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Hurricane Michael Response: Medical Legal Considerations Before, During, and After a Natural Disaster

BY MAJOR VINCENT L. DEFABO

This article will address what medical law practitioners and other legal professionals should do before, during, and after a natural disaster, based on the lessons learned from Hurricane Michael.

On **8 October 2018**, Hurricane Michael strengthened to Category 1^[1] and was projected to intensify as it moved through the Gulf of Mexico. Members of the 96th Medical Group at Eglin Air Force Base (AFB), Florida met to develop a plan for assisting with recovery to the local and base community and to discuss the “ride out” options. As a precautionary measure, the decision was made to close the hospital for the next two days.

On 9 October 2018, Hurricane Michael strengthened to Category 2 and it became evident there would be a direct impact on the Florida panhandle. Closure signs went up at Eglin’s hospital. A little over 90 miles to the east, the situation looked more precarious for Tyndall AFB and a mandatory evacuation was ordered for all personnel.

On 10 October 2018, as Hurricane Michael was about to make landfall, it had developed into a high-end Category 4

(measured wind speeds were only two miles per hour shy of criteria for Category 5 storm—the highest category).^[2]

On the evening of **11 October 2018**, Hurricane Michael quickly passed through the Florida panhandle, sparing Eglin but devastating Tyndall. While normal operations resumed on Eglin, almost all of Tyndall’s structures were damaged.^[3]

Several legal issues arose in the following days and weeks: what would be the Rules of Engagement (ROEs) for medical personnel responding on Tyndall; what would be the status of squadrons that had to move temporarily; and, who would assume responsibility for hospital operations ranging from unread lab tests to clinical adverse actions? This article will address what medical law practitioners and other legal professionals should do before, during, and after a natural disaster, based on the lessons learned from Hurricane Michael.

BEFORE THE DISASTER

Mutual Aid Agreements

Planning a medical response for a disaster should begin well before a hurricane, wildfire, earthquake, or other disaster materializes. Mutual Aid Agreements (MAAs) should be developed with civilian entities to provide a coordinated medical response.[4]

An MAA is an agreement between agencies or jurisdictions that provides a mechanism to quickly obtain emergency assistance in the form of personnel, equipment, materials, and associated services.

An MAA is an agreement between agencies or jurisdictions that provides a mechanism to quickly obtain emergency assistance in the form of personnel, equipment, materials, and associated services.[5] An MAA should define the type of assistance requested and/or available to support others (e.g., ambulance transport) and also include the procedures required for civil authorities to request assistance. Verbal requests must be followed by a written request to the installation commander with an offer to reimburse the DoD.[6] In the immediate aftermath of a disaster, the installation commander may authorize requests for immediate relief when there is not enough time for higher headquarters approval.[7] Therefore, the MAA should be signed by the installation commander, as opposed to a group commander, since the installation commander has been given the authority to provide assistance in the immediate aftermath of a disaster.

An MAA should also outline the specific timelines for enacting a request. Commanders may authorize a request for assistance as described above, which should be received from civilian agencies within 24 hours of the agency's damage assessments.[8] Any enactment of the MAA beyond 72 hours requires the installation commander to conduct an assessment to determine if the emergency still exists.[9]

A military commander may employ resources under his or her control to save lives, prevent human suffering, or mitigate property damage under imminently serious conditions.[10] It is not clear from DoD and Air Force guidance if group and squadron commanders may authorize assistance under the immediate response authority since they are military commanders with resources under their control, or if this responsibility rests solely with the installation commander. Therefore, an MAA should clearly delineate the installation commander's role in disaster response and if he or she is authorizing a group commander or a medical wing to act on requests to use medical group assets in a medical emergency. As such, the group commander can rely not only on immediate response authority, but also on the installation commander's direction under the MAA.

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During Hurricane Michael, Eglin did not have an MAA in place. This created the potential for confusion if Hurricane Michael directly hit Eglin. Tyndall did not have an MAA in place and ambulance responses had to be coordinated on an ad hoc basis. This included Eglin ambulance crews driving over 90 miles to assist Tyndall and then waiting for further clarification on response capabilities after arriving. After the hurricane, Eglin worked with local governmental authorities to develop an MAA to avoid confusion in the event of a future disaster.

