PREPARING A HEALTHCARE PROVIDER FOR A KNOWN AND IMPENDING DISRUPTIVE PUBLIC HEALTH EVENT

Authors: D. Jay Davis, Jr., Esq. and J. Camden Hodge, Esq.
YOUNG CLEMENT RIVERS, LLP
Charleston, SC

Presented by:

D. Jay Davis, Jr. Esq.

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INSURANCE COVERAGE FOR PANDEMIC-RELATED RISKS

Authored and Presented by:

Rich Gable, Esq.
BUTLER WEIHMULLER KATZ CRAIG LLP
Philadelphia, PA

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Preparing a Healthcare Provider for a Known and Impending Disruptive Medical Event

Authors:

D. Jay Davis, Jr., Esq. and J. Camden Hodge, Esq. of YOUNG CLEMENT RIVERS, LLP, *Charleston, SC. The authors can be reached at jdavis@ycrlaw.com and chodge@ycrlaw.com.*

A variety of events can disrupt the ability of healthcare providers nationwide to deliver essential, quality care to its patients and the general public. From terrorist attacks to natural disasters and communicable diseases, modern healthcare providers must be prepared to face both the practical and legal challenges of operating during a public health event.

No recent public health event captured the collective mind quite like the 2014 Ebola Virus Disease (hereinafter "Ebola") outbreak. Much of this notoriety is attributed to Ebola's high mortality rate and nightmarish symptoms. *See* Jeremy Ashkenas, et al., *How Many Ebola Patients Have Been Treated Outside of Africa?*, N.Y. TIMES (Jan 26, 2015). However, its presence in the public eye offers an opportunity to explore potential legal issues surrounding known and impending disruptive public health events generally, and communicable, highly infectious diseases specifically. Though we may be tempted to categorize disease disruptions as once-in-a-lifetime events relegated to movies, the legal and practical implications they produce cannot be ignored. Indeed, in the words of Director of the Centers for Disease Control (CDC) Dr. Thomas Friedman, "[w]e live in a world where we are all connected by the air we breathe, the water we drink, the food we eat, and by airplanes that can bring disease from anywhere to anywhere in a day." *CDC Press Conference: CDC Confirms First Ebola Case Diagnosed in the United States* (Sept. 30, 2014). Recent history teaches us that pandemic flu, the H1N1 virus, SARS, "bird flu," and drug resistant "superbugs" are contemporary concerns that should be examined through a legal lens. *See* Mark Rothstein, J.D., *From SARS to Ebola: Legal and Ethical Considerations for Modern Quarantine*, INDIANA HEALTH LAW REVIEW, vol. 12, no. 1 (forthcoming 2015). Law firms are taking heed, with some even creating their own Ebola Task Forces. *See* Beth Fitzgerald, *Global Ebola Task Force: Law Firm Prepares for myriad of virus-related questions.* NATIONAL JOURNAL OF BUSINESS (Oct. 21, 2014).

Accordingly, this paper will analyze potential legal issues that may result from disruptive communicable disease events (specifically Ebola) and how to prepare your hospitals and other healthcare providers for the same. While this paper focuses on the 2014 Ebola outbreak, the legal principles discussed herein rightfully can be applied to disruptive public health events generally.

I. PUBLIC HEALTH LAW – GENERAL PRINCIPLES

Principles of federalism divide authority between federal, state, and local governments in protecting the public health. The United States Constitution is largely silent on issues

surrounding public health, save for its authority to "promote the general Welfare." *U.S. Constitution, pmbl.* The federal government can use this grant of power to declare states of "emergency," appropriate money to states during public health events, limit the liability of certain officials, and even quarantine or isolate American citizens. *See, e.g.*, 42 U.S.C. § 264 (the Public Health Service Act, addressing regulations to control communicable diseases). A bevy of federal agencies have potential roles to play – principally the Department of Health and Human Services, the Department of Homeland Security, and the CDC.

