Legal considerations during pediatric emergency mass critical care events

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Introduction: Recent public health emergencies, such as the 2009 Influenza A/H1N1 Pandemic and Hurricane Katrina, underscore the importance of developing healthcare response plans and protocols for disasters impacting large populations. Significant research and scholarship, including the 2009 Institute of Medicine report on crisis standards of care and the 2008 Task Force for Mass Critical Care recommendations, provide guidance for healthcare responses to catastrophic emergencies. Most of these efforts recognize but do not focus on the unique needs of pediatric populations. In 2008, the Centers for Disease Control and Prevention supported the formation of a task force to address pediatric emergency mass critical care response issues, including legal issues. Liability is a significant concern for healthcare practitioners and facilities during pediatric emergency mass critical care that necessitates a shift to crisis standards of care. This article describes the legal considerations inherent in planning for and responding to catastrophic health emergencies and makes recommendations for pediatric emergency mass critical care legal preparedness.

Methods: The Pediatric Emergency Mass Critical Care Task Force, composed of 36 experts from diverse public health, medical, and disaster response fields, convened in Atlanta, GA, on March 29–30, 2010, to review the pediatric emergency mass critical care recommendations developed by a 17-member steering committee. During the meeting, experts determined that the recommendations would be strengthened by a manuscript addressing legal issues. Authors drafted the manuscript through consensus-based study of peer-reviewed research, literature reviews, and expert opinion. The manuscript was reviewed by Pediatric Emergency Mass Critical Care Steering Committee members and additional legal counsel and revised.

Task Force Recommendations: While the legal issues associated with providing pediatric emergency mass critical care are not unique within the overall context of disaster healthcare, the scope of the parens patriae power of states, informed consent principles, and security should be considered in pediatric emergency mass critical care planning and response efforts because parents and legal guardians may be unavailable to participate in healthcare decision making during disasters. In addition, practitioners who follow properly vetted and accepted pediatric emergency mass critical care disaster protocols in good faith should be protected from civil liability, and healthcare facilities that provide pediatric care should incorporate informed consent and security protocols into their disaster plans.

Key Words: children; consent; critical care; disaster; emergency; emergency mass critical care; law; legal; liability; pediatric; security

Liability is a significant concern for healthcare practitioners and facilities during mass critical care emergencies that necessitate a shift to crisis standards of care.

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Overview of legal issues during health emergencies

Significant research and scholarship address the legal issues that healthcare personnel and facilities could face while providing care during public health disasters (5–9). Additionally, recent reports from the Institute of Medicine (10) and the Agency for Healthcare Research and Quality (11, 12) identify and address the range of legal concerns that could arise during mass critical care emergencies requiring the use of crisis standards of care following government declarations of emergency or disaster (13, 14). Depending on the type of emergency declared and any specific conditions, the purpose is generally to make the legal environment more flexible to facilitate the response (including the provision of health care) and implement special liability protections for responders. Declarations may also suspend, alter, or waive certain federal and state laws or regulations (e.g., Emergency Medical Treatment and Labor Act) (15), implement state- or hospital-level disaster plans or mutual aid agreements, expand practitioner scopes of practice, and mobilize resources required for the response.

Various liability issues may arise for health practitioners and facilities as a result of the care that they provide during the emergency. For example, lawsuits may arise from alleged civil, criminal, or constitutional violations due to claims such as medical malpractice, discrimination associated with resource allocation, invasion of privacy, end-of-life decisions, or violations of federal and state statutes (7–10). Claims may also result from a facility’s failure to plan for emergencies (8).

Liability protections and limitations for responders

There are currently no comprehensive federal liability protections for health practitioners and entities who provide services in crisis care situations. Instead, a “patchwork” of liability protections that differ by state apply to healthcare personnel (5). Only a few states (e.g., Louisiana and Virginia) (16–18) have enacted comprehensive legislation to protect healthcare practitioners from liability during catastrophic events. Still, liability gaps remain in those states.

