

## Voluntarism in the Wake of Hurricane Katrina: The Uniform Emergency Volunteer Health Practitioners Act

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During the autumn of 2005, the combined impact of Hurricanes Katrina, Rita, and Wilma in the US Gulf Coast region resulted in immeasurable costs. More than 1800 people were killed and thousands more remain missing as of March 2007.<sup>1</sup> Hundreds of thousands of individuals were forcibly displaced by the storms. In some cases, entire communities were completely destroyed. Total economic costs in the affected regions are estimated in excess of \$150 billion.<sup>2</sup> Extensive flooding in New Orleans closed major hospitals and most other health care facilities, subjecting thousands of patients to medical treatment via triage. Public hospitals in the area have yet to recover fully, leaving many poorer patients without adequate access to care.<sup>3</sup> General states of emergency were declared by the federal government,<sup>4</sup> as well as the state governments of Alabama,<sup>5</sup> Louisiana,<sup>6</sup> Mississippi,<sup>7</sup> Oklahoma,<sup>8</sup> and Texas.<sup>9</sup> On September 2, 2005, 2 days after Katrina, Louisiana Governor Kathleen Babineaux Blanco separately declared a state of public health emergency.<sup>10</sup>

During these emergencies, government officials and private sector entities worked to address major gaps in the delivery of health care and public health services in New Orleans and elsewhere. To meet patient surge capacity, they relied on licensed volunteer health practitioners (VHPs; eg, physicians, nurses, public health workers, emergency medical responders). Additional VHPs, including morticians and veterinarians, were needed to handle human remains or treat animal populations. Many VHPs were deployed to the Gulf Coast region through governmental programs such as the federal Commissioned Corps, state-based emergency systems for the advance registration of VHPs (ESAR-VHP), local Medical Reserve Corps (MRC), or disaster management assistance teams.<sup>11</sup> The US Department of Health and Human Services registered more than 33,000 VHPs to respond to the disasters.<sup>12</sup> The Citizen Corps, coordinated nationally by the Department of Homeland Security, mobilized thousands of VHPs as part of its Community Emergency Response Teams program. Organized voluntarism through nonprofit organizations such as the National Voluntary Organizations Active in Disasters and for-profit corporate entities (eg, private sector hospitals, clinics, ambulance companies) were also an integral part of the public health emergency response. The American Red Cross estimates that it deployed 220,000 volunteers, many of whom were healthcare practitioners, during Hurricanes

Katrina and Rita.<sup>13</sup> Some volunteers, however, arrived in the Gulf Coast region without any formal deployment, organizational affiliation, or assignments. These “spontaneous volunteers” meant well, but actually may have impeded effective emergency responses due in part to the inability of emergency authorities to assess their qualifications.<sup>11</sup>

No matter how they arrived, volunteers seeking to provide emergency health services faced harsh conditions, scarce supplies, countless delays, and limited guidance. VHPs and the entities that sent and hosted them also met with a barrage of legal questions underlying their deployment and use. These questions included the following:

- Does the declaration of an “emergency” justify the deployment of volunteers?
- Who is a registered volunteer and on what grounds?
- When may volunteers who are licensed or certified in one state legally practice their profession in another state?
- What standard of care applies to the provision of health services during an emergency?
- Who will compensate volunteers for injuries or other harms they incur?
- May volunteers face civil or criminal liability for their actions during the emergency?

