



# Understanding Liability Risks and Protections for Pediatric Providers During Disasters

Robin L. Altman, MD, FAAP,<sup>a</sup> Karen A. Santucci, MD, FAAP,<sup>b</sup> Michael R. Anderson, MD, MBA, FAAP,<sup>c</sup>  
William M. McDonnell, MD, JD, FAAP,<sup>d</sup> COMMITTEE ON MEDICAL LIABILITY AND RISK MANAGEMENT

Although most health care providers will go through their careers without experiencing a major disaster in their local communities, if one does occur, it can be life and career altering. The American Academy of Pediatrics has been in the forefront of providing education and advocacy on the critical importance of disaster preparedness. From experiences over the past decade, new evidence and analysis have broadened our understanding that the concept of preparedness is also applicable to addressing the unique professional liability risks that can occur when caring for patients and families during a disaster. Concepts explored in this technical report will help to inform pediatric health care providers, advocates, and policy makers about the complexities of how providers are currently protected, with a focus on areas of unappreciated liability. The timeliness of this technical report is emphasized by the fact that during the time of its development (ie, late summer and early fall of 2017), the United States went through an extraordinary period of multiple, successive, and overlapping disasters within a concentrated period of time of both natural and man-made causes. In a companion policy statement ([www.pediatrics.org/cgi/doi/10.1542/peds.2018-3892](http://www.pediatrics.org/cgi/doi/10.1542/peds.2018-3892)), recommendations are offered on how individuals, institutions, and governments can work together to strengthen the system of liability protections during disasters so that appropriate and timely care can be delivered with minimal fear of legal reprisal or confusion.

## INTRODUCTION

A disaster, simply defined, is when community resources are challenged by an evolving circumstance, usually an acute event of unpredictable impact that has the potential for health effects, property damage, and disruption of services.<sup>1</sup> The timing of a disaster can be sudden and unexpected, or it can be slow and continual, each process having the potential of building

## abstract

<sup>a</sup>Department of Pediatrics, New York Medical College of Touro University and Maria Fareri Children's Hospital of Westchester Medical Center Health Network, Valhalla, New York; <sup>b</sup>Department of Pediatrics, School of Medicine, Yale University and Children's Emergency Department, Yale-New Haven Hospital, New Haven, Connecticut; <sup>c</sup>UCSF Benioff Children's Hospital, San Francisco, California; and <sup>d</sup>Department of Pediatrics, University of Nebraska Medical Center, Omaha, Nebraska

*Drs Santucci and Anderson substantially contributed to the conception and design of the policy statement and technical report, analysis and interpretation of information and references, writing of specific portions of the manuscripts, critical review, and revisions; Dr McDonnell substantially contributed to refining the conception and design of the policy statement and technical report, analysis and interpretation of information, critical review, and revisions; Dr Altman was responsible for the original ideas, conception, and design of the policy statement and technical report, acquisition and analysis of information and references, design of articles, outline of topics, draft of both manuscripts and writing of specific portions, compilation of other authors' contributions, editing, critical review and revisions, and response to American Academy of Pediatrics reviewers; and all authors approved final manuscripts as submitted.*

*This document is copyrighted and is property of the American Academy of Pediatrics and its Board of Directors. All authors have filed conflict of interest statements with the American Academy of Pediatrics. Any conflicts have been resolved through a process approved by the Board of Directors. The American Academy of Pediatrics has neither solicited nor accepted any commercial involvement in the development of the content of this publication.*

*Technical reports from the American Academy of Pediatrics benefit from expertise and resources of liaisons and internal (AAP) and external reviewers. However, technical reports from the American Academy of Pediatrics may not reflect the views of the liaisons or the organizations or government agencies that they represent.*

**To cite:** Altman RL, Santucci KA, Anderson MR, et al. AAP COMMITTEE ON MEDICAL LIABILITY AND RISK MANAGEMENT. Understanding Liability Risks and Protections for Pediatric Providers During Disasters. *Pediatrics*. 2019;143(3):e20183893

up to the point of resource exhaustion.<sup>2</sup> In general, disasters may be caused by environmental phenomena (eg, hurricanes, blizzards, floods, and earthquakes), natural or induced infectious exposures (eg, H1N1 influenza, Ebola, and bioterrorism), or man-made hazards (eg, industrial accidents and terrorism).<sup>3,4</sup> Although many pediatricians and health care entities take disaster preparedness seriously, the ability to withstand the demands of a disaster is directly linked to how well an individual or a practice and/or entity prepares.<sup>3,5</sup> Disaster preparedness takes many forms, such as training oneself and staff, securing supplies, conducting drills, learning the local disaster command structure, understanding one's potential role as a provider or practice, determining how to receive and disseminate communications, and identifying locations of stockpiles, to name a few. In this technical report, we examine the important elements surrounding preparing for the liability issues facing pediatric providers who are involved in responding to a disaster.

The terrorist attack on September 11, 2001, and the subsequent anthrax bioterrorism scare riveted the nation, and the attention of public health officials was focused on the importance of health care provider preparedness.<sup>6-9</sup> Four years later, Hurricane Katrina directed national focus to the response side and the unique challenges of caring for children during disasters.<sup>1,10-12</sup> Countless children, many displaced from families, received medical care during Hurricane Katrina and in the days to weeks after its devastation.<sup>6,13</sup> Over the past decade, that experience has been memorialized to help us understand how disaster conditions alter the provision of medical care and create liability risks for providers who are working in those conditions.<sup>6,14-24</sup>

Society benefits when pediatric providers move quickly to address

the emergency needs of children during disasters, regardless of the circumstances.<sup>4,25</sup> For providers who live and work within harm's way of a disaster, this would mean reporting to work despite likely personal obstacles.<sup>26-28</sup> Such providers would be followed and augmented by additional volunteer providers, as needed, to assist in the disaster's wake. Ideally, all providers functioning during crisis situations when resources may be scarce and demands for health care may exceed capacity would be able to care for patients without fear of facing unreasonable liability risks. Evidence reveals that concern or confusion about various legal protections during public health emergencies may interfere with providers' responsiveness and willingness to volunteer.<sup>2,7,11,26,29-35</sup> Ethically, providing necessary medical care should not be hampered by legal considerations.

Our purpose for this technical report is to educate and raise awareness for providers and policy makers about the current state of liability risk and protection for health care providers who are caring for children during disasters. The goal is to equip and encourage pediatric providers to respond to disasters without fear of unanticipated legal issues. This technical report also supports and is accompanied by a policy statement of the same title in which advocacy recommendations are provided to strengthen liability protections.<sup>36</sup>

### **ALTERED HEALTH CARE ENVIRONMENT AND PRACTICE DURING A DISASTER**

Disaster response has been described as an "imperfect process fraught with unpredictable dynamics and countless decisions."<sup>37</sup> Unpredictable dynamics relate to the interplay of 3 forces: the magnitude of the health care needs of the population affected by the disaster (ie, demand), the levels of resilience and preparedness

of the health care providers responding to the disaster, and the rate at which available resources become overwhelmed. Resilience and preparedness refer not only to the ability to ramp up space, staff, and supplies but also to the strength of individual and institutional training and the presence of predetermined strategies, such as emergency operations plans. The relative weight of each of the intersecting forces influences medical decision-making, which drives actions.<sup>1,13,38,39</sup>

If demand is matched by readiness and adequate resources, providers may not be faced with an environment of care that is different from that under normal conditions.<sup>14</sup> For example, health care entities with policies for addressing times of extreme surges in patient volume, such as during an infectious disease epidemic or after a single, contained community event (such as a train crash), have a better ability to scale up operations as needed.<sup>3,30</sup> On this end of the disaster spectrum, health care entities and providers who are prepared for potential disasters are likely able to use standard methods of triage and have access to usual diagnostic and therapeutic modalities.<sup>35,38</sup> Staffing may be extremely taxed, but decision-making is less likely to be altered.

However, if demand begins to outpace readiness and/or resources, such as during a major natural event (such as an earthquake), health care processes can be disrupted.<sup>37</sup> Providers may have to reallocate shrinking resources between patients or locations, assume new tasks outside their usual practice or location because of staff shortages, and provide care in temporary areas that might not have conventional capabilities because usual clinical areas are full or not available.<sup>2,5,38,40-43</sup> These changes can include, although are not limited to, providing critical care outside of critical care units or using alternate

care sites, such as mobile or community-based sites, for screening and delivering urgent care. Under these conditions, space, staffing, and supplies may not be consistent with daily practice, but medical decision-making and care provided may remain functionally equivalent to usual practice.<sup>35</sup>

If resources become inadequate during sustained overwhelming demand, such as in the aftermath of Hurricane Sandy (with widespread damage), providers may face caring for patients in an environment that makes it increasingly difficult to use traditional decision-making processes.<sup>17,18,44</sup> Faced with severe shortages of staff, space, supplies, equipment, and medication, health care providers will have to make difficult decisions about how to allocate limited resources and may not be able to provide care that is functionally equivalent to usual practice.<sup>35,45,46</sup> An example of this is when triaging is shifted to addressing patients with the best potential outcomes first because that is a more effective use of resources and time.<sup>14,39</sup> This approach has been described as shifting from individual-based care to population-based care, a trade-off to do the greatest good for the most people.<sup>14,25,39,43</sup>

At the extreme end of the continuum is the catastrophic disaster that causes devastation beyond the primary event, such as varying degrees of collapse of societal infrastructure, as happened after Hurricane Katrina and the resulting flooding.<sup>38</sup> There may be staff fear and confusion, people not showing up for work, lack of medications, lack of laboratory facilities, families separated, children displaced, lack of power, no access to clean water, loss of communication, loss of transportation, and lack of security.<sup>3,13,14,35</sup> Under these extreme circumstances when resources are surpassed, providers may face withholding or withdrawing life-

sustaining treatment so it can be redirected to a more salvageable patient because no other treatment option is available.<sup>6,24,31,35,38,40</sup>

Although the focus during disasters is typically on the role of the hospital as the center of disaster management, in fact, office-based providers can be faced with perilous conditions, limited or nonexistent resources, and challenges that may alter medical decision-making. These providers, whose practice locations may vary widely throughout a community, may have a small safety net for their practices during major catastrophes and may quickly become overwhelmed by a disaster's impact while being called on to serve vital community functions.<sup>19,23</sup> Conditions may result in the inability to get to the office because of impassable roads, inability to instruct patients because of disrupted telephone lines, and lack of access to medical records as well as loss or damage to equipment or medical supplies, such as medications or vaccines, because of power outages.<sup>16</sup> Patients in need of higher-level care may receive treatment in an ambulatory setting because emergency transfer services are not functioning, modes of communication between providers and hospitals are interrupted, or a receiving hospital is not responding.<sup>20</sup> In a catastrophic disaster, an outpatient facility may, by necessity, become a site of triage and urgent care because a devastated hospital may be forced to divert patients.<sup>9</sup> In these conditions, it is likely that local pharmacies and patient information and/or insurance systems are inoperable as well.<sup>20</sup> When a community is crippled, patients who would normally seek basic information and guidance from authorities regarding conditions and expectations may instead turn to their primary care provider(s) as a trusted source.