Hospital Closure Planning

Alongside establishing MAAs before a major disaster, closure planning is key. The concept of closing a hospital or clinic may seem unlikely or improbable, until a disaster is imminent. Simply having a discussion about closing the hospital or clinic is a necessary step for pre-disaster planning. The factors to consider in determining whether to close a Military Treatment Facility (MTF) are: (1) whether the Standard of Care (SOC) can be maintained if the facility remains

open; (2) notification procedures to patients and potential patients; and (3) procedures for handling unresolved patient encounters (i.e. open medical encounters)[11] in which further action is needed. Examples of follow up care for open medical encounters includes: unread radiology or lab results, referrals, and follow up treatment recommendations.

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While a facility remains open, the SOC does not necessarily change for hospital operations.[12] A hospital that remains open must be prepared for normal emergency response and transfer of patients to appropriate facilities despite hazardous conditions, meaning it is not an option to keep only the emergency room open. Courts have held hospitals liable for an individual physician's negligence under the theory of corporate negligence if the negligence was the result of deficiencies in staffing, which may apply to natural disasters.[13]

MTFs should discuss what services they can provide in the event of a disaster, taking into consideration supplies, backup power, and their ability to maintain proper staffing.

Manning positions with personnel whose qualifications do not meet the minimum SOC is also not an option. Hospitals can be liable for the negligence of individual health professionals when the resulting injuries could have been prevented through adequate supervision.[14] MTFs should discuss what services they can provide in the event of a disaster, taking into consideration supplies, backup power, and their ability to maintain proper staffing. At Eglin, the need to maintain the same SOC was central to the decision to close the hospital for 48 hours. The concern was that patients

would show up to receive emergency medical care and the hospital would not be able to provide proper services.

Proper notification of patients in the event of a closure is also part of closure planning. Clear signage should be posted to ensure patients have reasonable notice that the facility will be closing, or is closed, and to ensure that patients are aware of the anticipated duration of the closure. Notifications by phone should also occur to ensure patients are aware that their appointments and surgeries are canceled. Automated closure messages and local media can also be utilized in order to disseminate the message.

The final factor to consider in closure planning is to determine who will handle open medical encounters. Specifically, who will take care of unread radiology and lab results and relay those results to patients. Certain medical encounters require follow up care and providers should have plans for transferring or following up with patients. Under the **Health Information Technology for Economic and Clinical Health (HITECH) Act**, the federal government seeks to achieve interoperability by building a "nationwide health information technology infrastructure that permits the electronic exchange and use of health information." [15] This act may also create a requirement to ensure transmission of care and notification of results if a hospital is closed.[16]

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A similar, related consideration is that evacuees need to be able to obtain new medications and resume medical care. "With interoperability, authorized clinicians will have direct access to the results of all prior diagnostic tests and procedures, no matter where they were conducted." [17] In short, MTFs should have contingency plans to ensure continuity of medical care and these plans should be finalized and in place before a disaster strikes.

Planning for Continuing Operations

Part of the closure decision making process is determining the capabilities for continued medical operations during a disaster. Facilities that remain open may become part of the disaster response, which may call for ambulances to transport disaster victims to appropriate medical facilities.[18] Even clinics that are not normally engaged in emergency response may be called upon to assist disaster victims.

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In instances of continuing operations in which military medical personnel are called upon to assist civilians in a disaster, it is important to know that there are several legal protections shielding health care providers from liability. Under 10 U.S.C. § 1094, military personnel acting within their scope of care, as directed and authorized by the Department of Defense (DoD), may provide medical support outside of an installation, even if they do not have a medical license in the state.[19] Additionally, Good Samaritan laws in most states protect medical personnel, including those in the military, who are responding to emergency situations.[20] However, Good Samaritan law protections generally extend only to stabilization treatment and do not include patient transfers or sustained medical care.[21] To conduct a patient transfer or provide medical care beyond stabilization, providers should be relying on agreements—such as MAAs—or authorizations from commanders to treat civilians, especially off base. Working under an MAA or some other directive (such as a Presidential declaration of emergency or major disaster) provides proper authority and liability protections for responses beyond stabilizing patients.[22] In sum, stabilizing disaster victims may always occur to save life, limb, or eyesight; but, any sustained medical care or medical transport requires additional authorization.

