actually be deployed. Tensions between the need for federal military assistance and the uncertain legal author-

195. SELECT BIPARTISAN COMM. TO INVESTIGATE THE PREPARATION FOR AND RESPONSE TO HURRICANE KATRINA, A FAILURE OF INITIATIVE, H.R. REP. NO. 109-377, at 201 (2006), *available at* http://katrina.house.gov/full_katrina_report.htm [hereinafter A FAILURE OF INITIATIVE].

196. Although this assistance could have been more clearly coordinated, *see supra* notes 192–94 and accompanying text, it was remarkably extensive nonetheless. As stated by Senator John Warner,

the Department of Defense response to Hurricane Katrina represents the largest and most rapid “domestic” deployment of the military in contemporary military history. Even while over 75,000 National Guard and Reserves were deployed overseas fighting for freedom in Iraq and Afghanistan, an additional 50,000 troops were deployed in response to Hurricane Katrina. . . . At the peak of the Department of Defense deployment there were 20 ships; 346 helicopters; 68 fixed wing aircraft; and 72,614 Active Duty, Reserves, and National Guardsmen assisting the recovery effort. In addition, the DOD delivered 26.6 million Meals Ready to Eat, treated 26,304 patients, and flew 16,525 sorties . . . the Coast Guard [performed] 33,000 rescues [and] . . . the National Guard and Reserve saved 11,000 people from their rooftops.

COMM. ON HOMELAND SEC. & GOV'TAL AFFAIRS, HURRICANE KATRINA: A NATION STILL UNPREPARED, S. REP. NO. 109-322, at 713 (2006) (additional views of Senator John Warner, S. Comm. on Homeland Security and Governmental Affairs), *available at* <http://www.gpoaccess.gov/serialset/creports/pdf/sr109-322/app5f.pdf>.

197. *See* Posse Comitatus Act of 1878, 18 U.S.C. § 1385 (2000) (restricting use of the Army or Air Force to enforce state laws); *see generally* Joshua M. Samek, Note, *The Federal Response to Hurricane Katrina: A Case for Repeal of the Posse Comitatus Act or a Case for Learning the Law?*, 61 U. MIAMI L. REV. 441 (2007) (discussing the Posse Comitatus Act in the context of federal responses to disasters).

ity for its deployment can lead to discord between federal and state officials.¹⁹⁸

The use of military force for matters within the domestic boundaries of the nation has always been viewed with constitutional and popular skepticism.¹⁹⁹ This historic sensibility is embodied in the Posse Comitatus Act,²⁰⁰ which was enacted in 1878 and prohibits the use of the military in domestic law enforcement. Despite its antiquity, the Posse Comitatus Act continues to restrict the use of the military to those instances where authority is implied by the Constitution or in which direct authorization has been legislatively provided, such as through the Insurrection Acts.²⁰¹

The Insurrection Acts, which have operated in some form since the early years of the nation,²⁰² authorize the President to deploy the military in enforcing laws in the course of suppressing domestic insurrections and violence.²⁰³ In this sense, the Insurrection Acts provide an exception to the Posse Comitatus Act. Pursuant to the Insurrection Acts, the President can make such deployments with²⁰⁴ or without the invitation of the governor of an affected state.²⁰⁵ Recently, Congress broadened the President's power through an amendment to the John Warner Defense Author-

198. During the aftermath of Hurricane Katrina, confusion and delays ensued when Louisiana Governor Kathleen Blanco refused to relinquish control of National Guard and other resources to federal agencies. See Scott Shane, *After Failures, Government Officials Play Blame Game*, N.Y. TIMES, Sept. 5, 2005, at A1; see also *supra* notes 171–73.

199. Although some suggest that the Posse Comitatus Act arose solely as a function of Reconstruction Era dynamics between the South and the Union Army, see, e.g., Gary Felicetti & John Luce, *The Posse Comitatus Act: Setting the Record Straight on 124 Years of Mischief and Misunderstanding Before Any More Damage Is Done*, 175 MIL. L. REV. 86, 100–13 (2003), the Supreme Court has noted that the historic distaste in the United States for military involvement in civilian life dates to the founding of the nation, see, e.g., *Laird v. Tatum*, 408 U.S. 1, 15 (1972) (“[There is] a traditional and strong resistance of Americans to any military intrusion into civilian affairs [which] . . . has deep roots in our history and found early expression, for example, in the Third Amendment’s explicit prohibition against quartering soldiers in private homes without consent and in the constitutional provisions for civilian control of the military.”).