## LIABILITY RISKS DURING A DISASTER

Liability risk exists with all medical care scenarios, especially when there is a less-than-optimal or unanticipated outcome. Disaster circumstances can devolve into an environment of limited choices for both patients and providers.<sup>35</sup> Patient preference for health care options may necessarily carry less weight, and providers may have fewer treatment options available to them. Denial of treatment that would have been provided in a routine health care environment may increase the chance of a provider facing a lawsuit. It is important to note that malpractice claims after disasters are infrequent. However, there is evidence that the health care providers at greatest risk of being sued are those who live and work in the disaster-affected area and report to work instead of evacuating.<sup>11,14</sup>

Generally during disasters, the 3 broad categories of potential liability claims have been described as the following: suboptimal medical care, such as negligence; a regulatory or administrative breach, such as violating the Emergency Medical Treatment and Labor Act (EMTALA); and wanton behavior, such as criminal acts. Other types of potential claims, less discussed in the pediatric literature but nevertheless still possible, include constitutional violations and lack of preparedness.

### Claims Arising From Alleged Suboptimal Medical Care

Several types of potential claims can arise from conduct during direct patient care in a disaster. Three commonly described examples are negligence, abandonment, and lack of informed consent.<sup>2,47</sup>

#### *Negligence*

During a disaster, a provider may be forced to modify treatment of a particular patient because of limited supplies of medicine, vaccines, or equipment.<sup>45</sup> This has the potential to

increase risk of being accused of negligence if the patient's outcome is negatively affected by the modified treatment.<sup>48</sup> A court may find liability against the provider if it determines that the provider had a duty to treat, that the duty was breached, that the breach resulted in harm, and that the harm can be linked to damages.<sup>49</sup> To determine that a breach occurred, the court must find that the provider failed to deliver care that a reasonable individual would have provided under similar circumstances.<sup>2</sup>

When a disaster progresses to overwhelming conditions, practitioners face increased chances of an altered health care environment that will demand nonroutine actions.<sup>45</sup> Nonroutine actions may include diagnosing without laboratories or radiology, treating without medications or equipment, managing without consultative expertise from specialists, assessing symptoms and diseases outside the scope of a provider's training, or having fewer to no actual treatment options to consider. Providing evidence that a reasonable practitioner would have made similar decisions becomes more difficult in a disaster environment for many reasons. For example, contemporaneous documentation of medical decision-making, a primary defense for one's actions, may be compromised because lack of electricity renders the electronic health record inoperable.<sup>45</sup> Medical records for past medical history may not be available, which may affect the appropriateness of care provided. In addition, conditions may be changing so rapidly that it is virtually impossible to maintain the usual levels of information sharing, communication, and collaboration with patients or parents when medical care decisions must be made.<sup>45</sup> All of these factors can contribute to the perception of suboptimal care.

### *Abandonment*

In extreme conditions, providers may cease treating some patients entirely so they can focus their time and resources elsewhere, including potentially withholding or withdrawing life support for patients with a lower expected chance of survival.<sup>2,7,39,50</sup> These actions can increase the chance of a potential claim of abandonment, that is, the unilateral termination of a physician-patient relationship by the health care provider (without proper notice to the patient) when there is still the necessity of continuing medical attention.<sup>2</sup> During chaotic conditions and desperate circumstances, provider communication with patients may not keep pace with real-time decision-making, sowing seeds of dissatisfaction.<sup>45</sup> This dissatisfaction can occur around publicly visible decisions regarding the transfer of patients to another facility or general evacuation of people to other locations. Determining whom to transfer or evacuate can ignite potentially violent conflict with those remaining behind.<sup>14</sup>

### *Lack of Informed Consent*

Another liability risk is providing care without proper informed consent or, in the case of a child, without adequate parental consent.<sup>11</sup> Although the elements of what constitutes informed consent may vary between states, it generally means reviewing risks, benefits, and alternatives and receiving consent before starting a course of treatment. Unlike competent adults, minor children (with some exceptions, such as emancipated adolescents) lack the legal authority to provide informed consent for medical care, placing that responsibility on parents or legal guardians.<sup>5</sup> During disasters, families may be separated, and children may be displaced from parents, some of whom may themselves be injured, making it impossible to obtain

consent for necessary treatment.<sup>6,51,52</sup>

The primary exception to the legal requirement for informed consent before treating an unaccompanied minor is a medical emergency that a provider determines requires immediate action and the absence of any indication that the parent(s) would refuse consent.<sup>51</sup> In addition, EMTALA, described more in the next section, both empowers and requires providers in emergency departments to perform medical screening examinations and provide necessary stabilizing treatment of emergency conditions in the absence of express informed consent.<sup>52</sup> However, during a disaster, if a separated child presents for medical treatment of a nonemergency condition or at an alternative medical facility, these exceptions may not apply.<sup>53</sup> Unaccompanied children with preexisting but stable health conditions, who may be technology or medication dependent, are particularly vulnerable during disasters and may create legal challenges for health care providers.<sup>12,51</sup>

Courts generally allow considerable leeway in the likely scenario of implied consent, that is, a parent separated from a child would likely consent to treatment of an active medical condition.<sup>11</sup> However, if the provider is forced by disaster conditions to depart from routine medical practices, treatment without express informed consent could create an increased liability risk.<sup>2,11</sup> In addition, even when a parent is present, there may not be time to obtain informed consent for nontraditional care or for care by providers exceeding their usual scope of expertise.<sup>45</sup>

### **Claims Arising From Administrative or Regulatory Breach**

Claims that can arise from a regulatory or administrative breach relate to actions taken as real-time

demands are unfolding on the frontlines in the changing health care environment during a disaster, often during early stages. Providers may breach state regulation if they rush to where the need is regardless of whether they are properly licensed in that state. Overwhelmed hospitals and providers may violate EMTALA requirements if they are forced to turn away patients in need of emergency treatment because they lack the resources or the space to treat them. Providers may face a breakdown in their systems of documentation and communication, resulting in potential exposure of individually identifiable health information and a breach of the Health Insurance Portability and Accountability Act (HIPAA) privacy rule.<sup>45</sup>

#### *Practicing Without Proper State Licensure or Privileges*

A potential regulatory breach during a disaster is practicing without a properly recognized state license or assisting at a facility without proper privileges. This can occur when an out-of-state provider shows up at, or an in-state provider is reassigned to, an unfamiliar facility perceived to be in need of emergency manpower.<sup>2</sup> Spontaneous volunteers, although typically acting in good faith and out of a desire to help, create liability risks for themselves, for the institution, and for their full-time employer.<sup>54</sup>

#### *EMTALA Violation*

Under EMTALA, hospital emergency departments and physicians are obligated to provide medical screening and treatment of patients at a level consistent with the institution's capabilities. Providers in the emergency department or inpatient units are required to treat a patient until the condition has been resolved or stabilized.<sup>55</sup> During a disaster, hospitals may not be able to provide care in line with their usual services for many reasons, such

as insufficient staff or space, lack of electricity, or destroyed equipment.<sup>53</sup> Providers may be forced to refuse to treat patients outright, may refer patients to alternative community locations, or may transfer patients to facilities with less specialized capabilities but adequate power to function.<sup>41,50</sup> These actions can expose a hospital and its providers to sanctions under EMTALA, with further liability exposure if a diverted patient suffers an adverse outcome.