Often addressed in ad hoc ways or through hastily developed executive orders or government policies, these legal issues inhibited the full realization of volunteer services and contributions. Even when existing statutory or other laws sufficiently addressed some legal concerns, determining and communicating these answers delayed emergency response efforts. After the states of emergency subsided, numerous public and private sector entities examined the need for substantive legal reforms to facilitate the deployment and use of VHPs during emergencies. In December 2005 the National Conference of Commissioners on Uniform State Laws (NCCUSL) conducted its own assessment. With expert guidance, NCCUSL quickly concluded that the development of uniform state statutory provisions would facilitate future deployment and use of VHPs during emergencies. Supported by The Robert Wood Johnson Foundation, the Drafting Committee of the NCCUSL produced the comprehensive Uniform Emergency Volunteer Health Practitioners Act (UEVHPA). The UEVHPA was largely approved by the Conference in July 2006, in an unprecedented period of 7 months, and

immediately endorsed by a unanimous vote of the House of Delegates at the American Bar Association. The association's approval connotes the acceptability of the Act from multiple legal perspectives and guides state and local bar associations active in the enactment process. Although the Committee continues to work on finalizing the language of proposed sections on civil liability and workers' compensation protections for volunteers, the UEVHPA is already being introduced or considered in several state legislatures (eg, California, Colorado, Kentucky, Mississippi, Tennessee).

In this article we frame the core legal challenges underlying the deployment and use of VHPs during emergencies, and discuss how the UEVHPA responds to these challenges. Our intent is to demonstrate how the act provides a workable structure with meaningful answers to key legal questions for VHPs and the entities that send or host them.

### CORE LEGAL CHALLENGES FOR VHPS IN EMERGENCIES

As seen during the 2005 Gulf Coast hurricanes, and many prior national and regional public health emergencies and natural disasters, health care, public health, veterinary, and mortuary professionals are a limited resource that can become overwhelmed during emergencies. Meeting patients' basic health care needs is difficult as excessive numbers of people present for treatment at facilities that may be operating under harsh conditions with diminished staff. VHPs are essential to supplement or perform essential health care or public health functions to decrease incidences of morbidity and mortality among human and animal populations. Congress recognized this following the terrorist attacks of September 11, 2001 when it passed the Public Health Security and Bioterrorism Preparedness and Response Act of 2002.<sup>14</sup> This act authorizes the development of state-based ESAR-VHP systems to facilitate the effective use of VHPs during public health emergencies. More recently, Congress passed the Pandemic and All-Hazards Preparedness Act (PAHPA) of 2006.<sup>15</sup> PAHPA allows the Department of Health and Human Services to link and oversee volunteer health personnel called up for federal service through ESAR-VHP and MRC systems.

VHP roles during emergencies, however, may be compromised or hindered by legal impediments. These legal issues may differ for VHPs as contrasted with their nonvolunteer counterparts because VHPs are asked to serve expeditiously during emergencies when legal and health services environments are altered; serve for a limited period of time in places or positions in which they may not normally practice; may come from out of state, raising medical licensure issues; and may lack formal relationships with the entities they assist, implicating varying liability and workers' compensation issues. These and other legal challenges underlying the deployment and use of VHPs during emergencies are briefly examined below.

### Emergency Declarations and Powers

Every state and some local governments authorize the governor (or other governmental actor) to declare general states of emergency or disaster in response to terrorism, natural disasters, or other crises. Some states also allow for the declaration of a "public health emergency," consistent with the Model State Emergency Health Powers Act (MSEHPA). MSEHPA was developed in 2001 by the Center for Law and the Public's Health to provide a menu of statutory language for state legislatures considering reforms to address public health emergencies.<sup>16</sup> Public health emergencies specifically involve catastrophic illnesses or health conditions that result from bioterrorism, emerging infectious diseases, or other serious threats to communal health.<sup>17</sup> The primary intent of any emergency declaration is to assign public and private sector entities additional powers or duties to respond effectively. MSEHPA allows for the suspension of ordinary state regulations, utilization of available resources to facilitate emergency responses, and expedited powers to manage property and protect people.<sup>17</sup> These powers include recognition of professional licenses of health care providers from other jurisdictions and conferment of some liability protections on volunteers.<sup>16</sup>

These legal protections may facilitate the deployment and use of VHPs during emergencies, but they are highly variable across states depending on each state's laws and the type of emergency declared. For example, most states' emergency management agencies are legally charged with responses to declared states of emergency. In contrast, public health emergency responses are typically led by state public health authorities. Legal confusion may reign in states, such as Louisiana during Hurricane Katrina, that declare dual states of emergency and public health emergency. Laws focused on the role of VHPs during any emergency would help clarify responsibilities and facilitate their deployment and use.