DoD medical personnel may also rely on the **Federal Torts Claims Act (FTCA)** for liability protection.[23] For individual medical personnel employed by the DoD, protections extend to those who are acting within the scope of medical practice and job duties.[24] Having a clear directive of the medical support that will be provided to civilians ensures that FTCA protections extend to medical personnel providing such care. The FTCA not only protects individuals, but the entire MTF. NDAA FY 2020 does not alter the coverage that individual medical personnel employed by DoD (including military, civilian, and personal service contractors) have in terms of liability protection.[25]

Knowing the liability protections also helps to develop ROEs for medical response teams.

Knowing the liability protections also helps to develop ROEs for medical response teams. Preferably the development of ROEs occurs before a disaster to facilitate a speedy response. ROEs should clarify three items. First, what medical care can be provided to different statuses of patients (e.g. DoD beneficiaries and non-DoD beneficiaries) in emergency medical situations? Second, what medical care can be provided to these same categories of individuals in non-emergent situations? Third, what care is best provided off of a military installation and which options are available?

With regard to the first item, the law generally limits care for civilian non-beneficiaries to only emergency care to save life, limb, or eyesight. As to the second item, non-emergent care to non-active duty beneficiary patients may also be limited based on resources, in which case, patients should be directed to the nearest civilian medical facility. Finally, ROEs should be written at the time of the disaster and sent to all treating providers to delineate what care can be provided off a military installation (i.e. outside of exclusive/concurrent jurisdiction). Draft ROEs should be readily available based on the existing MAA and then modified based on the nature of the disaster. Without an MAA or some other authoriza-

tion of a declared disaster, off-base medical care by military medical personnel is limited to stabilizing patients.

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During Hurricane Michael, ROEs were developed at Tyndall with input from the medical law consultant, the Air Force advisor to the Surgeon General, and the Air Combat Command (ACC) Staff Judge Advocate. This ensured both local level support and knowledge, but also higher level considerations and institutional lessons learned from previous disasters.

AFTER THE DISASTER – FACILITY CLOSED

Relocation of Patients and Personnel

If the MTF closure will last an extended period of time, then patients will need to be seen at other facilities. In the case of Hurricane Michael, TriCare authorized most evacuees to receive medical care from a TriCare authorized provider without a referral.[26] This authorization lasted in some counties for one week and in more impacted counties for over three months.[27] In addition, MTFs in evacuation zones received an influx of patients from both active duty and dependent patient populations. MTFs in evacuation zones may have to carefully consider staff schedules and look for ways to manage resources and appointments, to meet the needs of new patients. For example, some providers may have to work extra hours in the short term and some patients may have longer wait times.

An extended closure of an MTF also means that military personnel and missions may be temporarily or permanently moved to new installations. Installation Support Agreements, Memoranda of Understanding (MOU), and Memoranda of Agreement (MOA) will have to be established between the host installation(s) and units leaving their closed installation.[28] These agreements can take time to negotiate while personnel wait to perform assigned duties. Thus, drafts and

reviews of MOAs and MOUs should begin as soon as it is anticipated a squadron or unit will be moving temporarily or permanently to a new installation.

Clinical Adverse Actions

Another consideration is the management of clinical adverse actions under **Air Force Instruction 44-119**, *Medical Quality Operations*. A clinical adverse action is one that is invoked against a healthcare provider (privileged or non-privileged) where there is a threat, or potential threat, to patient safety, the safe delivery of healthcare or to the integrity of the Air Force Medical Service.[29]

If the MTF is closed permanently, then the Air Force Medical Operations Agency (AFMOA) assumes responsibility for all pending clinical adverse actions.

As the privileging authority, the MTF commander is ultimately responsible for initiating and directing the majority of actions.[30] However, if the MTF is closed permanently, then the Air Force Medical Operations Agency (AFMOA) assumes responsibility for all pending clinical adverse actions.[31] For those MTFs on extended closure (e.g. more than 30 days), the MTF commander should consult with AFMOA to handle clinical adverse actions accordingly. During Hurricane Michael, the MTF commander and AFMOA discussed adverse actions as soon as the commander could divert focus away from recovery efforts. While clinical adverse actions are important, the actions can wait a few days or even weeks if a commander needs to focus on recovery efforts.