#### *HIPAA Privacy Rule Breach*

Another regulatory breach can occur when a patient's protected health information is compromised. During the chaotic conditions of a disaster, lack of electricity or destroyed equipment may render normally protected modes of communication and documentation inoperable, increasing the chances of unintentional leaks or public exposure of private health information.<sup>45</sup> Moments vulnerable to potential privacy breaches are those involving rationing resources, arranging transportation, or making evacuation decisions, especially for patients with special needs.<sup>12,13,34</sup>

#### **Claims Arising From Alleged Wanton Behavior**

In truly extreme conditions, providers can face claims of gross negligence or actual criminal conduct while providing care.<sup>48</sup> Gross negligence is when negligent behavior is particularly egregious or reckless and closer to willful or wanton misconduct.<sup>53</sup> A criminal act can be practicing without a license (in addition to being a regulatory breach) or wantonly withholding or withdrawing treatment, thereby causing injury or death.\* These types of allegations may arise in situations that are so extreme that providers

---

\* This is to be distinguished from careful, sensitive, and deliberative decisions regarding do-not-resuscitate status or foregoing nonbeneficial treatment in a patient who is terminally ill.

facing them have no other available recourse when making decisions that would never be made under normal circumstances.<sup>2</sup> Examples of such situations are when providers are forced to remove a ventilator from 1 patient to give it to a patient who is more salvageable or to escalate parenteral pain medication for a patient who is critical with severe pain but has a high risk of respiratory depression.<sup>24,45,48</sup> These situations can occur because the environment of care is extremely compromised or has collapsed, giving providers no other options. Although less likely than other types of claims to arise from care provided during an extreme disaster, criminal claims are also less likely to be covered or indemnified by malpractice insurance. Furthermore, these types of claims are excluded from legislation that provides immunity during disasters.<sup>48</sup>

#### **Other Potential Claims**

##### *Constitutional Violations*

Discrimination claims may arise from medical care decisions that appear to affect, either negatively or favorably, specific populations, including people with disabilities, minorities, and those with limited English proficiency.<sup>7</sup> In addition, equal protection claims may arise from individuals who believe they received inferior services because of their race, ethnicity, or socioeconomic class.<sup>29,48</sup>

##### *Failure to Prepare*

Health care entities have an obligation to prepare for emergencies, and lawsuits against hospitals and other health care entities alleging liability for patient harms are brought and settled routinely in the United States.<sup>30,56,57</sup> When patient harms can be linked to an entity's failure to prepare sufficiently for emergencies, defending the claims can be difficult because emergency preparedness is mandated by law, endorsed by practice, and ultimately beneficial to

patients.<sup>57,58</sup> These factors and others create a strong legal presumption that health care entities are obligated to avert preventable patient harms through emergency planning and preparedness.<sup>7</sup>

Multiple federal and state laws and agencies mandate or encourage hospital emergency planning and preparedness; furthermore, the US Department of Homeland Security requires funded hospitals to adopt its standards within their emergency plans.<sup>57</sup> State laws and licensing provisions also call for preparedness for catastrophic events, and The Joint Commission requires accredited hospitals to demonstrate levels of emergency preparedness.<sup>59-61</sup> The US Department of Health and Human Services has allocated hundreds of millions of dollars to hospitals to improve emergency preparedness by mandating the development of comprehensive emergency response plans and withholding funds from hospitals that do not meet certain benchmarks.<sup>9,62-64</sup> In 2016, the Centers for Medicare and Medicaid Services (CMS) issued new emergency preparedness requirements for facilities to develop and implement emergency continuity of operations plans that contain core elements of predisaster risk assessment, maintenance of communication, and regular training and testing of policies and procedures.<sup>65</sup>

## **LEGISLATION PROVIDING PROTECTIONS FROM CIVIL LIABILITY DURING A DISASTER**

### **Overview**

State tort law defines the rights and liabilities arising out of an injury and the framework through which damages are recoverable.<sup>66</sup> Tort law seeks accountability and aims to compensate victims when providers engage in negligent conduct. As noted earlier, the legal basis for accountability in medical negligence

is based on determining duty, breach, causation, and harm. Once determined, those responsible can be found liable for damages in a court of law.

Legislation can provide a powerful shield of liability protection to health care providers through either limiting the degree a provider could be held liable or by establishing an absolute prohibition on any liability. In the former case, laws can create limitations to personal liability for individual providers through processes such as reducing statutes of limitations, establishing caps on damage awards, or creating a victims' injury fund. In the latter, a different and arguably more controversial type of shield, legislation can provide immunity against any liability under certain conditions. This means that an individual provider who meets those conditions would either not be sued or ultimately be dropped as a defendant if a malpractice case arose.

There are no comprehensive national liability protections for all health care providers during disasters.<sup>10,25</sup>

Rather, many laws exist at the federal and state levels to reduce civil liability for certain health care practitioner categories by providing immunity against certain types of claims.<sup>34,48</sup> Table 1 provides a summary of existing federal legislation, and the following sections provide basic highlights of these laws and regulations. Important references and informational Web sites are provided for a more in-depth discussion. These laws are described as "patchwork" with wide variability and important exclusions.<sup>11,35,47,48</sup>

Protections only apply to providers acting in good faith and without willful misconduct, gross negligence, or recklessness.<sup>2</sup>

### **Government Declarations and Waivers**

Most of the laws providing liability protections are triggered once an

emergency is declared by the government.<sup>2,9,35</sup> Under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, a governor may request a presidential declaration of a major disaster or emergency.<sup>67</sup> In addition, the US Secretary of Health and Human Services can declare a public health emergency under section 319 of the Public Health Service Act. Government declarations activate emergency management systems that provide a wide range of federal assistance programs to the affected area(s) and trigger emergency liability protections for certain health care providers, especially volunteers.<sup>68</sup> If a disaster is beyond the combined response capabilities of state and local governments, section 1135 of the Social Security Act additionally authorizes the US Secretary of Health and Human Services to temporarily waive or modify certain Medicare, Medicaid, Children's Health Insurance Program, and HIPAA requirements, as determined necessary by CMS.<sup>69</sup>

The purpose of waivers is to ensure that sufficient health care supplies and services are available in the emergency areas during the emergency time periods to meet the needs of individuals enrolled in Social Security Act programs and that providers who provide such services in good faith can be reimbursed and exempted from sanctions (absent any determination of fraud or abuse). Examples of 1135 waivers include the following: program certification requirements; preapproval requirements; state licensure for interstate volunteers, as long as the provider has equivalent licensure in another state; EMTALA sanctions, such as for the transfer of an individual who has not been stabilized or the redirection of an individual to receive medical screening; and penalties for noncompliance with

**TABLE 1** Survey of State and Federal Laws Providing Limited Immunity From Civil Liability for Health Care Providers During Disasters

Law or Act	Federal or State	Year First Enacted	Individuals Protected	Conditions
Tort Claims Act	Federal, State	1946	Government employees	Government consents to substitute as defendant
Good Samaritan laws	State	1980	Volunteers	Rendering aid at scene of emergency
Emergency Management Assistance Compact	State	1996	Volunteers	Rendering care as an agent of the requesting state
Volunteer Protection Act	Federal	1997	Volunteers	Serving nonprofit organization or government entity
Model State Emergency Health Powers Act	State	2001	All providers	Rendering care under contract with or at request of a state
Model Intrastate Mutual Aid Legislation	State	2004	Volunteers	Rendering care as an employee of the state
Public Readiness and Emergency Preparedness Act	Federal	2005	All providers	When dispensing a countermeasure
Uniform Emergency Volunteer Health Practitioners Act	State	2007	Volunteers	Rendering care under host entity at direction of requesting state

Adapted from Pope TM, Palazzo MF. Legal briefing: crisis standards of care and legal protections during disasters and emergencies. *J Clin Ethics*. 2010;21(4):358–367; Hodge JG Jr, Garcia AM, Anderson ED, Kaufman T. Emergency legal preparedness for hospitals and health care personnel. *Disaster Med Public Health Prep*. 2009;3(suppl 2):S37–S44; Hodge JG Jr. The evolution of law in biopreparedness. *Biosecur Bioterror*. 2012;10(1):38–48; Courtney B, Hodge JG Jr; Task Force for Pediatric Emergency Mass Critical Care. Legal considerations during pediatric emergency mass critical care events. *Pediatr Crit Care Med*. 2011;12(suppl 6):S152–S156; Burkle FM Jr, Williams A, Kissoon N; Task Force for Pediatric Emergency Mass Critical Care. Pediatric emergency mass critical care: the role of community preparedness in conserving critical care resources. *Pediatr Crit Care Med*. 2011;12(suppl 6):S141–S151; Rothstein MA. Currents in contemporary ethics. Malpractice immunity for volunteer physicians in public health emergencies: adding insult to injury. *J Law Med Ethics*. 2010;38(1):149–153; Rosenbaum S, Harty MB, Sheer J. State laws extending comprehensive legal liability protections for professional health-care volunteers during public health emergencies. *Public Health Rep*. 2008;123(2):238–241; Hanfling D, Altevogt BM, Viswanathan K, Gostin LO, eds; Committee on Guidance for Establishing Crisis Standards of Care for Use in Disaster Situations; Institute of Medicine. *Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response*. Washington, DC: The National Academies Press; 2012. Available at: [https://www.ncbi.nlm.nih.gov/books/NBK201063/pdf/Bookshelf\\_NBK201063.pdf](https://www.ncbi.nlm.nih.gov/books/NBK201063/pdf/Bookshelf_NBK201063.pdf). Accessed July 24, 2017; Barnett DJ, Taylor HA, Hodge JG Jr, Links JM. Resource allocation on the frontlines of public health preparedness and response: report of a summit on legal and ethical issues. *Public Health Rep*. 2009;124(2):295–303; Eddy A. First responder and physician liability during an emergency. *Am J Disaster Med*. 2013;8(4):267–272; Hoffman S, Goodman RA, Stier DD. Law, liability, and public health emergencies. *Disaster Med Public Health Prep*. 2009;3(2):117–125; Rutkow L, Vernick JS, Wissow LS, Tung GJ, Marum F, Barnett DJ. Legal issues affecting children with preexisting conditions during public health emergencies. *Biosecur Bioterror*. 2013;11(2):89–95; Foltin GL, Lucky C, Portelli I, et al. Overcoming legal obstacles involving the voluntary care of children who are separated from their legal guardians during a disaster. *Pediatr Emerg Care*. 2008;24(6):392–398; Sauer LM, Catlett C, Tosatto R, Kirsch TD. The utility of and risks associated with the use of spontaneous volunteers in disaster response: a survey. *Disaster Med Public Health Prep*. 2014;8(1):65–69; Pandemic and All-Hazards Preparedness Act, 42 USC 300hh et seq (2006); and Cole C, Marzen C. A review of state sovereign immunity statutes and the management of liability risks by states. *Journal of Insurance Regulation*. 2013;32:45–82; and Lopez W, Kershner SP, Penn MS. EMAC volunteers: liability and workers' compensation. *Biosecur Bioterror*. 2013;11(3):217–225.