While the federal government enjoys significant power, authority, and responsibility during disruptive public health events, primary responsibility for enacting public health policy, enforcing those policies, and providing emergency services falls upon the individual states. This authority is established by the Tenth Amendment and the Constitution's attendant police powers. All states have the authority to manage and investigate disease outbreaks, including the ability to enact and enforce laws designed to protect public health. This power is recognized by statute and our highest court. In *Jacobsen v. Massachusetts*, the U.S. Supreme Court upheld a mandatory smallpox vaccination order issued by a local municipality's board of health, emphasizing the state's right to protect the liberty and health of its own citizens. 197 U.S. 11, 27 (1905) ("Upon the principle of self-defense, of paramount necessity, a community has the right to protect itself against an epidemic of disease which threatens the safety of its members."). In doing so, the Court recognized that states could delegate certain authority to health agencies and local governments to safeguard public health. *Id.* at 25 ("[T]he state may invest local bodies…with authority…to safeguard the public health and the public safety. The mode or manner in which those results are to be accomplished is within the discretion of the state."). This state power is not without check; the *Jacobsen* court warned that liberty must not be unduly restrained and due process must be provided. *Id.* at 29.

This fragmented and decentralized balance of public health power can cause considerable confusion in preparing a hospital for a known and threatening public health event and offering sound legal advice. There is no one guiding plan or set of specific regulatory or statutory principles that drive public health policy. Instead, we are left with a "menu of legal powers and options rather than a definitive guide for action." Jane Jordan, Greg Measer, Asha Agrawal, and James G. Hodge Jr., *Legal, Operational, and Practical Considerations For Hospitals and Health Care Providers in Responding to Communicable Diseases Following the 2014 Ebola Outbreak*, 23 U. MIAMI BUS. L. REV. 341 (2014). Given the understandable lack of a set of comprehensive, controlling public health guidelines and laws, hospitals must look to this "menu" of sources for direction. *Id.* The wise lawyer will look to federal directives, state health agency regulations, the recommendations of national and international health organizations, and the advice of legal and health organizations in advising their clients as to operating during an impending public health event.

II. PREPARING FOR POSSIBLE CAUSES OF ACTION

Ebola-related lawsuits have been filed and threatened by caretakers and families of victims, bringing with them allegations of negligence, medical malpractice, privacy intrusions, impairment of civil rights, and violation of various federal and state statutes. *See* Jess Bidgood

and Dave Phillips, *Judge in Maine Eases Restrictions on Nurse*, N.Y. TIMES (Oct. 31, 2014) (Discussing Maine nurse's allegations that she was wrongfully quarantined); *Texas: Ebola Victim's Family to be Paid by Hospital*, N.Y. TIMES (Nov. 12, 2014) (First Ebola patient on American soil, Thomas Eric Duncan, settles claim against hospital for undisclosed sum). The most visible of these suits was filed by Nina Pham, a nurse at Texas Health Presbyterian Hospital in Dallas, TX. Ms. Pham contracted Ebola after treating an infected man who had arrived in the country from Liberia. *See Nina Pham v. Texas Health Resources, Inc.*, DC-15-02252 (Dallas County District Court, TX) (March 2, 2015). A brief review of Ms. Pham's allegations is illustrative in understanding the legal consequences healthcare providers can face during a disruptive health event.

By early September of 2014, the CDC and American Hospital Association warned the Texas Health Resources ("THR") hospital system – of which Texas Presbyterian allegedly is a part – that Ebola was an "imminent threat" that warranted the development and implementation of policies and procedures designed to mitigate the threat. *Id.* at 5. The news cycle was saturated with Ebola-related information, and the American Bar Association even offered a complimentary webinar discussing the legal implications of the disease and how to best prepare healthcare providers in the event an infected patient came to their doors.[1] Against this backdrop, Thomas Eric Duncan brought the virus to America when he arrived in Dallas on September 20, 2014. *Nina Pham, supra* at 8. Five days later he presented to the Texas Presbyterian ER, where he was discharged with a diagnosis of sinusitis and a prescription for antibiotics – all despite exhibiting the "classic" symptoms of Ebola and reporting that he recently had been in Liberia, which was among the African countries embroiled in the Ebola outbreak. His condition worsened, and he was again brought to the Texas Presbyterian ER on September 28. He finally was admitted to the hospital the next afternoon, and placed in an intensive care ("ICU") unit from which all other patients were removed. Mr. Duncan died 8 days later.