### Medical Licensure

During nonemergencies, state laws and professional standards require comprehensive evaluation of many health care worker's qualifications and competencies before issuing a medical license, credentialing, or granting clinical privileges. In emergencies, it may not be possible to systematically evaluate VHPs in real time. For this reason, advance registration systems such as ESAR-VHP, MRC, and those operated by nongovernmental organizations (eg, American Red Cross Disaster Services Human Resources System) create prequalified lists of VHPs that meet quality standards consistent with state licensure laws or other professional requirements.<sup>18</sup>

Some states feature laws that recognize professional licenses of out-of-state physicians, nurses, and other VHPs during declared emergencies.<sup>19</sup> In addition, all states have agreed through the Emergency Management Assistance Compact (EMAC)<sup>20</sup> to recognize the professional licenses and certifications of state forces issued by other states subject to any limitations or conditions imposed by the governor of the

requesting state during an emergency. Interstate licensure recognition is limited to state officers, employees, or other VHPs formally incorporated into forces of the state via written agreements. The provisions of EMAC do not apply to VHPs deployed by most nongovernmental disaster relief organizations.

Although state licensure recognitions and EMAC provisions promote interstate voluntarism among health practitioners, they are limited as well. Not every state automatically recognizes out-of-state licenses via statute during emergencies, necessitating the development of executive orders or other time-consuming legal authorizations. Volunteers who are not among state forces responding through EMAC do not automatically receive licensure recognition, unless provided through other legislative or regulatory provisions. This limitation of EMAC, although significant, is understandable. EMAC represents an interstate mutual aid assistance agreement between states during any declared emergency or disaster. All 50 states, Puerto Rico, the US Virgin Islands, and the District of Columbia have ratified EMAC, typically by adopting verbatim a model EMAC agreement. Consistency among these agreements is key to sharing state resources seamlessly during emergencies. Although proposals to amend EMAC agreements to allow states to share private sector resources have been made, the original focus of EMAC on the sharing of state-based resources remains.

### Civil and Criminal Liability

Of importance to many prospective VHPs is whether they may be personally liable for their actions. Anxiety regarding financial and professional risks discourages some qualified VHPs and the entities that send or host them from participating fully in emergency responses. Liability concerns have severely limited services to special needs patients in emergency shelters and hampered efforts to develop plans for responding to pandemic influenza. Questions of when civil or criminal liability may arise from the actions of VHPs during emergencies are dependent on specific facts, laws, and circumstances. In general, civil liability may arise from a VHP's breach or deviation from statutory, regulatory, contractual, or judicial requirements. Negligence claims based in malpractice may allege that an individual failed to adhere to a certain standard of care, resulting in injury to another.<sup>18</sup> Assessing the appropriate standard of care is difficult during medical triage when a health practitioner's skills or capabilities may be diminished due to scarce resources, limited staff, or damage to the supporting infrastructure.<sup>11</sup>

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Criminal liability may also apply to VHPs during an emergency if their actions meet the elements of a crime. In a well-reported case in July 2006, 3 healthcare workers who voluntarily remained at the New Orleans Memorial Medical Center to treat patients<sup>21,22</sup> were accused of second-degree murder in the deaths of 4 patients. They were alleged to have intentionally injected the patients with a concoction of morphine and midazolam to cause their death.<sup>22,23</sup> Many medical and public health professionals and organizations expressed their strong opposition to these accusations.<sup>24–28</sup> They collectively viewed these healthcare workers as heroes who sought to comfort patients amidst horrific conditions, not as criminals who intentionally killed patients. Although the facts in this case are unclear, the lesson for prospective VHPs is that their actions during an emergency will be scrutinized and if findings suggest the perpetration of criminal acts, specific charges may follow.<sup>29</sup>