Existing liability protections arise through state Good Samaritan statutes, Volunteer Protection Acts, Tort Claims Acts, the Emergency Management Assistance Compact, acting through official response teams, and the federal Public Readiness and Emergency Preparedness Act (5, 9, 10, 14). These protections are limited. For example, state-level liability protections may focus only on volunteer (rather than compensated) responders. State Good Samaritan statutes typically do not provide coverage if payment is received for services or if services are provided as part of an organized emergency response effort. Some liability protections are only triggered by an emergency declaration. Most protections apply only for good-faith acts or omissions, during specific time periods, and to registered responders (e.g., through Emergency Systems for Advance Registration of Volunteer Health Professionals) following an official disaster protocol. No liability protections indemnify responders against gross negligence, criminal acts, or willful or wanton misconduct (10). Even if protections are provided for personnel acting outside of one’s scope of practice, their medical malpractice insurance may not provide coverage (19).

For these reasons, healthcare practitioners should become familiar with applicable state liability protection, licensure, and credentialing statutes for responding to disasters, as well as the terms of their medical malpractice insurance. They should also consult with appropriate authorities (e.g., hospital counsel, state Attorney General’s office) for specific liability questions or concerns. During emergencies, they should respond pursuant to official government or facility-approved plans and response efforts rather than showing up as spontaneous volunteers (20).

Legal considerations for pediatric disaster response

Although children are especially vulnerable to the impacts of disasters for numerous reasons ranging from physiologic to cognitive and sociological susceptibilities (21–23), legal issues associated with providing health care to pediatric patients during catastrophic emergencies are not unique. Rather, most legal issues arising during health emergencies apply to all types of healthcare providers. However, pediatric disaster planners and healthcare providers should become familiar with the scope of the parens patriae power of states, as well as informed-consent principles and security issues.

Parens Patriae Power. Pediatric disaster response issues should be understood in light of the parens patriae power of states to protect and act in the best interest of individuals—typically minors and the incompetent—who are unable to care for or protect themselves (24–26). Concerning children, these powers may also apply when the minor’s parent or guardian is not available to make decisions on their child’s behalf.

Under parens patriae, the state has the power to care for such individuals as a guardian (24, 25). Typically, the power is invoked “to make decisions on behalf of individuals who are incapable of doing so for themselves, and to assert the state’s general interest and standing in communal health … and welfare” (24). During catastrophic disasters, parents and legal guardians may be unavailable to participate in healthcare decision making for their children. Therefore, state legal interests in the health and welfare of children may mitigate in favor of stronger protections and prioritized efforts to provide for their care.

Informed Consent. Informed consent is “a process of communication between a patient and physician that results in the patient’s authorization or agreement to undergo a specific medical intervention” (27–29). This type of communication, which is viewed as an ethical and legal obligation of practitioners, involves discussions between practitioner and patient about such issues as the diagnosis; purpose, risks, and benefits of a proposed treatment or procedure; and alternatives to the proposed treatment or procedure (27). In research settings, the “informed
As the result of a disaster, children may become more easily separated from their parents or legal guardians due to the parents’ or guardians’ death or injury, ongoing care, or inability to contact or travel to their child’s facility because of infrastructure damage. Timely advance informed consent for pediatric patients may be difficult or impossible to obtain. Advance informed consent is not generally necessary to treat imminently life-threatening or serious conditions of unaccompanied children in an emergency department (33), but it is less clear whether parental consent is needed to treat child victims with other types of conditions, such as minor injuries or psychological injuries, and in nontraditional care settings (e.g., alternate care facilities) (34). It is also unclear whether health providers can rely on the consent of other individuals (e.g., members of the child’s extended family, family friends, hospital staff), particularly when it becomes difficult or impossible for the state to intervene given the nature of the disaster. Additional pediatric informed consent issues are implicated through research conducted during and in the aftermath of a disaster and Investigational New Drug applications, especially because of the current lack of medical countermeasures approved and stockpiled for children (21, 35).

Security. Security can be of particular concern for pediatric patients who may be separated from their families or legal guardians during a disaster (33, 36). During Hurricane Katrina, child tracking and reunification challenges resulted from such factors as disrupted lines of communication and insufficient tracking of the location of evacuees (21). Three months after Hurricanes Katrina and Rita, during which over 5,000 children became separated from their families, 740 children remained separated from their parents or guardians (21).