certain patient privacy provisions of HIPAA.<sup>7,35</sup>

A significant limitation of 1135 waivers and other liability protections triggered by declarations is that they commence on the date of the declaration, which may lag from the start of the disaster, and end when the declaration is terminated, which may precede conditions returning to normal operations.<sup>30,41</sup> This can potentially leave responders whose efforts precede or exceed the time period of the formal declaration unprotected.<sup>70</sup> Waivers may be granted retrospectively to the start of a disaster, but that is not guaranteed.<sup>42,53</sup> Waivers must be pursuant to a state emergency preparedness plan, must be necessitated by the circumstances of the disaster, must be linked to implementation of a hospital disaster protocol, and do not apply to

hospitals nearby but outside of the disaster declaration that may experience surge conditions from receiving diverted patients. In addition, waivers are not automatic.<sup>2,42</sup> Once 1135 waiver authority has been invoked, governors and individual hospitals must submit requests to CMS, after which need is determined. Depending on the scope, severity, and duration of the disaster, CMS may grant “blanket” waivers to all similarly impacted providers in the disaster area. Of note, 1135 waiver authority applies only to federal program requirements. State law and gubernatorial authority determine state modifications to requirements for professional licensure, credentialing or privileging at certain facilities, and authorization of emergency liability protections for certain health care providers.

### Tort Claims Act and Government Employees

An exception to tort law accountability is the doctrine of sovereign immunity. Sovereign immunity is a legal doctrine that protects a sovereign body (ie, federal or state government and their agencies) from being held liable for civil wrongs committed by its employees.<sup>66</sup> The Federal Tort Claims Act, enacted in 1946, limits this immunity by allowing the federal government to incur liability for injuries caused by the negligent acts of a federal employee acting within the scope and course of their employment.<sup>71</sup> Under the Federal Tort Claims Act, the government waives its sovereign immunity by allowing itself to be sued and giving plaintiffs the option of suing the government instead of an individual employee (ie, defendant substitution). As long as the government employee

commits the tort within the scope and course of employment, the employee cannot incur personal liability.<sup>71</sup> A majority of states have enacted similar statutes. Federal and state tort claims acts give government-employed health care providers a unique shield from liability and relatively more protection against medical negligence lawsuits than private clinicians.

With narrow exceptions, government-employed health care providers working at a public facility and performing their official duties during a public health emergency will have immunity from liability for negligence.<sup>48</sup> However, the exceptions can be important. For instance, there must be a credible connection between the provider's activities and the government's interest, and the government must consent to be substituted as the defendant. If these conditions do not apply, the individual physician can be exposed to major liability.<sup>66</sup>

Under the tort claims acts, discretionary decisions by government officials are immune. Therefore, nonmedical government employees have immunity for discretionary actions during a disaster. Nonmedical government employees may include public health officials, law enforcement officers, or agency managers who may make decisions regarding evacuation of patients or staff, resource allocation, or interstate patient transfers to institutions outside of the disaster zone. Each of these decisions may directly and profoundly influence management options available for the frontline medical providers, thereby shifting potential liability risks to providers without the same level of immunity.<sup>48</sup>

## Volunteers

After September 11, 2001, and Hurricane Katrina, legislative focus has been to create improved systems to streamline processes to facilitate

the movement of volunteers between states during emergencies. In addition to liability concerns, out-of-state volunteers are faced with the need for rapid licensing and privileging.<sup>2,30,72,73</sup>

### *Liability Protections*

Under the federal provisions listed in Table 1, volunteers will receive immunity from claims of negligence if they are properly licensed in the state where care is rendered, are working for a nonprofit or government entity or through an established response system, and are not compensated.<sup>48,74</sup>

In addition to federal laws, all states and the District of Columbia have enacted statutes extending qualified immunity protections to volunteers who provide emergency-related health care. The vast majority of states stipulate immunity for care provided at the scene of an emergency in good faith, without expectation of compensation, and absent of gross negligence or wanton misconduct. These Good Samaritan laws are intended to permit physicians to render emergency aid without fear of malpractice claims stemming from that care.<sup>†</sup> These statutes do not block the provider from being sued, but act as a defense from liability if invoked during a malpractice trial.<sup>34</sup> However, there is much variability and ambiguity between states. For instance, state laws vary on whether protection applies only for care provided at the scene of an isolated emergency, such as a car crash, and may not extend to other locations, including a hospital, during a disaster.<sup>47</sup> Furthermore, state laws vary considerably on what

<sup>†</sup> It should be noted that Good Samaritan laws differ from laws that address administration of opioid antagonist drugs for the treatment of overdose or that shield lay people who render aid or assist overdose victims to reach the emergency department from drug possession charges, which are also often referred to as Good Samaritan laws.

constitutes "good faith" and "without compensation," that is, whether protection applies for a provider who is otherwise salaried in a regular job.<sup>2,48,53,75</sup>

### *Licensing and Privileging*

Regarding licensing, states' emergency laws recognize out-of-state health care licenses for the duration of a declared emergency through licensure reciprocity provisions.<sup>48</sup> These provisions allow for the interstate sharing of out-of-state health care personnel whose licenses are viewed as in-state licenses for the duration of the declared emergency.<sup>76</sup> In 2007, the Uniform Emergency Volunteer Health Practitioners Act established a system whereby health professionals may register either in advance of or during an emergency to provide volunteer services in another state.<sup>35,51,77,78</sup> Registration may occur in any state by using governmentally established registration systems, such as the federally funded Emergency System for Advance Registration of Volunteer Health Professionals.<sup>30,33,72</sup> These national systems allow states to verify an out-of-state volunteer's identity, licensing, and credentialing.<sup>79</sup> The Emergency Management Assistance Compact authorizes license reciprocity between states for health care practitioners during a declared state of emergency.<sup>35</sup>

Providers of telemedicine not themselves experiencing technological failures can assist with patient monitoring and online consultations during a disaster. Interstate providers temporarily volunteering their services via telemedicine must have an appropriate state license, be part of a multistate reciprocal or compact license, or obtain a temporary practice permit.<sup>80</sup> Information is available from the respective licensing boards.

### *The National Disaster Medical System*

The National Disaster Medical System (NDMS) and the Medical Reserve Corp are responsible, during declared emergencies, for the mobilization and assignment of trained volunteers who are considered federal employees during their deployment.<sup>10,41,53,81</sup>

The role of the NDMS is to provide civilian medical support to state and local governments for disaster victims through a national network of rapidly deployable medical teams.<sup>41</sup>

The NDMS teams that provide general medical care are disaster medical assistance teams. Under these systems, out-of-state volunteers are considered to be either federal or state government agents and receive liability protections accordingly. For a volunteer who is not registered with such a system to receive liability protection, the volunteer must work either through another established response system, for a designated "host entity," or at the direction of the requesting state.<sup>35,48,77,82</sup>

### **Private Sector Providers**

In contrast to volunteers and government employees, private sector providers performing in their regular job capacity during a disaster are generally not provided immunity for negligence by any legislation.<sup>2</sup> A notable exception in some states is the Model State Emergency Health Powers Act, which may provide immunity for negligence if the private provider is rendering care under contract with or at the request of a state. However, a private provider who runs to his or her office or a local hospital to help will not receive protection through any of these laws. Even Good Samaritan laws, considered to be the safety net of protection from claims of negligence for some actions taken during a disaster, may not apply unless care is rendered at the scene of an emergency.<sup>83</sup> Another exception is the Public Readiness and Emergency Preparedness Act, which provides

immunity for all providers from claims that may arise from dispensing a specific medical countermeasure during a declared public health emergency.<sup>35</sup> Examples of medical countermeasures, many of which would require consent before distribution to children, are medications, vaccines, medical devices, or lifesaving equipment required to protect or treat children for possible chemical, biological, or nuclear threats.<sup>84</sup>

Health care providers in the private sector are likely to bear the brunt of the burden of a disaster, especially in the early stages, as hundreds or thousands of patients rush to emergency departments, clinics, and physicians' offices to receive care.<sup>10</sup> Yet, legislation does not address the associated disproportionate liability risk burden of this large percentage of crucial frontline providers.<sup>7</sup>

A small number of states have attempted to bridge this gap by enacting laws that provide immunity more broadly for health care providers, regardless of volunteer or compensation status.<sup>35</sup> Elements of the laws<sup>‡</sup> of these few states include acting in response to a declared emergency or disaster, in which there is a recognized depletion of resources attributable to the disaster, at express or implied request of government and consistent with emergency plans.

### **ROLE OF MALPRACTICE INSURANCE**

For health care practitioners who are not protected through federal or state legislation that provides immunity or a shield against claims, malpractice insurance would be the next layer of protection for defense and potential indemnification if necessary. Malpractice insurance coverage differs across states and is dependent on the specific insurance policy

<sup>‡</sup> On file with the American Medical Association Advocacy Resource Center and available via e-mail at [ARC@amaassn.org](mailto:ARC@amaassn.org).

language. Many providers receive professional malpractice insurance through an employer and may have little input into the scope of coverage. Providers in the private sector may obtain their own malpractice insurance. In either case, there might be need for supplemental coverage for care provided out of state during a disaster.

Most, but not all, malpractice coverage is limited to the provider's usual practice scope in his or her usual practice setting and may not cross over state lines. Plans may not cover a practitioner's actions during an emergency if the actions fall outside the individual's normal scope of activity or location. This may leave the provider completely unprotected if, for instance, a Good Samaritan law in that state does not apply to the circumstances giving rise to a claim.