200. 18 U.S.C. § 1385 (2000).

201. 10 U.S.C. §§ 331–335 (2000).

202. See Stephen I. Vladeck, Note, *Emergency Power and the Militia Acts*, 114 YALE L.J. 149, 159 (2004).

203. 10 U.S.C. § 332 (2000).

204. *Id.* § 331.

205. *Id.* § 332.

ization Act of 2007.²⁰⁶ This amendment allows military troops to be deployed in a state, absent a gubernatorial invitation, to enforce law during a natural or man-made disaster whenever “the President determines that [the] . . . authorities of the state . . . are incapable of maintaining public order.”²⁰⁷ Representing states’ interests, the National Governors Association vociferously objected to the provision, leading to its ultimate repeal the next year in the National Defense Authorization Act for Fiscal Year 2008.²⁰⁸ While some suggest that the amendment would not have significantly expanded the President’s existing powers,²⁰⁹ the strong reaction from the states and the subsequent demise of the provision illustrate the vibrancy of federalism concerns in this arena.

As a result of the repeal of the amendment to the Insurrection Acts, the ability to use federal military personnel—including National Guard battalions—to respond to declared emergencies remains unclear. Both federal and state governments have the authority to deploy National Guard troops during declared emergencies.²¹⁰ During Hurricane Katrina, the Louisiana National

206. Pub. L. No. 109-364, Div. A, Title X, Subtitle H, § 1076(a)(1), 120 Stat. 2083, 2404 (2006).

207. *Id.*

208. Pub. L. No. 110-181, 122 Stat. 3, 299 (2008).

209. Michael Greenberger, *Did the Founding Fathers Do “A Heckuva Job”?* *Constitutional Authorization for the Use of Federal Troops to Prevent the Loss of a Major American City*, 87 B.U. L. REV. 397, 416 (2007). Greenberger notes that concerns about the enlargement of federal power at the expense of state sovereignty are misplaced because

[they] overlook[] the principal controlling caveat within the amendment. It is not triggered until the President makes a finding, as clearly could have been made in Katrina, that a state is “unable” to respond to the disaster. As has been historically true, even serious natural disasters will normally stay within the control of the states when they maintain the ability to sustain or restore order. This is reflected in the default rule within the NRP, i.e., that disasters should be dealt with at the lowest level of government possible. Stated most pointedly, this measure does not interfere with state sovereignty because it is only triggered when there is no sovereignty within the state.

Id.

210. GOV’T ACCOUNTABILITY OFFICE, HURRICANE KATRINA: BETTER PLANS AND EXERCISES NEEDED TO GUIDE THE MILITARY’S RESPONSE TO CATASTROPHIC NATURAL DISASTERS 11 (2006), available at <http://www.gao.gov/new.items/d06643.pdf> [hereinafter BETTER PLANS & EXERCISES] (“During disasters and catastrophes, the military may provide support at two different levels. First, the military may provide support at the state level through its National Guard personnel and units. The governor of a state may call the National Guard forces within that state to active duty in response to a local or statewide emergency The governor of the affected state, through the state’s adjutant general, commands both the National Guard forces from the affected state and the out-of-state National Guard forces

Guard was deployed by Governor Kathleen Blanco at the onset of the hurricane.²¹¹ As the severity of the situation became apparent, the federal government began a massive deployment of active-duty Federal National Guardsmen.²¹² To streamline the integration of these state- and federally controlled military forces, federal officials proffered a proposed memorandum of agreement, which requested that all the National Guard troops be brought under unified command.²¹³ The only way to accomplish this was to federalize the Louisiana National Guard.²¹⁴ Governor Blanco refused to agree because she believed it would constitute a relinquishment of her control to the Federal DHS.²¹⁵ This created confusion and delay in the deployment of greatly needed military forces, which eventually were deployed under multiple, non-integrated chains of command.²¹⁶

Ultimately, Governor Blanco's decision may have benefited the City of New Orleans. During the aftermath of Hurricane Katrina, local law enforcement authorities were unable, or at times unavailable²¹⁷ or unwilling,²¹⁸ to deal with the considerable civil disorder,

that may flow into the affected state under emergency management assistance compacts The military can also respond to disasters at the federal level. The federal military response can consist of active component or Reserve or National Guard personnel. Active component troops that deploy to disaster areas remain under the control of the President and the Secretary of Defense, but they usually deploy in response to a request from an affected state.”)