AFTER THE DISASTER – FACILITY REOPENS

Medical Response Liability Considerations

Once a disaster has occurred, the medical response begins almost immediately. It is of primary importance to save lives. Saving life, limb, and eyesight for disaster victims is both the proper ethical and legal response.[32] If an MTF fails to respond to a disaster victim's medical emergency on

the installation, there is potential for a medical malpractice claim, especially if the patient presents at the MTF.

The Emergency Medical Treatment and Active Labor Act (EMTALA) requires a medical screening and stabilization for all emergency medical conditions.[33] EMTALA does not expressly waive the sovereign immunity of the DoD, or creates a mechanism outside the Federal Tort Claims Act (FTCA) to pursue tort claims for injury or loss caused by MTF providers in the course of their duties. Regardless, the Air Force and DoD have historically abided by EMTALA, due in part to EMTALA's 30-plus years of implementation at civilian hospitals making the Act's response protocols the SOC. This means that an MTF failing to abide by EMTALA standards risks falling below the SOC even though there is arguably no statutory requirement to follow it.[34] Since the DoD follows EMTALA for SOC considerations during normal operations, EMTALA standards should be followed during disasters.

During some situations a medical facility may be held to the same standard as if there were no disaster.

Significant EMTALA standards were set since the enactment of the law for normal medical conditions, but there still remain open questions about hospitals' liability in mass casualties or disasters.[35] During some situations a medical facility may be held to the same standard as if there were no disaster. For example, SOC remains the same for hospitals during power outages.[36] Hospitals are expected to anticipate power outages in order to provide the same level of patient care. There must be backup plans for some disaster situations, such as having hand pumping equipment if the power goes out completely.[37] During disasters normal operations must be maintained to some degree if the MTF remains open.

On the other side of the equation, there are some liability protections if the disaster is so widespread that the system is overwhelmed. For example, certain patient transfer rules are

changed if patient transfers are not possible or are severely limited based on road conditions and facility availability.[38]

The **Bioterrorism Preparedness Act** expressly authorizes federal authorities in an emergency area to waive or modify, for sixty days, certain health care laws and requirements on health care providers regarding patient transfers during an emergency period.[39] The Bioterrorism Preparedness Act is implemented when the President declares an "emergency period" under the **Federal Robert T. Stafford Disaster Relief and Emergency Assistance** authority, or the Secretary of HHS (**Health and Human Services**) declares it under the **Federal Public Health Service Act**. [40] Medical screening and stabilization requirements may also be relaxed, but this is not readily apparent in the Stafford Act.[41] Thus, the major application of the Bioterrorism Preparedness Act for MTFs, as it relates to liability, is primarily in limiting the requirements of patient transfers.[42]

However, there are some indications the liability requirements for patient transfers remain the same. According to Sara Rosenbaum and Brian Kamoie, "The law does not change the underlying duty itself, nor does it extinguish the private right of action on the part of injured individuals. Furthermore, the law does not affect hospitals' screening obligations." [43] Thus, to the extent possible, MTFs should provide the same level of care during all forms of disaster.

Related to the level of care is the liability arrangements for civilian beneficiaries and active duty personnel. Civilian beneficiaries have always been able to file medical claims under the FTCA.[44] Additionally, they have access to judicial remedy if their claim is denied. In contrast, active duty service members have historically been barred from filing claims under *Feres*. [45] However, under NDAA 2020, Section 731, active duty service members can now file a claim; but unlike civilian beneficiaries, active duty personnel still do not have a judicial remedy if their claim is denied.[46] For both civilian beneficiaries and active duty personnel, the initial claims should be filed in writing, typically on Standard Form 95.[47] Base level JAGs should contact their local Medical Law Consultant (MLC) or the Medical Law

Branch after receiving claims under the FY20 NDAA, as the law will evolve for the foreseeable future.

Commanders may authorize assistance to civilian non-beneficiaries for “imminently serious conditions” in disaster situations.

Care to Non-Beneficiaries and National Guard Members

As previously discussed, commanders may authorize assistance to civilian non-beneficiaries for “imminently serious conditions” in disaster situations.[48] This authorization includes support to off installation civilian non-beneficiaries. Every 72 hours a re-evaluation needs to occur to determine if there is still an “imminently serious condition.”[49] Installation commanders may authorize support to save lives and prevent human suffering; but are prohibited from authorizing support that is systematic in nature or to provide widespread medical care.