Nina Pham was a nurse in that Texas ICU. On the morning of September 29, her supervisor allegedly was told that Mr. Duncan would be her patient. Ms. Pham had no special training in infectious diseases nor been provided any in-services, training, or guidance concerning Ebola. She claims that she did not volunteer for the job. Approximately 3 days after the death of Mr. Duncan, Ms. Pham learned she also had Ebola. Nina eventually was transferred to the National Institute of Health in Bethesda, MD, which had a team capable of treating Ebola patients. According to Ms. Pham's Complaint, before she departed for Maryland her treating THR physicians entered her hospital room with a video camera and coerced her into making "optimistic statements" about her condition and the treatment provided by THR. After editing the video, THR allegedly released it to the press and put it on their YouTube site. Fortunately, Ms. Pham survived her bought with Ebola.

Ms. Pham filed suit against THR in state district court, alleging that she was a **"symbol of corporate neglect – a casualty of a hospital system's failure to prepare for a known and impending medical crisis."** *Id.* (emphasis added). Her principle allegation sounds in negligence, claiming that THR failed to recognize the likelihood and appreciate the danger of the Ebola virus coming to its hospitals; failing to develop and implement adequate policies and

[1] *Ebola 2014: A Public Health and Legal Perspective*, available at: http://www.americanbar.org/groups/health_law/events_cle/ebola14.html

procedures; failing to ensure proper training; failing to provide appropriate equipment; and failing to obtain qualified professionals to manage Ebola patients. Ms. Pham also brought various invasion of privacy causes of action.

This real-world factual scenario presents concerns that could arise in regard to many disruptive public health events. It serves as an appropriate reminder of the legal consequences of failing to properly prepare for known emergencies, and offers an opportunity to examine how best to avoid falling into an unfortunate position. Below is an analysis of the legal issues hospitals could face during such events. A number of recommendations to reduce the likelihood of liability will follow.

A. Is There a Duty to Treat Patients With Highly Infectious, Deadly, and Communicable Diseases?

The rights of medical professionals and other hospital employees must be considered in assessing potential liability for failing to treat and accept patients. At common law, medical professionals had no duty or only a limited duty to treat patients in certain circumstances. *See, e.g., Anderson v. Houser,* 523 S.E.2d 342 (Ga. Ct. App. 2000) (no duty to treat without existing physician-patient relationship); *see also Birmingham Baptist Hospital v. Crews,* 229 Ala. 398, 157 (1934) and *Wilmington General Hospital v. Manlove,* 54 Del. 15, 174, A.2d 135 (1961). However, this "no duty" theory can erode during public health events.

1. Emergency Medical Treatment and Active Labor Act ("EMTALA")

EMTALA places an affirmative obligation upon hospitals to treat and stabilize certain patients in emergency room settings. *See* 42 U.S.C. §§ 1395dd(a) – (b). EMTALA was enacted in 1986 in an effort to prevent hospitals from denying emergency medical treatment as a method of cost-cutting.[2] Also known as the "patient dumping" statute, EMTALA was intended to guarantee emergency health care access to all persons regardless of their ability to pay. EMTALA imposes a duty upon Medicare-provider hospitals to screen and stabilize patients that appear at their ER experiencing a statutorily defined "emergency." *Id*; 42 C.F.R. § 489.24(a). Liability turns on the determination of whether an "emergency" exists, such as a cardiac event, seizure event, or childbirth. An "emergency medical condition" is defined as:

> (1) A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in—

[2] Note that EMTALA's application is, in most instances, is constrained to hospitals with "dedicated emergency departments" and, in certain cases, urgent care centers. The Final Rule explains that "dedicated emergency department" means any department or facility, located on or off the main hospital campus, that is: (i) licensed by the State as an emergency department, (ii) held out to the public (by name, signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without a previously scheduled appointment, or (iii) based on a representative sample of patient visits that occurred during the calendar year, that department or facility provided at least one-third of all its out-patient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment. *See* 42 C.F.R. § 489.24(b)(4).