No laws may seek to protect VHPs for their criminal acts during emergencies; however, governments may provide limited immunity or indemnification for civil liability through statutory or regulatory provisions. Federal and state volunteer protection acts may immunize non-compensated, licensed volunteers working for government and nonprofit entities.<sup>11</sup> These acts, however, do not grant liability protections to volunteers who provide services to for-profit entities or who receive compensation for their services (other than minimal payments or expense reimbursements), and may not apply to professionals practicing outside jurisdictions in which they are licensed. Governmental (or sovereign) immunity provisions protect government officials and employees from civil liability for actions performed in the scope of their employment.<sup>30</sup> Whereas some states extend sovereign immunity protections to volunteers by statutorily providing them with the same rights and immunities as state employees, these waivers vary and often require states to formally deputize or authorize the activities of VHPs.<sup>31,32</sup>

Additional potential legal sources of immunity include Good Samaritan statutes, emergency laws, and mutual aid compacts. Good Samaritan laws, found in every state, protect from civil liability volunteers who render spontaneous care.<sup>33,34</sup> However, these laws typically apply to individuals providing assistance at the scene of an emergency, not to volunteers systematically rendering care in a health facility during declared states of emergency. The Public/Private Legal Preparedness Initiative at the University of North Carolina School of Public Health seeks to expand liability protections to businesses and nonprofit entities that provide assistance in



response to public health emergencies.<sup>35</sup> Emergency statutes and mutual aid compacts, such as MSEHPA and EMAC, may also provide immunity protections for some VHPs, but may be limited to individuals acting in specific capacities for state or local governments.

### Workers' Compensation

In addition to their potential liability for harms to patients, VHPs are concerned about the harm or injury they may experience while responding to emergency events. In non-emergencies health care workers are entitled to workers' compensation benefits in their capacities as employees. These benefits cover work-related injuries or death, regardless of fault.<sup>36</sup> The applicability of these benefits to VHPs responding to emergencies is questionable. Workers' compensation laws typically only cover employees, and therefore exclude volunteers or gratuitous workers.<sup>11</sup> Employers that may send or allow VHPs to deploy to specific emergencies may not view them as acting within the scope of their employment. Thus, they would not be covered under the employer's workers' compensation plan.<sup>18</sup> Some state (eg, Connecticut,<sup>37</sup> Illinois,<sup>38</sup> Ohio,<sup>39</sup> and Wisconsin<sup>40</sup>) and local governments explicitly extend coverage to volunteer workers by classifying them as government employees for the duration of an emergency. EMAC provides compensation for the injury or death of members of the state emergency forces. Unless a VHP is deployed through EMAC (or other governmental routes) or is fortunate enough to serve in a state that extends workers' compensation benefits to volunteers, the individual may lack protection during an emergency.

### UEVHPA

UEVHPA responds to these legal challenges and others by establishing an automatic, robust, and standardized structure for the swift and organized deployment and use of VHPs to provide health, veterinary, or mortuary services in declared emergencies. Coextensively, the act provides reasonable safeguards to ensure that health practitioners are qualified; clarifies the scope of permissible interstate practices; and allows a host state or entity (the state or entity in which the services are provided) to regulate, direct, and restrict the scope and extent of services provided by volunteers to maximize their efficient deployment while protecting the public's health. Additional policy objectives of the UEVHPA include the following:

- Requiring that before deployment, volunteers are registered with public or private systems that are capable of confirming to the host state or entity during an emergency that volunteers are properly licensed and in good standing within their principal jurisdiction of practice
- Regulating the activities of out-of-state volunteers by vesting authority over their activities in the licensing boards of the host state, requiring that unprofessional conduct be reported to the licensing jurisdiction, and confirming the ability of licensing jurisdictions to impose

sanctions for unprofessional conduct that occurs outside their boundaries

- Mandating that VHPs provide services through health care facilities or other host entities that coordinate their activities with governmental emergency management agencies to ensure effective use of volunteers

These and other facets of UEVHPA are explained further below.