For medical care that will last more than 72 hours or beyond “imminently serious conditions,” the President of the United States may authorize medical care on public and private lands for the preservation of life.[50] Air Force medical response units may provide immediate medical care for imminently serious conditions if it is anticipated that the President will declare a disaster or emergency.[51] However, the anticipation of a Presidential declaration is limited to Air Force MTFs and is not to exceed 10 days, absent Presidential declaration or other authority. While Air Force regulations do not delineate who may make this call, MTF commanders could authorize the immediate response in order to preserve life and then immediately notify the installation commander. The installation commander is the best authority to authorize a response beyond the first few hours of an imminently serious condition and then make required notification up the chain of command properly. Of note, the authority is limited to providing non-beneficiaries with emergency medical treatment only and to allow for the restoration of medical capabilities.

Sustained medical care is permissible under the Stafford Act if a state Governor makes a request for assistance and the President declares an *emergency* in order to save lives, protect property, and public health and safety, or to lessen the threat of or otherwise avert a catastrophe in any part of the country. [52] Emergency medical care may be provided to civilian non-beneficiaries under a declared emergency.[53] If the President declares a *major disaster*, then military treatment medical units may be called on to perform more sustained functions.[54] Assistance may include distributing medicine or food, providing medical care beyond triage and stabilization (i.e. normal medical care), and taking part in medical rescues. The wording of the authorization is critical as responding medical units need to know whether an *emergency* or a *major disaster* has occurred to understand the parameters of authorized medical care for civilian non-beneficiaries. The range of assistance available for state and local governments, private individuals, and families is broader under a *major disaster* compared to an *emergency*. [55] Consequently, the amount of resources and time that will need to be dedicated to a *major disaster* will generally be more than an *emergency*.

There may be other disaster response situations where MTFs may be called on to provide medical care or incidental medical assistance to civilian non-beneficiaries.

There may be other disaster response situations where MTFs may be called on to provide medical care or incidental medical assistance to civilian non-beneficiaries. This situation can occur under a different set of authorizations that allow for treatment of civilian non-beneficiaries on a federal military installation. In past natural disasters, such as during Hurricane Harvey, the Under Secretary of Defense (Personnel and Readiness), in coordination with the **Federal Emergency Management Agency** (FEMA), authorized certain bases to provide only emergency treatment and follow-on hospital care, if necessary.[56] As part of these past authorizations, civilian FEMA personnel, including

Red Cross workers, and civilian personnel who were affected by the disaster were provided medical care at MTFs. FEMA reimbursed the MTFs for the cost of the treatment. In this situation, patients received more sustained care than the type of care authorized under emergency response situations (i.e. more than just triage care).

According to the Congressional Research Service, governors routinely utilize their state National Guard to assist with disaster response and recovery.[57] Federal authorities may also order the National Guard to active duty.[58] Concerning military health care, if the National Guard members are on **Title 10** status, they are entitled to the same medical care as active duty members. Members of the National Guard on **Title 32** orders for more than 30 consecutive days are eligible for TriCare and can receive medical care at MTFs.[59] Absent another source of entitlement to military health care (for example, marriage to an active duty service member) a National Guardsman not on Title 10 status or on orders for more than 30 consecutive days is treated like a civilian non-beneficiary.

HIPAA Rules in Disasters

The DoD and the Air Force follow the rules of the **Health Insurance Portability and Accountability Act (HIPAA)**, which protects the privacy of protected health information (PHI).[60] HIPAA contains special disclosure rules are specifically related to disasters. In disasters, PHI may be disclosed in order to “assist in disaster relief efforts” for the purpose of coordinating with entities engaged in disaster relief.[61] Of note, if this HIPAA rule is utilized, this does not mean HIPAA is suspended. The Secretary of HHS has the ability to temporarily waive certain HIPAA rules under the **Bioshield Act**.[62] For example, the Secretary of HHS may waive the requirement to give the patient the opportunity to object to disclosure of his location to family members that is usually required under the registry information rule.[63]

Disasters will strike, and there is never one perfect response to them. However, responses can be improved through proper disaster planning.