> (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; or
> (ii) Serious impairment to bodily functions; or
> (iii) Serious dysfunction of any bodily organ or part; or
> (2) With respect to a pregnant woman who is having contractions—
> (i) That there is inadequate time to effect a safe transfer to another hospital before delivery; or
> (ii) That transfer may pose a threat to the health or safety of the woman or the unborn child.
>
> § 489.24(b)(4).

If such an emergency is present, the hospital is obligated to treat the patient absent a federally-declared state of emergency and attendant EMTALA waiver. In regard to infectious diseases, the application of EMTALA may well depend on the specific disease, whether the patient presents in a non-emergent state, and whether the patient enters the hospital ER or some other area. *See* Jordan, et al., *supra*. Taking Ebola as an example, the application of EMTALA likely will rest on the time-period when the patient presents to the ER: Ebola has a 2 to 21 day incubation period, meaning that the patient often does not become symptomatic until three weeks after becoming infected. *Ebola Virus Disease* (April 2015), WORLD HEALTH ORGANIZATION MEDIA CENTRE. If an asymptomatic patient presents to the ER, it is unlikely that he or she will be considered to have an "emergency medical condition" as defined by EMTALA. However, if a symptomatic patient ambles into the ER with the hemorrhagic fever or internal and external bleeding characteristic of Ebola, then you should be adequately prepared to treat them.

2. **Duty Conferred by Disability Laws**

This common law "no duty to treat" theory disappears in a number of other scenarios. For example, a medical professional cannot categorically refuse to treat persons defined as "disabled patients" pursuant to the Americans with Disabilities Act of 1990 ("ADA") for discriminatory reasons. *Bragdon v. Abbot*, 524 U.S. 624 (1998). Whether infectious disease patients can be considered "disabled patients" has yet to be decided. Relevant to the present discussion is the Rehabilitation Act of 1973 ("Rehab Act"), which has been addressed by our Supreme Court in the context of communicable disease. Like the ADA, the Rehab Act prohibits covered entities such as hospitals from refusing to treat persons with disabilities. The question of whether an infectious disease constitutes a disability or handicap under the Rehab Act has been the subject of much litigation. In *School Board of Nassau County v. Airline*, the Supreme Court held that an individual with tuberculosis was considered handicapped for purposes of the Rehab Act. 482 U.S. 273 (1973). *Airline* helped shape modern disability law, and subsequent case law noted that Hepatitis-C and HIV also can be considered disabilities in certain situations. *See Bragdon*, 524 U.S. at 642 (person infected with asymptomatic HIV considered protected under ADA); *see also Sussle v. Sirina Protection Sys. Corp.*, 267 F. Supp. 2d 285 (E.D.N.Y. 2003) (holding that although Hepatitis C is a "physical impairment" and thus a disability, plaintiff failed to demonstrate that the impairment substantially limited a major life activity and thus was

not subject to ADA protection). Thus, in determining whether a hospital owes a duty to a patient during a known public health event involving an infectious, communicable disease, legal counsel should examine whether an infected person is considered handicapped under the Rehab Act or "disabled" as defined by the ADA.