211. See Sharon Theimer, *Congress Likely to Probe Guard Response*, WWLTV.COM (New Orleans), Sept. 3, 2005, <http://www.wvlv.com/sharedcontent/nationworld/katrina/stories/090405ccKatrinajrwcccongressguard.1f974ad6.html>.

212. BETTER PLANS & EXERCISES, *supra* note 210, at 205–06.

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213. *Id.* at 206–07.

214. *Id.* at 206. Interestingly, the federal proposal “would not have put National Guard troops under federal control.” *Id.* Rather, the new commander would have answered to the President with regard to the use of Federal National Guard troops and would have answered to Governor Blanco with regard to the Louisiana National Guard troops. *Id.* at 206–07.

215. See Amanda Ripley et al., *4 Places Where the System Broke Down*, TIME, Sept. 19, 2005, at 34.

216. BETTER PLANS & EXERCISES, *supra* note 210, at 207 (noting that federal and state National Guard troops remained under separate and uncoordinated command structures despite the recognition by state and federal officials that unified command would be preferable).

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217. Mary Foster, *New Orleans Police Fire 51 for Desertion*, ASSOCIATED PRESS, Oct. 29, 2005, http://www.breitbart.com/article.php?id=D8DHNDJ80&show_article=1.

218. Investigations have suggested that at least some of the New Orleans police force allowed or actually participated in looting. See, e.g., Steve Caparotta, *Investigation Launched Concerning Looting by NOPD Officers*, WAFB CHANNEL 9, <http://www.wafb.com/Global/story.asp?S=3918267>; Adam Nossiter, *New Orleans Probing*

which included looting and violence.²¹⁹ If the Louisiana National Guard had been federalized, they would have been prevented by the Posse Comitatus Act from engaging in law enforcement activities.²²⁰ Because the Louisiana Guard was not federalized, it was able to take an active role in bringing safety to hostile and violent areas of New Orleans.²²¹ This illustrates the types of legal tradeoffs that underlie the coordination of interjurisdictional personnel during public health emergencies, which may only be resolved in real time via legal triage.

V. CONCLUSION

Legal triage, or the real-time prioritization of conflicting legal norms during declared emergencies, is critical to facilitating responses to legal issues that arise in a changing, unpredictable legal environment resulting from exigent circumstances. Law plays an important role in shaping responses to public health catastrophes, yet the scope of legal authority during emergencies is unstable. Emergency laws support flexibility in this legal framework by endowing government actors with enhanced powers and authorities. Emergency declarations instantly and drastically alter the legal environment. As a consequence, legal and other practitioners must be able to assess and respond to the changing legal environment in real time via legal triage. Public health legal practitioners must (1) fundamentally understand how existing emergency statutes change the legal environment upon the declaration of a state of exigency; (2) be able to assess the public health implications of different options in a shifting legal environment; and (3) use improvisational skills to create legal interventions that are appropriately responsive to and protective of individual and communal interests.

Alleged Police Looting, WASH. POST, Sept. 30, 2005, at A10 (“News reports in the aftermath of the storm put officers at the scene of some of the heaviest looting, at the Wal-Mart in the Lower Garden District. Some witnesses, including a Times-Picayune reporter, said police were taking items from shelves.”).

219. Robert D. McFadden et al., *Bush Sees Long Recovery for New Orleans; 30,000 Troops in Largest U.S. Relief Effort*, N.Y. TIMES, Sept. 1, 2005, at A1 (“With police officers and National Guard troops giving priority to saving lives, looters brazenly ripped open gates and ransacked stores for food, clothing, television sets, computers, jewelry and guns, often in full view of helpless law-enforcement officials. Dozens of carjackings, apparently by survivors desperate to escape, were reported, as were a number of shootings.”).

220. A FAILURE OF INITIATIVE, *supra* note 195, at 210 (“Because the National Guard was never federalized, they could fully participate in all law enforcement missions.”).

221. *See id.*