CONCLUSION

It is naive to believe a disaster will never strike. Disasters will strike, and there is never one perfect response to them. However, responses can be improved through proper disaster planning. Such planning begins before a hurricane, flood, wildfire or other major disaster occurs. Assisting in the response to Hurricane Michael helped me to learn plans should be considered for both closing and keeping the MTFs open in the aftermath of a disaster. Plans addressing both short-term and long-term closures should be formulated and reduced to writing well ahead of a disaster. The personnel in medical readiness, the medical squadron and group leaders at Eglin and Tyndall, and the Tyndall AFB JAGs did an exceptional job of adjusting course and having some preliminary plans in place. They are the reason the disaster was not worse. However, there are always things that could have been done better, such as having an MAA in place or not having to develop ROEs several days after Hurricane Michael struck. Concrete agreements must be in place before a storm hits and it is the good community relationships and dedicated efforts of many individuals that allowed the lack of an MAA to not be a stumbling block. Finally, the Air Force medics and JAGs who responded to Hurricane Michael were truly dedicated to limiting the tragedy and are the reason the Florida panhandle is on the path to recovery.

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ENDNOTES

- [1] Hurricanes are categorized from 1 to 5 on the Saffir-Simpson Hurricane Wind Scale, which is based on a hurricane's sustained wind speed. A category 1 has "very dangerous winds," sustained at 74-95 miles per hour (mph) and will produce "some damage." A category 2 has "extremely dangerous winds," sustained at 96-110 mph, and will cause "extensive damage." Categories 3, 4, and 5 are considered major hurricanes. Category 3 has sustained winds 111-129 mph and produces devastating damage. Category 4 has sustained winds 130-156 mph and Category 5 has sustained winds 157 mph or higher. Both cause "catastrophic damage." <https://www.nhc.noaa.gov/aboutsshws.php>.
- [2] *Summary of Tropical Cyclone Michael*, National Weather Service, available at https://www.weather.gov/akq/Oct_11_Michael_Summary. January 15, 2019.
- [3] Joel Achenbach, Kevin Beoges, Dan Lamothe; *Hurricane Michael: Tyndall Air Force Base Was in the Eye of the Storm, and Almost Every Structure Was Damaged*; https://www.washingtonpost.com/national/hurricane-michael-tyndall-air-force-base-was-in-the-eye-of-the-storm-and-almost-every-structure-was-damaged/2018/10/23/26cca0b0-d6cb-11e8-aeb7-ddcad4a0a54e_story.html last accessed January 15, 2019.
- [4] U.S. DEP'T OF AIR FORCE, INSTR. 10-2501, AIR FORCE EMERGENCY MANAGEMENT PROGRAM, para. 4.11.1 (26 Sep. 2018) (hereinafter AFI 10-2501).
- [5] U.S. DEP'T OF DEFENSE INSTR. 6055.17, DoD EMERGENCY MANAGEMENT (EM) PROGRAM, G.2. Definitions "MAA" (13 Feb. 2017) [hereinafter DoDI 6055.17]; see also AFI 10-2501, *supra* note 4, Attachment 1.
- [6] U.S. DEP'T OF DEFENSE DIR. 3025.18, DEFENSE SUPPORT OF CIVIL AUTHORITIES (DSCA) para. 4.d (29 Dec. 2010, Incorporating Change 2, 19 Mar. 2018) [hereinafter DoDD 3025.18] (citing the Robert T. Stafford Disaster Relief and Emergency Assistance Act (Stafford Act), 42 U.S.C. § 5121 et seq., and the Economy Act (31 U.S.C. § 1535)).
- [7] DoDD 3025.18, *supra* note 6, G.2 Definitions "emergency authority"; see also U.S. DEP'T OF AIR FORCE, INSTR. 10-801, DEFENSE SUPPORT OF CIVIL AUTHORITIES, para 3.1.2.1 (23 Dec. 2015) (hereinafter AFI 10-801).
- [8] *Id.*
- [9] AFI 10-801, para. 3.2.4.
- [10] DoDD 3025.18, para. 4g.
- [11] An "open encounter" is a term used in the medical community denotes an interaction with a patient that means "All unsigned and incomplete encounters (outpatient encounters, telephone consults, ambulatory procedure visits, and inpatient records), both in paper and electronic formats. Open encounters may include system errors (e.g., write-back errors), test appointments, appointments created in error, duplicate encounters, or draft documentation a provider has not yet completed." U.S. DEFENSE HEALTH AGENCY INTERIM PROCEDURE MEMORANDUM 18-021, Definitions "MAA" (18 Nov. 2018).
- [12] James G. Hodge, Jr., Stephanie H. Calves, et. al. *Risk Management in the Wake of Hurricanes and Other Disasters: Hospital Civil Liability Arising from the Use of Volunteer Health Professionals During Emergencies*, 10 MICH. ST. J. MED. & LAW 57, 61 (2006).
- [13] *Id.*
- [14] *Id.* at 73.
- [15] Sharona Hoffman and Andy Podgurski, *E-Health Hazards: Provider Liability and Electronic Health Record Systems*, 24 BERKELEY TECH. L.J. 1523, 1531 (2009).
- [16] The area of law of transmission of care is still developing and there is not currently a statutory requirement to transfer the notifications in the event of a disaster.
- [17] *Id.*
- [18] Elizabeth Weeks, *After the Catastrophe: Disaster Relief for Hospitals*, 85 N.C.L. REV. 223, 244 (2006); Sara Rosenbaum & Brian Kamoie, *Finding a Way Through the Hospital Door: The Role of EMTALA in Public Health Emergencies*, 31 J.L. MED. & ETHICS 590, 591 (2003).