Insurance coverage does not prevent litigation, which can cause emotional stress, a damaged reputation, and increased insurance premiums. Furthermore, there is a distinction between a malpractice insurance carrier's role in providing legal advice and defense against a claim and providing indemnification for damages that are based on a monetary award by a jury verdict. Typical insurance plans provide both defense and indemnification for negligence up to a specified cap in award payments. However, most malpractice carriers will defend against claims but not indemnify for verdicts of gross negligence, willful or wanton misconduct, or crimes, which leaves the individual practitioner at risk for payment of monetary awards for these types of judgments.<sup>2,14</sup>

### **MITIGATING LIABILITY RISKS DURING A DISASTER**

At the heart of mitigating liability risks during a disaster is being prepared. Being prepared is not just learning about disaster medicine. It necessitates taking steps in advance

of a crisis to have a strategy that can be implemented as a disaster unfolds.<sup>9</sup> An all-hazards approach to emergency planning for disasters can identify many different types of potential threats with varied approaches to management and mitigation.<sup>85</sup> In general, a disaster preparedness strategy can have 3 overlapping components: educating self and personnel, securing the physical aspects of the health care environment, and creating a framework through which the provision of care may be sustained during and after a disaster.

### Education

For all providers, a disaster strategy starts with training and preparing themselves and their staff for possible contingencies.<sup>5,86,87</sup> The American Academy of Pediatrics (AAP) Disaster Preparedness Advisory Council has established a strategic plan for disaster preparedness in which a roadmap for the advocacy of children as well as preparedness for pediatricians is outlined.<sup>88</sup>

Addressing pediatric readiness is especially important because the majority of children in the United States who go to emergency departments are seen in community hospitals with a low pediatric volume.<sup>89</sup> The AAP has many readily available resources, including a preparedness checklist, for pediatric providers to keep themselves and their patients informed and to play a key role for families, schools, and communities.<sup>86,90-92</sup>

### Securing the Health Care Environment

This mitigation strategy involves proactively assigning contingency staff roles and lines of communication; identifying transportation obstacles; exploring back-up energy sources or alternate locations to provide services; creating temporary medical records; protecting valuable equipment or

medical supplies, such as vaccines and medication; identifying how to receive accurate information and up-to-date instructions from authorities; and considering the impact on patients with special needs, especially those who are technology dependent.<sup>8,93</sup>

### Framework for Sustained Provision of Care

Liability risk mitigation also includes taking steps to improve the likelihood that provision of care will not be interrupted. This involves developing methods for keeping patients and families informed during prolonged periods of relentless and unpredictable change. Cultural sensitivity during disasters is especially important because beliefs about disasters may make communication even more difficult and add to confusion.<sup>94</sup> Liability risk mitigation also includes understanding how to tap into local resources, such as emergency rescue services, nearby hospitals, and the local disaster command center. For providers affiliated with hospitals or other health care entities, it necessitates being familiar with the institution's crisis management plan. In considering one's support network, providers need to be prepared for the possibility of having to care for patients or conditions beyond their training, such as caring for adult family members. Disaster preparedness training that includes the potential lack of other specialists when urgent treatment is needed during disasters can mitigate the liability risk associated with this situation.

Although documentation is not a priority during a disaster, accurate documentation that reflects and memorializes the reasoning behind decision-making in an altered environment could mitigate liability risk.<sup>45</sup> Documentation could also improve postdisaster care and patient outcomes. Accordingly, it behooves

providers to consider including relevant information about resource limitations in the medical record if such limitations influence decision-making. However, there are currently no guidelines or consensus on the best way to achieve the most efficient, appropriate, and transparent medical chart during a disaster.

National recognition for the need to better elucidate how medical care delivery changes under disaster-response conditions and the resulting liability risks led the US Department of Health and Human Services to engage with the National Academy of Sciences' Institute of Medicine (now the National Academy of Medicine) to issue reports in 2009 and 2012. A key element of the Institute of Medicine analysis is that the best outcomes during a disaster occur with integration of all components of the health care system (hospitals, emergency medical services, government agencies, and community providers).<sup>39</sup> A second key element is that effective crisis-level preparation requires anticipating and preparing for how a disaster can alter delivery of health care services (ie, "crisis standards of care"<sup>3,35</sup>). It is through development and implementation of effective disaster planning that providers can take active steps to reduce their liability risks during disasters.<sup>25</sup>

### THE BRIDGE BETWEEN LIABILITY CONCERNS AND PATIENTS' RIGHTS

It is important to understand how laws providing immunity for health care providers may negatively affect some segments of the population. In the years since September 11, 2001, and Hurricane Katrina, a prominent concern among public health officials has been ensuring the presence of adequate health care providers during a public health emergency.<sup>27</sup> One way of preventing a shortage is to encourage providers from outside the affected areas to volunteer their services, and laws that provide

volunteers with immunity can remove potential obstacles for volunteers. However, experience has shown that when large numbers of volunteers have been needed after a disaster, the predominant populations served were those without health insurance or those too poor to evacuate.<sup>27</sup> Therefore, legislation providing immunity only for volunteer health care providers may have the unintentional impact of creating a system of unequal patients' rights and a distinction between nonvolunteer and volunteer physicians.<sup>3,27</sup> During some disasters, patients in specific at-risk populations, such as the elderly, racial minorities, and those of lower socioeconomic status, may suffer disproportionately relative to others. Therefore, any laws offering immunity from liability for health care workers may have a disproportionate effect if they deny certain patient populations the right to seek recourse for injuries caused by negligent acts.<sup>35</sup>

The extremely important role of the pediatric provider through the entire spectrum of disaster preparedness and response has been well described.<sup>50,84,87</sup> Infants, children, adolescents, and young adults have unique physical, emotional, behavioral, developmental, communication, therapeutic, and social needs that make them particularly vulnerable during disasters.<sup>50,56,95</sup> Pediatric providers are best positioned to address those vulnerabilities.<sup>25,96</sup> Being an active participant in the analysis and discussion of liability risks and protection during disasters serves to advance the important advocacy role of the pediatrician.<sup>97</sup>

### **OVERSIGHT OF PEDIATRIC MEDICAL RESPONSE DURING DISASTERS**

Oversight and direction of medical assets during times of crisis are complicated. Local jurisdictions maintain control of their assets and

personnel during times of crisis (ie, local hospitals, emergency medical services, etc). When a governor declares a disaster, state agencies can then mobilize assets and augment local medical responses.<sup>74</sup> For instance, the State of California engages the Emergency Medical Services Authority, which can send medical response teams and emergency medical services equipment to bolster the on-site responses. Each state has unique approaches and possesses different types of assets.

The federal oversight of disaster medical response is housed within the National Disaster Framework (Federal Emergency Management Agency in 2016) under the Emergency Services Framework 8.<sup>98</sup> The lead federal agency for the Emergency Services Framework 8 is the Department of Health and Human Services, under the guidance of the Assistant Secretary of Preparedness and Response (ASPR). Formed under the Pandemic and All-Hazards Preparedness Act of 2006, the ASPR is charged with the massive responsibility of preparing for and responding to the health needs of Americans during times of disasters.<sup>64</sup> The Pandemic All-Hazards Preparedness Reauthorization Act of 2013 reaffirmed consideration for children in disaster preparedness and response.<sup>99</sup>

The ASPR has been key in assessing and implementing needed changes for children affected by disasters. In response to the 2011 final report of the National Commission on Children and Disasters, the ASPR established a multiagency work group on children's needs and subsequently housed the National Advisory Committee on Children and Disasters, supported by federal and nonfederal disaster experts.<sup>100</sup> The formation of the National Advisory Committee on Children and Disasters was due, in large part, to the legislative and

advocacy leadership of the AAP and embodied in the language of the Pandemic All-Hazards Preparedness Reauthorization Act. A second advisory committee, the National Biodefense Science Board, is currently charged with assessing the science and data supporting current disaster planning.<sup>101</sup> Other key federal partners in assuring that children's unique needs in disasters are being addressed include the Centers for Disease Control and Prevention and the Federal Emergency Management Agency. Since Hurricane Katrina, these agencies have formed important relationships with the AAP and other advocacy organizations.

This complicated federal structure is important for ensuring adequate pediatric response. Only through federal collaboration with states and regions can the nation be truly prepared.

### **CONCLUSIONS**

National experiences over the past 15 years have revealed that preparing for and responding to disasters are national security concerns.<sup>102-104</sup> Health care providers typically occupy critically important roles in leadership and the implementation of frontline responses. Children and infants are likely to be victims in a disaster and are more vulnerable than adults.<sup>73</sup> Specialized resources needed to care for children who are ill and injured vary widely by geographical region. In a disaster, pediatric centers may be overwhelmed or rendered inoperable, and many children may be taken to hospitals that cannot provide specialized pediatric care. Developing prehospital pediatric protocols and transfer agreements are of paramount importance.<sup>21,25,30,73</sup>

Because of the vulnerabilities of children during disasters, pediatric health care providers play a uniquely important role.<sup>13,25</sup> History has revealed that pediatricians and other

pediatric providers are eager to help children affected by major disasters.<sup>1,13,14,39,56</sup> Although much progress has been made in addressing the needs of children affected by disasters, work remains to protect the risk of liability for those health care providers who step up to help the most vulnerable among us.<sup>11</sup>

Areas of liability protection inequity deserve attention. Although all providers responding to a disaster will face similar conditions, arguably, the frontline nonvolunteers will be faced with unfolding conditions with an uncertain end point and a higher chance of exposure to the kinds of liability risks explored in this report. In addition, government agents and law enforcement officials who are responsible for discretionary decisions, such as evacuation, are usually protected for those decisions, whereas the providers left to care for patients affected by those decisions are not.<sup>7,48</sup> Liability protection that is linked to a government-declared emergency might not completely reflect, in timeliness or scope, the conditions being faced by providers on the front lines.