Although unaccompanied children in the hurricanes were not all hospital patients, the situation highlights the potential impact of separated children on patient transfer, tracking, care, supervision, discharge, and family reunification (34). Some security and consent issues may overlap in disasters, including medical or other personal information that may be released, to whom children may be released if the parent or legal guardian is unavailable, and what documentation may be required for safe discharge or healthcare services (34).

Recommendations

To address gaps, the Task Force recommends strengthening several areas of legal preparedness. First, as outlined in the Institute of Medicine crisis standards of care guidance (10):

- Necessary legal protections must be provided for healthcare practitioners and entities that implement crisis standards of care plans. During declared emergencies, this involves state and tribal governments authorizing appropriate agencies to implement crisis standards of care in disaster-affected regions, expanding practitioner scopes of practice, and altering licensing and credentialing as needed.
- Unless comprehensive, national liability protections are implemented, state and tribal governments must link existing health practitioner and entity liability protections to crisis standards of care.
- Courts and other adjudicators should consider whether adherence to the Institute of Medicine guidance provides evidence of meeting the standard of care and “the legal effect of changing standards of care during emergencies” in medical malpractice and other claims.

In addition to the Institute of Medicine recommendations, the following suggestions should be considered for PEMCC preparedness:

- PEMCC disaster protocols should be properly vetted and accepted; when providing pediatric mass critical care, practitioners who follow such accepted and vetted protocols in good faith should be protected from civil liability (1, 4, 10). PEMCC protocols should be included in state and regional disaster plans. Health facilities should ensure that their pediatric disaster plans are consistent with state plans and, to the extent possible, with neighboring health facilities (in particular, with children’s hospitals) in the jurisdiction or region. Protocols should define a clear process for fair and equitable decision making in scarce-resource situations, such as that developed by officials in Massachusetts (6).
- Facilities that care for pediatric patients should develop specific informed consent and security protocols to incorporate into their disaster plans. For example, in advance of emergencies when patients are admitted to hospitals, pediatric practitioners and care facilities might consider providing advice on advance consent, powers of attorney, living wills, and advance directives, particularly for families of children with special healthcare needs or who live out of town (37). In addition, they should consider the types of treatments or procedures for which informed consent could be waived during emergencies, what medical or other personal information may be released and with whom it may be shared, how unidentified patients may be located, and how and to whom a minor may be released (34). Because they probably face these or similar concerns more often than other facilities, children’s hospitals and other hospitals that routinely provide care to pediatric populations well-positioned to provide recommendations for addressing disaster informed consent and security issues (including those arising during transfer, evacuation, discharge, and family reunification) (21). Additional research should also be undertaken on informed consent and security concerns for minors to more comprehensively assess these legal issues and to further develop recommendations.

Facilities that do not normally care for pediatric patients or that do not routinely provide care for critically ill pediatric patients should also consider incorporating such planning or partnering with other facilities that provide such care in the event that pediatric patients arrive at their facilities during emergencies. In addition, practitioners who do not routinely care for critically ill pediatric patients (e.g., office-based pediatricians or family
practitioners) should be familiar with disaster response and liability issues if they are asked to participate in critical care responses (20).

As PEMCC planning efforts evolve, liability issues should be further assessed through research. For example, planners may need to identify whether legislative or regulatory action is needed to strengthen or develop pediatric disaster informed consent and security protocols, such as those specifying the types of treatment that may be provided without parental consent during catastrophic disasters (33).

Federal, state, and local legal tools exist to facilitate public health emergency responses and provide liability protections for healthcare practitioners and facilities, but significant gaps remain. While the provision of health care to pediatric populations during a disaster leading to PEMCC does not necessarily raise unique liability concerns, the range of often complex legal issues that may arise during such catastrophic emergencies reinforces the need for comprehensive and collaborative advance planning. Further, individuals responsible for disaster planning within facilities that care for pediatric patients should assess whether there are liability issues that are distinct to their facilities or jurisdictions.

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APPENDIX

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