- [19] 10 U.S.C. § 1094. 10 U.S.C. § 1094 allows “health care professionals” to practice medicine in any state or the District of Columbia if the individual a) has a current license to practice medicine, osteopathic medicine, dentistry, or another health profession b) is performing authorized duties for the Department of Defense. While there is a patchwork of regulations and memorandums that further clarify this authority, it is best when working with civilian authorities to directly cited to the US Code because that holds more sway than DoD Regulations or Instructions. “Health care professional” includes active duty and civilians, as well as doctors, nurses, physician assistants, and others who have a license. Additional rules and regulations vary if the healthcare professional is part of the National Guard or if the healthcare worker does not have a license, such as an unlicensed technician.
- [20] Vincent C. Thomas, *Good Samaritan Law: Impact on Physician Rescuers*, 17 WYO. L. REV 149, 154-155 (2017) (Good Samaritan law protections vary from state to state. Some states cover providers at hospitals, some do not. Other states, like California, avoid liability if a ‘medical disaster’ is declared).
- [21] *Id.*; see e.g. Florida Statute (F.S.) 768.13, *Florida’s Good Samaritan Law* (allows protection for healthcare providers responding to an emergency medical situation up to the point of stabilizing a patient).
- [22] DoDD 3025.18, para. 4.d.
- [23] 28 U.S.C. §§ 1346(b), 2671-2680 (2018).
- [24] *Id.*
- [25] See Maj Leslie Newton, *Administrative Relief from Feres Bar*, 35 AF. Med. Law Quarterly Vol. 1, 3-4 (Winter 2020) (citing 28 U.S.C. §§ 2679(b)(1) (only relief someone has when injured by a governmental employee when the employee is acting within the scope of their duty is to bring a claim in accordance with the FTCA).
- [26] *Emergency Procedures Due to Hurricane Michael*, <https://tricare.mil/michael>. Last accessed January 15, 2019.
- [27] *Id.*
- [28] See generally U.S. DEP’T OF DEFENSE INSTR. 4000.19 (31 Aug. 2018); see also U.S. DEP’T OF AIR FORCE, INSTR. 25-201, INTRA-SERVICE, INTRA-AGENCY, AND INTER-AGENCY SUPPORT AGREEMENTS (10 Aug. 2013).
- [29] U.S. DEP’T OF AIR FORCE, INSTR. 44-119, MEDICAL QUALITY OPERATIONS, para. 9.1 (16 Aug. 2011) [hereinafter AFI 44-119].
- [30] AFI 44-119, para. 9.7.3.
- [31] AFI 44-119, para. 9.73.
- [32] Rosenbaum & Kamoie, *supra* note 16, at 591.
- [33] Pub. L. No. 99-272, § 9121, 100 Stat. 164-67 (1986) codified at 42 U.S.C. § 1395dd (2003). An “emergency medical condition” is defined in regulation as “a medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in: (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part.” A pregnant woman who is having contractions is considered to have an emergency medical condition when “there is inadequate time to effect a safe transfer to another hospital before delivery, or “that transfer may pose a threat to the health or safety of the woman or the unborn child.” 42 C.F.R. § 489.24(b))
- [34] Rosenbaum & Kamoie, *supra* note 16, at 591 (private litigation has become part EMTALA component of enforcement).
- [35] *Id.* at 594 (private litigation has become part EMTALA component of enforcement).
- [36] See Hodge, Calves, et. al, *supra* note 6, at 70.
- [37] *Id.*
- [38] Emergency Preparedness, Response & Recovery Checklist: Beyond the Emergency Management Plan, Vol. 37, No. 4, HOSPLW Pg. 503, Belmont, Elizabeth
- [39] See The Public Health Security and Bioterrorism Preparedness and Response Act of 2002, Pub. L. No 107-188, 116 Stat. 594 [hereinafter Bioterrorism Preparedness and Response Act]; 42 U.S.C. § 1320b-5; see also Sara Rosenbaum & Brian Kamoie, *Finding a Way Through the Hospital Door* at 591.
- [40] See Bioterrorism Preparedness and Response Act; see also Robert T. Stafford Disaster Relief and Emergency Assistance Act of 1988 (Stafford Act) Pub. L. No. 93-288, as amended; 42 U.S.C. §§ 5121–5207; Elizabeth Weeks, *supra* note 16, at 249.
- [41] *Id.*
- [42] Rosenbaum & Kamoie, *supra* note 16, at 596.
- [43] *Id.*
- [44] See 28 U.S.C. §§ 1346(b), 2671-2680.
- [45] See Newton, *supra* note 25 at 1-3. The Supreme Court had previously ruled under *Feres v. United States* that active duty personnel could not recover medical malpractice claims filed against the DoD under the FTCA for injuries “incident to service.” *Feres v. United States*, 340 U.S. 135, 137 (1950).