There are increased potential risks for liability amid attempting to treat patients with limited resources in difficult conditions.<sup>10,30,53</sup> The better prepared health care providers, institutions, volunteers, and communities are to care for children and families during disasters, the better the outcomes will be and the smaller the chances of unintended harm.<sup>105</sup> With that in mind, the most important step to reducing liability risk for providers during a disaster, regardless of type and location of

health care practice, is to remain informed and prepared for a potential disaster. Expanding the pool of properly trained pediatric volunteers who can be quickly mobilized remains a national priority.

The time has long passed when health care providers can think that it will never happen to them. In 2000, the AAP Committee on Pediatric Emergency Medicine and the AAP Committee on Medical Liability issued a joint statement on the need for professional liability insurance coverage for pediatricians volunteering during disasters.<sup>106</sup> Since that time, considerably more information has become available to broaden the understanding of the scope of this issue, allowing for it to be addressed more fully.<sup>§</sup> Reducing liability risks for health care providers delivering essential medical care amid disasters requires a multilayered, coordinated approach through education, preparation, and, when appropriate, legislative protections. Recommendations related to this technical report are found in the accompanying policy statement of the same title ([www.pediatrics.org/cgi/doi/10.1542/peds.2018-3892](http://www.pediatrics.org/cgi/doi/10.1542/peds.2018-3892)).<sup>36</sup>

#### LEAD AUTHORS

Robin L. Altman, MD, FAAP  
Karen A. Santucci, MD, FAAP  
Michael R. Anderson, MD, MBA, FAAP  
William M. McDonnell, MD, JD, FAAP

<sup>§</sup> State laws are amended on a frequent basis. For information about current laws addressing medical liability in your state, please contact the AAP Division of State Government Affairs at [stgov@aap.org](mailto:stgov@aap.org).

#### COMMITTEE ON MEDICAL LIABILITY AND RISK MANAGEMENT, 2017–2018

Jon Mark Fanaroff, MD, JD, FAAP, Chairperson  
Robin L. Altman, MD, FAAP  
Steven A. Bondi, JD, MD, FAAP  
Sandeep K. Narang, MD, JD, FAAP  
Richard L. Oken, MD, FAAP  
John W. Rusher, MD, JD, FAAP  
Karen A. Santucci, MD, FAAP  
James P. Scibilia, MD, FAAP  
Susan M. Scott, MD, JD, FAAP  
Laura J. Sigman, MD, JD, FAAP

#### FORMER COMMITTEE MEMBER

William M. McDonnell, MD, JD, FAAP

#### CONSULTANT

Michael R. Anderson, MD, MBA, FAAP

#### STAFF

Julie Kersten Ake

#### ACKNOWLEDGMENT

We extend our appreciation to Jay Goldsmith, MD, FAAP, for his review and technical advice.

#### ABBREVIATIONS

AAP: American Academy of Pediatrics  
ASPR: Assistant Secretary of Preparedness and Response  
CMS: Centers for Medicare and Medicaid Services  
EMTALA: Emergency Medical Treatment and Labor Act  
HIPAA: Health Insurance Portability and Accountability Act  
NDMS: National Disaster Medical System

The guidance in this report does not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

All technical reports from the American Academy of Pediatrics automatically expire 5 years after publication unless reaffirmed, revised, or retired at or before that time.

**DOI:** <https://doi.org/10.1542/peds.2018-3893>

Address correspondence to Robin L. Altman, MD, FAAP. Email: [robin\\_altman@nymc.edu](mailto:robin_altman@nymc.edu).

**FINANCIAL DISCLOSURE:** The authors have indicated they have no financial relationships relevant to this article to disclose.

**FUNDING:** No external funding.

**POTENTIAL CONFLICT OF INTEREST:** The authors have indicated they have no potential conflicts of interest to disclose.

## REFERENCES

1. Kelly F. Keeping PEDIATRICS in pediatric disaster management: before, during, and in the aftermath of complex emergencies. *Crit Care Nurs Clin North Am.* 2010;22(4):465–480
2. Pope TM, Palazzo MF. Legal briefing: crisis standards of care and legal protections during disasters and emergencies. *J Clin Ethics.* 2010;21(4):358–367
3. Hanfling D. When the bells toll: engaging healthcare providers in catastrophic disaster response planning. *South Med J.* 2013;106(1):7–12
4. Brandenburg MA, Arneson WL. Pediatric disaster response in developed countries: ten guiding principles. *Am J Disaster Med.* 2007;2(3):151–162
5. Tegtmeyer K, Conway EE Jr, Upperman JS, Kissoon N; Task Force for Pediatric Emergency Mass Critical Care. Education in a pediatric emergency mass critical care setting. *Pediatr Crit Care Med.* 2011;12(suppl 6):S135–S140
6. Sirbaugh PE. Katrina changed us (and me) in so many ways. *Pediatrics.* 2011;128(suppl 1):S20–S22
7. Hodge JG Jr, Garcia AM, Anderson ED, Kaufman T. Emergency legal preparedness for hospitals and health care personnel. *Disaster Med Public Health Prep.* 2009;3(suppl 2):S37–S44
8. American Academy of Pediatrics Committee on Pediatric Emergency Medicine; American Academy of Pediatrics Committee on Medical Liability; Task Force on Terrorism. The pediatrician and disaster preparedness. *Pediatrics.* 2006;117(2):560–565
9. Markenson D, Reynolds S; American Academy of Pediatrics Committee on Pediatric Emergency Medicine; Task Force on Terrorism. The pediatrician and disaster preparedness. *Pediatrics.* 2006;117(2). Available at: [www.pediatrics.org/cgi/content/full/117/2/e340](http://www.pediatrics.org/cgi/content/full/117/2/e340)
10. Hodge JG Jr. The evolution of law in biopreparedness. *Bio Secur Bioterror.* 2012;10(1):38–48
11. Courtney B, Hodge JG Jr; Task Force for Pediatric Emergency Mass Critical Care. Legal considerations during pediatric emergency mass critical care events. *Pediatr Crit Care Med.* 2011;12(suppl 6):S152–S156
12. Mace SE, Sharieff G, Bern A, et al. Pediatric issues in disaster management, part 3: special healthcare needs patients and mental health issues. *Am J Disaster Med.* 2010;5(5):261–274
13. Garrett AL, Grant R, Madrid P, Brito A, Abramson D, Redlener I. Children and megadisasters: lessons learned in the new millennium. *Adv Pediatr.* 2007;54:189–214
14. Pou AM. Ethical and legal challenges in disaster medicine: are you ready? *South Med J.* 2013;106(1):27–30
15. VanDevanter N, Kovner CT, Raveis VH, McCollum M, Keller R. Challenges of nurses' deployment to other New York City hospitals in the aftermath of Hurricane Sandy. *J Urban Health.* 2014;91(4):603–614
16. Gruich M Jr. Life-changing experiences of a private practicing pediatrician: perspectives from a private pediatric practice. *Pediatrics.* 2006;117(5, pt 3):S359–S364
17. Barkemeyer BM. Practicing neonatology in a blackout: the University Hospital NICU in the midst of Hurricane Katrina: caring for children without power or water. *Pediatrics.* 2006;117(5, pt 3):S369–S374
18. Spedale SB. Opening our doors for all newborns: caring for displaced neonates: intrastate. *Pediatrics.* 2006;117(5, pt 3):S389–S395
19. Thomas DE, Gordon ST, Melton JA, Funes CM, Collinworth HJ, Vicari RC. Pediatricians' experiences 80 miles up the river: Baton Rouge pediatricians' experiences meeting the health needs of evacuated children. *Pediatrics.* 2006;117(5, pt 3):S396–S401
20. Shapiro A, Seim L, Christensen RC, et al. Chronicles from out-of-state professionals: providing primary care to underserved children after a disaster: a national organization response. *Pediatrics.* 2006;117(5, pt 3):S412–S415
21. Baldwin S, Robinson A, Barlow P, Fargason CA Jr. Moving hospitalized children all over the southeast: interstate transfer of pediatric patients during Hurricane Katrina. *Pediatrics.* 2006;117(5, pt 3):S416–S420
22. Sirbaugh PE, Gurwitch KD, Macias CG, Ligon BL, Gavagan T, Feigin RD. Caring for evacuated children housed in the Astrodome: creation and implementation of a mobile pediatric emergency response team: regionalized caring for displaced children after a disaster. *Pediatrics.* 2006;117(5, pt 3):S428–S438
23. Madrid PA, Schacher SJ. A critical concern: pediatrician self-care after disasters [published correction appears in *Pediatrics.* 2006;118(5):2271]. *Pediatrics.* 2006;117(5, pt 3):S454–S457
24. Fink S. The deadly choices at memorial. *The New York Times.* August 25, 2009. Available at: [www.nytimes.com/2009/08/30/magazine/30doctors.html?pagewanted=all](http://www.nytimes.com/2009/08/30/magazine/30doctors.html?pagewanted=all). Accessed July 24, 2017
25. Burkle FM Jr, Williams A, Kissoon N; Task Force for Pediatric Emergency Mass Critical Care. Pediatric emergency mass critical care: the role of community preparedness in conserving