B. **OSHA and the FMLA**

Employers normally have a duty to provide a workplace devoid of "recognized hazards that are causing or are likely to cause death or serious physical harm" to its employees." *See* 29 U.S.C. § 654. In 2004, the Occupational Safety and Health Administration ("OSHA") created a set of "response guidelines" designed to assist employers in cases of workplace emergencies. While the guidelines do not specifically address infectious diseases, the guidelines expect employers to minimize complications by:

> (1) conducting employee awareness and other trainings regarding the potential hazard; (2) creating protocols and procedures requiring the issuance of protective personal equipment if necessary to prevent infection and transmission; (3) providing a means of reporting infection and medical surveillance for infected employees; (4) maintaining appropriate documentation of all of the foregoing; (5) preserving and maintaining patient medical records; and (6) appropriately recording with OSHA any occupationally-related infections.
>
> *See* Jordan, et al., *supra.*

Employers take care to comply with OSHA's broad "refusal to work" provisions. *See* 29 U.S.C. §143; 29 U.S.C. § 660(c); 29 U.S.C. § 654. In certain situations, employees can refuse to work when they have a reasonable apprehension of death or serious harm and no "less drastic alternative is available." *Whirlpool Corp. v. Marshall*, 445 U.S. 1 (1980); *Marshall v. N.L. Indus., Inc.*, 618 F.2d 1220, 1224 (7th Cir. 1980) (holding that discharge of an employee in response to his good faith refusal to expose himself to certain dangerous conditions is discriminatory). In order to avoid liability, the employer cannot terminate that employee unless it can prove through "objective" evidence that there is no hazard or that the employer's "response plan" will protect employees from exposure. *See id.*

Hospitals also must meet the standards relating to applicability of the Family and Medical Leave Act ("FMLA") and the potential for providing workers' compensation benefits. *See* 29 U.S.C. § 2601; 29 C.F.R. § 825 (2014). In the event that an employee contracts an infectious disease such as Ebola through occupational exposure, the employee may be eligible to receive temporary disability benefits, reasonable and necessary medical treatment, and awards for resulting permanent disability. *Id.* Employers should be careful to identify medical professionals with infectious disease control expertise who can advise the employer as to whether the employee is infectious; whether his or her condition presents a risk to other employees; and when the employee can return to work. Mark A. Lies II et al., *Ebola and Employer Liability Issues*, Seyfarth Shaw LLP (Oct. 10, 2014). This issue has particular

pertinence in the *Pham* case, as the parties argued over the application of the state workers' compensation act and whether the workers' compensation bar or the state district court had jurisdiction over the matter. *See* Plaintiff's Supplement to Her Original Petition to Include Application for TRO and Application for Temporary Injunction, No. DC-15-02252 (Dallas County District Court, TX) (April 16, 2015); *see also* Order Granting Plaintiff's Application for TRO (April 20, 2015).

These considerations, particularly those regarding the FMLA and application of workers' compensation benefits, should be addressed long before a known, impending infectious disease or other disruptive public health event occurs. Emory University Hospital – which successfully treated a number of Ebola patients – nipped those issues in the bud by determining that the FMLA would be utilized if requested and applicable; ensuring that any worker who contracted Ebola be compensated at a rate above that mandated by state law; and ensuring that those who worked with Ebola patients volunteered to do so under their own volition. *See* Jordan, et al., *supra*.

C. **Confidentiality and the HIPAA Privacy Rule**

Given the intrinsic fear and attendant media attention that high-mortality infectious diseases inspire, ensuring patient privacy is of paramount importance. The overriding concern in safeguarding patient information is compliance with the Health Insurance Portability and Accountability Act and its Privacy Rule. *See* Publ. L. 104-191, 110; 45 CFR §§ 160, 164, et seq. HIPAA explains the federal intent to protect health information in no uncertain terms, stating in its preamble that:

> [i]n an era where consumers are increasingly concerned about the privacy of their personal information, the Privacy Rule creates, for the first time, a floor of national protections for the privacy of their most sensitive information-health information…Under the Privacy Rule, health plans, health care clearinghouses and certain health care providers must guard against misuse of individuals' identifiable health information and limit the sharing of such information, and consumers are afforded significant new rights to enable them to understand and control how their health information is used and disclosed.
>
> 67 Fed. Reg. 53162 (August 14, 2002) (HIPAA Preamble).