- [46] Some items like discovery, will not occur for active duty personnel who file claims since they have no judicial remedy. *Id.* at 3.
- [47] *Id.*
- [48] DoDD 3025.18, para. 4d(3).
- [49] *Id.*
- [50] 42 U.S.C. § 5170b(c)(1).
- [51] *Id.*; AFI 10-801, para. 3.1.2.3; AFI 10-2501, para. 4.12.1.
- [52] 42 U.S.C. § 5191, 42 U.S.C. §5122(1).
- [53] *Id.*
- [54] *Id.*
- [55] Congressional Research Service, Jared T. Brown and Bruce R. Lindsay *Congressional Primer on Responding to Major Disasters and Emergencies*, September 13, 2018.
- [56] U.S. Dep't of Defense, Under Secretary of Defense (Personal and Readiness), Memorandum for Medical Treatment for Hurricane Harvey Victims (August 31, 2017).
- [57] *Id.*
- [58] 10 U.S.C. § 12301 (d) (A member of the National Guard may be ordered to active duty voluntarily with the consent of the Governor); 10 U.S.C. § 12302 (In time of national emergency, the President may order a unit to federal status); 10 U.S.C. § 1204 (The President may call up the National Guard to augment the active duty force).
- [59] *Id.*
- [60] Public Law 104-191, *Health Insurance Portability and Accountability Act of 1996*, August 21, 1996 (also known as "HIPAA"), as amended; 45 CFR Parts 160 to 164; U.S. Dep't of Defense Manual, DoDM 6025.18, Implementation of the Health Insurance and Portability Act (HIPAA) Privacy Rule in DOD Health Care Programs, March 13, 2019 (hereinafter DoDM 6025.18); *see also* U.S. Dep't of Air Force, Instr. AFI 41-200, Health Insurance and Accountability Act (HIPAA), July 25, 2017 (hereinafter AFI 41-200).
- [61] DoDM 6025.18, para. 4.3b.4.
- [62] Project Bioshield Act of 2004 (PL 108-276) and section 1135(b) of the Social Security Act; *see also* 42 USC § 1320b-7.
- [63] DoDM 6025.18-R, para. 4.3b.4.