- critical care resources. *Pediatr Crit Care Med*. 2011;12(suppl 6):S141–S151
26. Watson CM, Barnett DJ, Thompson CB, et al. Characterizing public health emergency perceptions and influential modifiers of willingness to respond among pediatric healthcare staff. *Am J Disaster Med*. 2011;6(5):299–308
  27. Rothstein MA. Currents in contemporary ethics. Malpractice immunity for volunteer physicians in public health emergencies: adding insult to injury. *J Law Med Ethics*. 2010; 38(1):149–153
  28. Iserson KV, Heine CE, Larkin GL, Moskop JC, Baruch J, Aswegan AL. Fight or flight: the ethics of emergency physician disaster response. *Ann Emerg Med*. 2008;51(4):345–353
  29. Jacobson PD, Wasserman J, Botosaneanu A, Silverstein A, Wu HW. The role of law in public health preparedness: opportunities and challenges. *J Health Polit Policy Law*. 2012;37(2):297–328
  30. Courtney B, Hodge JG Jr, Toner ES, et al; Task Force for Mass Critical Care. Legal preparedness: care of the critically ill and injured during pandemics and disasters: CHEST consensus statement. *Chest*. 2014;146(suppl 4):e134S–e144S
  31. Qureshi K, Gershon RM, Conde F. Factors that influence Medical Reserve Corps recruitment. *Prehosp Disaster Med*. 2008;23(3):s27–s34
  32. Rutkow L, Vernick JS, Thompson CB, Piltch-Loeb R, Barnett DJ. Legal protections to promote response willingness among the local public health workforce. *Disaster Med Public Health Prep*. 2015;9(2):98–102
  33. Weiss RI, McKie KL, Goodman RA. The law and emergencies: surveillance for public health-related legal issues during Hurricanes Katrina and Rita. *Am J Public Health*. 2007;97(suppl 1): S73–S81
  34. Rosenbaum S, Harty MB, Sheer J. State laws extending comprehensive legal liability protections for professional health-care volunteers during public health emergencies. *Public Health Rep*. 2008;123(2):238–241
  35. Hanfling D, Altevoigt BM, Viswanathan K, Gostin LO, eds; Committee on Guidance for Use in Disaster Situations; Institute of Medicine. *Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response*. Washington, DC: The National Academies Press; 2012. Available at: [https://www.ncbi.nlm.nih.gov/books/NBK201063/pdf/Bookshelf\\_NBK201063.pdf](https://www.ncbi.nlm.nih.gov/books/NBK201063/pdf/Bookshelf_NBK201063.pdf). Accessed July 24, 2017
  36. Altman RL, Santucci KA, Anderson MR, McDonnell WM; Committee on Medical Liability and Risk Management. Understanding liability risks and protections for pediatric providers during disasters. *Pediatrics*. 2019; 143(3):e20183892
  37. Barnett DJ, Taylor HA, Hodge JG Jr, Links JM. Resource allocation on the frontlines of public health preparedness and response: report of a summit on legal and ethical issues. *Public Health Rep*. 2009;124(2):295–303
  38. Antommaria AH, Kaziny BD. Ethical issues in pediatric emergency medicine's preparation for and response to disasters. *Virtual Mentor*. 2012;14(10):801–804
  39. Altevoigt BM, Stroud C, Hanson SL, Hanfling D, Gostin LO, eds; Committee on Guidance for Establishing Standards of Care for Use in Disaster Situations; Institute of Medicine. *Guidance for Establishing Crisis Standards of Care for Use in Disaster Situations: A Letter Report*. Washington, DC: The National Academies Press; 2009. Available at: [https://www.ncbi.nlm.nih.gov/books/NBK219958/pdf/Bookshelf\\_NBK219958.pdf](https://www.ncbi.nlm.nih.gov/books/NBK219958/pdf/Bookshelf_NBK219958.pdf). Accessed July 24, 2017
  40. Mace SE, Sharieff G, Bern A, et al. Pediatric issues in disaster management, part 2: evacuation centers and family separation/reunification. *Am J Disaster Med*. 2010; 5(3):149–161
  41. Weiner DL, Manzi SF, Waltzman ML, Morin M, Meginniss A, Fleisher GR. FEMA's organized response with a pediatric subspecialty team: the National Disaster Medical System response: a pediatric perspective. *Pediatrics*. 2006;117(5, pt 3):S405–S411
  42. Roszak AR, Jensen FR, Wild RE, Yeskey K, Handrigan MT. Implications of the Emergency Medical Treatment and Labor Act (EMTALA) during public health emergencies and on alternate sites of care. *Disaster Med Public Health Prep*. 2009;3(suppl 2):S172–S175
  43. Iserson KV, Moskop JC. Triage in medicine, part I: concept, history, and types. *Ann Emerg Med*. 2007;49(3): 275–281
  44. Markovitz BP. Pediatric critical care surge capacity. *J Trauma*. 2009;67(suppl 2):S140–S142
  45. Zoraster RM, Burkle CM. Disaster documentation for the clinician. *Disaster Med Public Health Prep*. 2013; 7(4):354–360
  46. Cohen R, Murphy B, Ahern T, Hackel A. Regional disaster planning for neonatology. *J Perinatol*. 2010;30(11): 709–711
  47. Eddy A. First responder and physician liability during an emergency. *Am J Disaster Med*. 2013;8(4):267–272
  48. Hoffman S, Goodman RA, Stier DD. Law, liability, and public health emergencies. *Disaster Med Public Health Prep*. 2009; 3(2):117–125
  49. Williams SP, Boyd HS. Is there much limited legal liability protection for physicians in crisis standards of care in SC? *J S C Med Assoc*. 2011;107(3): 96–98
  50. Schonfeld DJ, Demaria T; Disaster Preparedness Advisory Council; Committee on Psychosocial Aspects of Child and Family Health. Providing psychosocial support to children and families in the aftermath of disasters and crises. *Pediatrics*. 2015;136(4). Available at: [www.pediatrics.org/cgi/content/full/136/4/e1120](http://www.pediatrics.org/cgi/content/full/136/4/e1120)
  51. Rutkow L, Vernick JS, Wissow LS, Tung GJ, Marum F, Barnett DJ. Legal issues affecting children with preexisting conditions during public health emergencies. *Biosecur Bioterror*. 2013; 11(2):89–95
  52. Fanaroff JM; Committee on Medical Liability and Risk Management. Consent by proxy for nonurgent pediatric care. *Pediatrics*. 2017;139(2):e20163911
  53. Foltin GL, Lucky C, Portelli I, et al. Overcoming legal obstacles involving the voluntary care of children who are separated from their legal guardians during a disaster. *Pediatr Emerg Care*. 2008;24(6):392–398

54. Sauer LM, Catlett C, Tosatto R, Kirsch TD. The utility of and risks associated with the use of spontaneous volunteers in disaster response: a survey. *Disaster Med Public Health Prep.* 2014;8(1): 65–69
55. Bailey PV. A crisis in the ED: liability protection needed STAT. *Bull Am Coll Surg.* 2012;97(3):19–22
56. Thompson T, Lyle K, Mullins SH, Dick R, Graham J. A state survey of emergency department preparedness for the care of children in a mass casualty event. *Am J Disaster Med.* 2009;4(4):227–232
57. Hodge JG Jr, Brown EF. Assessing liability for health care entities that insufficiently prepare for catastrophic emergencies. *JAMA.* 2011;306(3): 308–309
58. Chokshi NK, Behar S, Nager AL, Dorey F, Upperman JS. Disaster management among pediatric surgeons: preparedness, training and involvement. *Am J Disaster Med.* 2008; 3(1):5–14
59. Maldin B, Lam C, Franco C, et al. Regional approaches to hospital preparedness. *Biosecur Bioterror.* 2007; 5(1):43–53
60. The Joint Commission. Surge hospitals: providing safe care in emergencies. 2006. Available at: [https://www.jointcommission.org/assets/1/18/surge\\_hospital.pdf](https://www.jointcommission.org/assets/1/18/surge_hospital.pdf). Accessed July 24, 2017
61. Ferrer RR, Balasuriya D, Iverson E, Upperman JS. Pediatric disaster preparedness of a hospital network in a large metropolitan region. *Am J Disaster Med.* 2010;5(1):27–34
62. Public Health Service Act, 42 USC §247d-6d (2006)
63. Fink S. Trial to open in lawsuit connected to hospital deaths after Katrina. *The New York Times.* March 20, 2011. Available at: [www.nytimes.com/2011/03/21/us/21hospital.html?r=1&ref=tenethealthcarecorporation](http://www.nytimes.com/2011/03/21/us/21hospital.html?r=1&ref=tenethealthcarecorporation). Accessed July 24, 2017
64. US Department of Health and Human Services. Pandemic and All-Hazards Preparedness Act, 42 §USC 300hh et seq (2006). Available at: <https://www.phe.gov/preparedness/legal/pahpa/pages/default.aspx>. Accessed January 29, 2019
65. Centers for Medicare and Medicaid Services. Emergency preparedness rule. Available at: <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Emergency-Prep-Rule.html>. Accessed July 24, 2017
66. Suk M. Sovereign immunity: principles and application in medical malpractice. *Clin Orthop Relat Res.* 2012;470(5): 1365–1369
67. Federal Emergency Management Agency. The disaster declaration process. Available at: <https://www.fema.gov/disaster-declaration-process>. Accessed July 24, 2017
68. Hodge JG, Anderson ED. Principles and practice of legal triage during public health emergencies. *Annu Surv Am Law.* 2008;64:249–291
69. US Department of Health and Human Services, Office of the Assistant Secretary for Preparedness and Response. 1135 waivers. Available at: <https://www.phe.gov/Preparedness/legal/Pages/1135-waivers.aspx>. Accessed July 24, 2017
70. Hershey TB, Van Nostrand E, Sood RK, Potter M. Legal considerations for health care practitioners after Superstorm Sandy. *Disaster Med Public Health Prep.* 2016;10(3):518–524
71. Cole C, Marzen C. A review of state sovereign immunity statutes and the management of liability risks by states. *Journal of Insurance Regulation.* 2013; 32:45–82
72. Stier DD, Goodman RA. Mutual aid agreements: essential legal tools for public health preparedness and response. *Am J Public Health.* 2007;97 (suppl 1):S62–S68
73. Mace SE, Sharieff G, Bern A, et al. Pediatric issues in disaster management, part 1: the emergency medical system and surge capacity. *Am J Disaster Med.* 2010;5(2):83–93
74. Lopez W, Kershner SP, Penn MS. EMAC volunteers: liability and workers' compensation. *Biosecur Bioterror.* 2013; 11(3):217–225
75. Hanna J. Good Samaritan Act doesn't shield on-duty emergency doctors. *Ill Bar J.* 2014;102(5):214
76. Hodge JG Jr, Pepe RP, Henning WH. Voluntarism in the wake of Hurricane Katrina: the uniform emergency volunteer health practitioners act. *Disaster Med Public Health Prep.* 2007; 1(1):44–50
77. Foxhall K. License to serve: a model law could make it easier for medical volunteers to respond immediately during emergencies. *State Legis.* 2008; 34(4):27–28
78. Uniform Law Commission. Emergency volunteer health practitioners. Available at: <https://www.facs.org/advocacy/state/uevhpa>. Accessed July 24, 2017
79. Hodge JG Jr, Gable LA, Cálves SH. Volunteer health professionals and emergencies: assessing and transforming the legal environment. *Biosecur Bioterror.* 2005;3(3):216–223
80. American Telemedicine Association. Disaster relief center: resources to prepare for and respond to natural disasters. Available at: <http://www.americantelemed.org/main/policy-page/state-policy-resource-center>. Accessed July 24, 2017
81. Hoard ML, Tosatto RJ. Medical Reserve Corps: strengthening public health and improving preparedness. *Disaster Manag Response.* 2005;3(2):48–52
82. Orenstein DG. When law is not law: setting aside legal provisions during declared emergencies. *J Law Med Ethics.* 2013;41(suppl 1):73–76
83. The Network for Public Health Law. Legal liability protections for emergency medical/public health responses. Available at: [https://www.networkforphl.org/\\_asset/xbt7sg/Liability-Protections-for-Emergency-Response.pdf](https://www.networkforphl.org/_asset/xbt7sg/Liability-Protections-for-Emergency-Response.pdf). Accessed July 24, 2017
84. Disaster Preparedness Advisory Council. Medical countermeasures for children in public health emergencies, disasters, or terrorism. *Pediatrics.* 2016;137(2):e20154273
85. US Department of Homeland Security. Planning. Available at: <https://www.ready.gov/planning>. Accessed July 24, 2017
86. Disaster Preparedness Advisory Council; Committee on Pediatric Emergency Medicine. Ensuring the health of children in disasters. *Pediatrics.* 2015;136(5). Available at:

- www.pediatrics.org/cgi/content/full/136/5/e1407
87. Krug SE, Needle S, Schonfeld D, Aird L, Hurley H. Improving pediatric preparedness performance through strategic partnerships. *Disaster Med Public Health Prep.* 2012;6(2):94–96
  88. American Academy of Pediatrics. Strategic plan for disaster preparedness. Available at: [www.aap.org/disasters/strategicplan](http://www.aap.org/disasters/strategicplan). Accessed July 24, 2017
  89. Emergency Medical Services for Children Innovation and Improvement Center. National pediatric readiness project. Available at: <https://emscimprovement.center/projects/pediatricreadiness/>. Accessed July 24, 2017
  90. Krug SE, Tait VF, Aird L. Helping the helpers to help children: advances by the American Academy of Pediatrics. *Pediatrics.* 2011;128(suppl 1):S37–S39
  91. American Academy of Pediatrics. Children and disasters. Available at: [www.aap.org/disasters](http://www.aap.org/disasters). Accessed July 24, 2017
  92. American Academy of Pediatrics. Preparedness checklist for pediatric practices. 2013. Available at: [www.aap.org/disasters/checklist](http://www.aap.org/disasters/checklist). Accessed July 24, 2017
  93. American Academy of Pediatrics. Children and youth with special needs. Available at: [www.aap.org/disasters/cyshcn](http://www.aap.org/disasters/cyshcn). Accessed July 24, 2017
  94. US Department of Health and Human Services, Office of the Assistant Secretary for Preparedness and Response. Cultural and linguistic competency for disaster preparedness planning and crisis response. Available at: <https://www.phe.gov/Preparedness/planning/abc/Pages/linguistic.aspx>. Accessed July 24, 2017
  95. Stankovic C, Mahajan P, Ye H, Dunne RB, Knazik SR. Bioterrorism: evaluating the preparedness of pediatricians in Michigan. *Pediatr Emerg Care.* 2009; 25(2):88–92
  96. Branson RD. Disaster planning for pediatrics. *Respir Care.* 2011;56(9): 1457–1463; discussion 1463–1465
  97. Allen GM, Parrillo SJ, Will J, Mohr JA. Principles of disaster planning for the pediatric population. *Prehosp Disaster Med.* 2007;22(6):537–540
  98. Federal Emergency Management Agency; US Department of Homeland Security. National response framework. 2016. Available at: [https://www.fema.gov/media-library-data/20130726-1914-25045-1246/final\\_national\\_response\\_framework\\_20130501.pdf](https://www.fema.gov/media-library-data/20130726-1914-25045-1246/final_national_response_framework_20130501.pdf). Accessed July 24, 2017
  99. US Department of Health and Human Services, Office of the Assistant Secretary for Preparedness and Response. Pandemic and All-Hazards Preparedness Reauthorization Act. Available at: <https://www.phe.gov/preparedness/legal/pahpa/pages/pahpra.aspx>. Accessed July 24, 2017
  100. US Department of Health and Human Services, Office of the Assistant Secretary for Preparedness and Response. National advisory committee on children and disasters. Available at: <https://www.phe.gov/Preparedness/legal/boards/naccd/Pages/default.aspx>. Accessed July 24, 2017
  101. US Department of Health and Human Services, Office of the Assistant Secretary for Preparedness and Response. National biodefense science board. Available at: <https://www.phe.gov/nprsb>. Accessed July 24, 2017
  102. Benjamin GC, Moulton AD. Public health legal preparedness: a framework for action. *J Law Med Ethics.* 2008;36(suppl 1):13–17
  103. Gausche-Hill M. Pediatric disaster preparedness: are we really prepared? *J Trauma.* 2009;67(suppl 2):S73–S76
  104. Dunlop AL, Logue KM, Isakov AP. The engagement of academic institutions in community disaster response: a comparative analysis. *Public Health Rep.* 2014;129(suppl 4):87–95
  105. Fitch E. Managing the risks of incorporating volunteers into public health emergency response: the other side of the liability issue. *Disaster Med Public Health Prep.* 2010;4(3):252–254
  106. Committee on Pediatric Emergency Medicine; Committee on Medical Liability. Pediatricians' liability during disasters. *Pediatrics.* 2000;106(6): 1492–1493

## Understanding Liability Risks and Protections for Pediatric Providers During Disasters

Robin L. Altman, Karen A. Santucci, Michael R. Anderson, William M. McDonnell  
and COMMITTEE ON MEDICAL LIABILITY AND RISK MANAGEMENT

*Pediatrics* 2019;143;

DOI: 10.1542/peds.2018-3893 originally published online February 25, 2019;

<b>Updated Information &amp; Services</b>	including high resolution figures, can be found at: <a href="http://pediatrics.aappublications.org/content/143/3/e20183893">http://pediatrics.aappublications.org/content/143/3/e20183893</a>
<b>References</b>	This article cites 81 articles, 13 of which you can access for free at: <a href="http://pediatrics.aappublications.org/content/143/3/e20183893#BIBL">http://pediatrics.aappublications.org/content/143/3/e20183893#BIBL</a>
<b>Subspecialty Collections</b>	This article, along with others on similar topics, appears in the following collection(s): <b>Committee on Medical Liability and Risk Management</b> <a href="http://www.aappublications.org/cgi/collection/committee_on_medical_liability_and_risk_management">http://www.aappublications.org/cgi/collection/committee_on_medical_liability_and_risk_management</a> <b>Disaster Preparedness</b> <a href="http://www.aappublications.org/cgi/collection/disaster_prep_sub">http://www.aappublications.org/cgi/collection/disaster_prep_sub</a>
<b>Permissions &amp; Licensing</b>	Information about reproducing this article in parts (figures, tables) or in its entirety can be found online at: <a href="http://www.aappublications.org/site/misc/Permissions.xhtml">http://www.aappublications.org/site/misc/Permissions.xhtml</a>
<b>Reprints</b>	Information about ordering reprints can be found online: <a href="http://www.aappublications.org/site/misc/reprints.xhtml">http://www.aappublications.org/site/misc/reprints.xhtml</a>

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™



# PEDIATRICS®

OFFICIAL JOURNAL OF THE AMERICAN ACADEMY OF PEDIATRICS

## **Understanding Liability Risks and Protections for Pediatric Providers During Disasters**

Robin L. Altman, Karen A. Santucci, Michael R. Anderson, William M. McDonnell  
and COMMITTEE ON MEDICAL LIABILITY AND RISK MANAGEMENT

*Pediatrics* 2019;143;

DOI: 10.1542/peds.2018-3893 originally published online February 25, 2019;

The online version of this article, along with updated information and services, is  
located on the World Wide Web at:

<http://pediatrics.aappublications.org/content/143/3/e20183893>

Pediatrics is the official journal of the American Academy of Pediatrics. A monthly publication, it has been published continuously since 1948. Pediatrics is owned, published, and trademarked by the American Academy of Pediatrics, 141 Northwest Point Boulevard, Elk Grove Village, Illinois, 60007. Copyright © 2019 by the American Academy of Pediatrics. All rights reserved. Print ISSN: 1073-0397.

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