HIPAA is not suspended during a public health or other emergency. Memorandum from the Dep't of Health & Human Servs., Bulletin: *HIPAA Privacy in Emergency Situations* (Nov. 2014). However, in extraordinary circumstances the Department of Health and Human Services' (DHHS) Secretary may waive certain provisions of the Privacy Rule pursuant to the Project Bioshield Act of 2004 (Pub. L. 180-276) and § 1135(b)(7) of the Social Security Act. Further, in the event that the President and DHHS Secretary declare a public health emergency, the Secretary has the authority to waive certain sanctions and penalties against a covered hospital. *Id.*

The easiest course of action, of course, would be to release no patient information without the informed, written consent of the patient. Given the media attention lavished on Ebola and similar viral infections – coupled with the need to protect the public by disseminating accurate medical information – this is not always possible. In a Special Bulletin issued by DHHS specifically related to the Ebola outbreak, the agency clarified that under the Privacy Rule protected health information *can* be disclosed: (1) to a public health authority; (2) at the direction of a public health authority or foreign government agency acting in collaboration with the public health authority; (3) to a person at risk of contracting or spreading the disease or condition if other law, such as state law, authorizes the entity to notify such persons as necessary to prevent or control the spread of the disease; (3) to family friends, and others "involved in the individual's care and for notification; (5) to anyone "as necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or the public"; and (6) to the media if the patient has not objected to or restricted to the release of such information or, if the patient is incapacitated, if the disclosure is believed to be in the best interest of the patient and is consistent with any prior expressed preferences of the patient. *See* 45 CFR §§164.501, 164.512(b)(1); 164.510(b); 164.512(j); 164.508. DHHS cautions covered hospitals to use a "minimally necessary" approach when releasing patient information in these situations. *Id.*

Protecting patient information is a gargantuan task in the best of circumstances; however, even with the complications of a disruptive public health event, information can properly be safeguarded. For example, when Emory University Hospital accepted its first Ebola patient, its Chief Privacy Officer was immediately designated to be a part of the Ebola clinical care and operational personnel. *Hospitals with Ebola Patients are Under Great Pressure to Ensure Their Privacy*, 14 REP. ON PATIENT PRIVACY at 1, (November 14, 2014). Emory sent email blasts to all of its healthcare employees reiterating their obligations to ensure patient privacy both at home and in the workplace. It also ensured that its electronic medical records system required those who tried to access Ebola patients' records to affirmatively check a box stating that they had authorization to view the records. *Id.* In addition, the University of Nebraska Medical Center combed through its electronic "audit trails" after it accepted an Ebola patient, eventually learning that two employees inappropriately viewed protected health information and terminating them accordingly. *Id.*

D. **Negligence**

Ordinary negligence and medical malpractice claims can arise from a wide variety of acts and omissions during a known disruptive public health event. Claims can stem from a physician's failure to diagnose the disease, or an institution's failure to develop and implement adequate policies and procedures, properly train staff, provide appropriate equipment, or to obtain qualified professionals to manage patients. *See, e.g.* Jordan, et al., *supra*. Safeguarding against these deficiencies requires comprehensive effort, planning, and coordination set in motion long before a disruptive public health event emerges. These strategies are discussed below.

III. RECOMMENDATIONS

As stated in the Introduction, there is no overarching, controlling set of regulatory standards or statutory law capable of methodically guiding a hospital's preparations or actions regarding a "known, imminent" public health event such as an Ebola outbreak. Accordingly, the first step is to heed federal and state directives. In the case of Ebola, the White House, DHHS, and the CDC provided continuous updates and comprehensive recommendations as to how to prepare for the disease's arrival. *See, e.g., CDC Infection Prevention and Control Recommendations for Hospitalized Patients Under Investigation for EVD in U.S. Hospitals* (Feb. 12, 2015). Many state governments and their public health agencies offered similar guidelines. *See, e.g., State Ebola Protocols, CDC Public Health Law Program* (March 9, 2015) (compiling state Ebola protocols and various state public health statutes and regulations); *South Carolina Public Health Emergencies: A Resource for Bench and Bar*, SC DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL (2012); Gregory Sunshine and Montrece Ransom, *Ebola and the Law: Legal Preparedness for Physicians and Hospitals*, PUBLIC HEALTH LAW: OFFICE FOR STATE, TRIBAL, LOCAL, AND TERRITORIAL SUPPORT (CDC) (February 19, 2015) (compiling state laws, regulations, and directives). Further, organizations such as the American Bar Association and the American Hospital Association proved to be outstanding resources, providing free informational seminars, written materials, suggested protocols, and draft legal documents.