### Trigger

UEVHPA is triggered upon the declaration of an emergency by an authorized state or local official, and remains in effect for the duration of the emergency.<sup>41</sup> Automatic implementation of UEVHPA during emergencies is intended to expedite the deployment and use of VHPs without further governmental action. During Hurricane Katrina, for example, Louisiana Governor Blanco recognized professional licenses of out-of-state VHPs via executive order. Because of communications difficulties, this recognition did not become known immediately by relief agencies seeking to deploy to the state. Under UEVHPA, no such order would have been necessary because appropriately registered, out-of-state VHPs are allowed to practice in the host state for the duration of the emergency as if that state had issued the practitioner its own license.<sup>42</sup>

Although the act is automatically set in motion by the declaration of an emergency, a governor may also issue an order or directive to limit or restrict its application. Some types of emergencies do not have a significant impact on human or animal health and may not require VHPs to meet surge capacity or protect the public's health. In other cases a government may determine that only specific types of VHPs are needed. The act is flexible to allow a governor to limit its application depending on the circumstances through well-publicized orders designed to reach VHPs and their registries.

### Application

UEVHPA applies broadly to all licensed volunteer practitioners providing health or veterinary services, including physicians, nurses, dentists, psychologists, public health professionals, veterinarians, and practitioners licensed to provide funeral, cremation, cemetery, or other mortuary services. Unlike many existing laws that confine their protections to a smaller pool of "uncompensated" volunteers, UEVHPA applies broadly to all types of VHPs, both compensated and uncompensated, during emergencies. In defining who constitutes a VHP, the focus of the act is on the volitional acts of practitioners, not on their receipt of some sort of compensation. What matters is that an individual freely chooses to provide health or veterinary services in emergency circumstances. Receipt of compensation for their services does not remove a volunteer from the protections of the act, unless they are paid pursuant to a preexisting employment relationship with a host entity. In such cases they are acting as employees, not as volunteers.

Thus, practitioners who provide health or veterinary services

intra- or interstate during an emergency may be considered volunteers, even if their existing employers continue to pay for their time or they receive other compensation. For the purposes of the act, out-of-state residents employed by a disaster relief organization providing emergency services in the host state are not viewed as employed in the host state. Simply stated, out-of-state disaster relief workers are also considered volunteers whether or not they are compensated.

## Registration

Ensuring that VHPs are qualified is critical. In every emergency there is opportunity for a few, unscrupulous individuals to provide health services without a license, credentials, or concern for the public's health. During the emergency response efforts following September 11 and Hurricane Katrina, governmental authorities documented several instances in which impostors posed as physicians or other health care workers. Even when deception or fraud is not implicated, emergency responses seek qualified, willing volunteers who are vetted, trained, and experienced.<sup>11</sup> Unlike spontaneous volunteers who simply show up on the scene, these volunteers are organized, capable, and ready to handle triage or other emergency environments.

A goal of UEVHPA is to empower responsible groups and organizations active in coordinating the deployment of qualified VHPs during emergencies. Accordingly, the act applies only to VHPs who are registered before deployment with systems operated by designated organizations and sharing basic characteristics. These systems must provide for the registration of health practitioners in advance of, as well as during, an emergency, be capable of verifying that practitioners are licensed and in good standing in their primary practice jurisdiction at the time of deployment, and be able to confirm this information to health facilities and officials in the host state.<sup>43</sup> Prototype volunteer registration systems include state-based ESAR-VHP systems<sup>44</sup> or local MRC units.<sup>45</sup> Additional, authorized registration systems include those operated by government, disaster relief organizations, multistate associations of professional licensing boards or health practitioners, and comprehensive health facilities (eg, tertiary care facilities, teaching hospitals).<sup>46</sup> Other systems may be designated as qualified by an appropriate state agency under criteria it may set via regulation.<sup>47</sup>

## Scope of Practice

To ensure the effective use of VHPs and their provision of quality services, UEVHPA requires that they serve within a host entity,<sup>48</sup> typically a health facility or disaster relief organization operating in the host state.<sup>49</sup> Host entities must, to the extent practicable, consult and coordinate with the appropriate emergency management agencies.<sup>50</sup> VHPs may

perform only those services that a similar practitioner licensed by the host state would be permitted to provide.<sup>51</sup> This approach is intended to clarify the scope of practice requirements during emergencies. Instead of expecting out-of-state VHPs to adhere to their own practice limitations in their resident jurisdictions, the act recognizes a single standard for all volunteers regardless of where they come from. VHPs must adhere to the practice limits in the host state, subject to the caveats that services provided are within the volunteer's normal scope of practice<sup>52</sup> and practitioners comply with any restrictions on their activities imposed by the host state or host entity.<sup>53</sup> States may, for example, modify the scope of practice through emergency orders.<sup>54</sup>

VHPs who fail to adhere to these requirements may be subject to administrative sanctions in the host state and any other jurisdiction in which they are licensed. Licensing boards in the host state must report any sanctions imposed on the VHP to other jurisdictions in which the practitioner is licensed.<sup>55</sup> Although sanctions may flow from a VHP's actions during an emergency, the circumstances in which the VHP serves must be considered. The act advises licensing boards or other disciplinary authorities to account for the exigent circumstances in which the conduct took place, as well as the practitioner's scope of practice, education, training, experience, and specialized skill.<sup>56</sup> Given predictable disruptions in communications during an emergency, a VHP who has no reason to know of a practice limitation may be excused from administrative sanctions.<sup>57</sup>

## Incorporation Into "Emergency Forces"

Although UEVHPA mimics principles relating to interstate recognition of professional licenses established by EMAC for government employees, it also allows volunteers to be incorporated directly into "emergency forces" pursuant to EMAC.<sup>58</sup> Incorporating local government or private sector volunteers into state emergency forces automatically qualifies them for EMAC's protections from civil liability and allows states to extend them workers' compensation benefits. During Hurricane Katrina, several states (including Maryland and Ohio) incorporated extensive numbers of these volunteers into their state-based emergency forces to better respond to requests for assistance from the Gulf Coast region.

## Civil Liability and Workers' Compensation

UEVHPA has been formally approved without specific language related to civil liability and workers' compensation; however, NCCUSL reserved 2 sections to address these critical issues. The Drafting Committee is working on provisions to provide limited immunity from civil liability for VHPs and the entities that send, host, or register them, as well as workers' compensation protections for volunteers injured or killed during the course of an emergency response. Current

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proposals offer alternatives that provide similar protections from civil liability and for workers' compensation offered to governmental actors through existing volunteer protection laws (eg, the federal Volunteer Protection Act of 1997) or EMAC.<sup>59</sup>

Civil liability protections may generally extend to VHPs who provide health or veterinary services in a manner that is not willful, wanton, grossly negligent, reckless, or criminal in nature. Existing volunteer protection laws do not immunize VHPs from criminal or wanton acts. Thus, civil liability protections would not apply to health care workers who have been found to have intentionally committed a criminal act. Concerning workers' compensation benefits, the UEVHPA Drafting Committee proposes to treat VHPs as employees of the host state for purposes of this coverage, provided other coverage is not available to the volunteer. VHPs would be covered for physical or mental injuries, diseases, or deaths that occur while providing health or veterinary services just the same as an employee of the state.

These proposed revisions to the UEVHPA are expected to be acted upon by NCCUSL at its July 2007 annual meeting, but these issues are controversial. The US Congress has proposed legislation to provide strong liability protections for VHPs nationally,<sup>60,61</sup> but these bills have not passed to date. Underlying the default patchwork of VHP liability and workers' compensation protections across states are competing, legitimate interests. VHPs and the entities that rely on them need to be able to provide services during emergencies without excessive concerns of postemergency liability for mistakes or harm that may arise. Such concerns tend to limit the scope and extent of emergency response services. Coextensively, persons receiving health care and services are normally entitled to reasonable compensation for their injuries and losses that occur due to negligent or wrongful acts. Balancing these competing interests is perplexing during public health emergencies that pose immediate and disabling threats to communal health. The community needs VHPs to meet surge capacity, but without adequate liability or workers' compensation protections, the best available volunteers may be deterred from serving. Lacking qualified volunteers, countless people 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 could be severe.

### Legislative Activity

Even as amendments to the Act are being considered by the Uniform Law Conference, many states are examining enactment of the 2006 approved version of UEVHPA. California has recently introduced a version of the Act<sup>62</sup> and is considering adding civil immunity and compensation provisions based upon draft language prepared by the Drafting Committee. Colorado, Kentucky, Maine, Mississippi, Oregon, Tennessee, and the US Virgin Islands have also introduced versions of the Act. With or without the addition of civil

liability and workers' compensation provisions, the Act is intended to help avoid many of the significant problems experienced during Hurricanes Katrina and Rita as well as improve this nation's disaster response efforts.

### CONCLUSIONS

Lessons learned from the deployment and use of VHPs during the 2005 Gulf Coast hurricanes provided valuable insight into effective legislative reforms. National, state, and local efforts to better organize and deploy VHPs through programs and registries may enhance their utility and roles in emergencies, but only if legal impediments do not inhibit their effectiveness. UEVHPA responds to specific legal dilemmas related to the definition of VHPs, the allowance of medical licensure to qualified out-of-state practitioners, as well as scope of practice concerns. Its provisions would be automatically triggered with the declaration of an emergency, thus absolving significant confusion about the deployment and use of VHPs. Forthcoming, proposed sections on civil liability and workers' compensation will attempt to address these critical issues in a way that harmonizes competing interests. As the Act is further introduced among states, the goal of facilitating voluntarism among health practitioners during emergencies may be realized.

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43. UEVHPA § 5(a)(1)-(3).
44. Public Health Services Act, 42 USC § 247d-7b as amended.
45. UEVHPA § 5(a)(4)(B).
46. UEVHPA § 5(a)(4)(C).
47. UEVHPA § 5(a)(4)(D).
48. UEVHPA § 3.
49. UEVHPA § 2(9).
50. UEVHPA § 4(c)(1).
51. UEVHPA § 8(a).
52. UEVHPA § 8(b).
53. UEVHPA § 8(c), (d).
54. UEVHPA § 8(c).
55. UEVHPA § 8(f).
56. UEVHPA § 8(g).
57. UEVHPA § 8(e).
58. UEVHPA § 9(b).
59. UEVHPA Reserved §§ 11 and 12.
60. S 1638. Hurricane Katrina Emergency Health Workforce Act of 2005. Available at: <http://thomas.loc.gov/cgi-bin/query/D?c109:1:./temp/~mdbsIrEvvj>. Accessed February 23, 2007.
61. S 2319. Hurricane Katrina Recovery Act of 2006. Available at: <http://thomas.loc.gov/cgi-bin/query/D?c109:1:./temp/~mdbsy8r6rS>. Accessed February 23, 2007.
62. AB 46. Uniform Emergency Volunteer Health Practitioners Act. Available at: [http://www.leginfo.ca.gov/pub/07-08/bill/asm/ab\\_0051-0100/ab\\_64\\_bill\\_20061204\\_introduced.html](http://www.leginfo.ca.gov/pub/07-08/bill/asm/ab_0051-0100/ab_64_bill_20061204_introduced.html). Accessed February 23, 2007.