Experience remains the best teacher. Based upon Emory University Hospital's successful treatment of Ebola patients – and the alleged mistakes of THR – as well as an analysis of international, federal, state, and local guidelines, the following recommendations may assist in preparing for a known and imminent disruptive public health event such as Ebola:

- Create a "Preparedness Team" dedicated to **establishing comprehensive policies and procedures**.
- This team should include clinical, legal, communication, and administrative professionals.
- In creating policies and procedures, follow established federal and state guidelines and update annually.
- Don't reinvent the wheel – follow published guidelines and recommendations, as well as policies and procedures released by other healthcare providers.[3] Emory has publicly released its entire Ebola preparedness protocols (available at: http://www.emoryhealthcare.org/ebola-protocol/resources.html).

  <u>Legal</u>:

  a. Educate staff on HIPAA compliance and other privacy concerns, EMTALA, informed consent, and employment policies.
  b. With the assistance of administration, agree on a course of action regarding the provision of workers' compensation benefits and application of employment policies.

[3] Emory has publicly released its entire Ebola preparedness protocols (available at: http://www.emoryhealthcare.org/ebola-protocol/resources.html).

c. Familiarize in-house legal counsel with both state and federal public health law.
d. Identify key contacts at local, state, and federal level that represent and control public health interests

Clinical:

a. Create team dedicated to treatment of known disruptive public health event/disease; if possible, ensure that these employees volunteer to treat the patients.
b. Hold in-house refresher courses on infection control and waste management.
c. Ensure that hospital has proper equipment to treat the specific patient population; teach health professionals how to use said equipment.
d. Ensure that hospital has properly qualified personnel present, i.e., infectious disease specialists, emergency room physicians, and ICU nurses.
e. Provide proper internal and public warnings: posters; electronic email "blasts"; specialized and relevant admission questionnaires with travel history.

Administrative and Communications:

a. Identify appropriate, consistent spokespersons with substantive knowledge of the medical issues and the ability to educate media about medical and scientific facts. The most visible spokesperson's at Emory were clinicians and care providers.
b. Explain to the media methods of collaboration with federal, state, and private entities.
c. Review patient privacy guidelines and collaborate with legal department and clinical staff to implement additional measures as necessary.
c. Ensure all staffing concerns are addressed.

Insurance Coverage for Pandemic-related Risks

Author:

Rich D. Gable, Jr. of BUTLER WEIHMULLER KATZ CRAIG, LLP *of Philadelphia, PA. The author can be reached at rgable@butler.legal.*

Insurance coverage for the impacts of communicable or contagious diseases is uncommon. The general purpose of most insurance coverage is to protect against unforeseen risk. Contagions, however, are viewed as a risk that can be both set in motion and controlled by human intervention. For this reason, the majority of insurance coverage for infectious diseases is found in "manuscripted" or specifically written policies designed to cover loss caused by a specific contagion. Below is a discussion of some of the different types of insurance that may be triggered by a public health event and the manner in which insurers and the courts have responded.

I. LIABILITY INSURANCE

A. Commercial General and Professional Liability Insurance

Commercial General Liability (CGL) insurers are likely the most common target for contagious disease claims. CGL forms provide for defense and indemnity against claims resulting in liability against insureds due to an "occurrence," most often described as an accident. However, many CGL policies contain a virus or bacteria exclusion, something that has been more frequently included in the past 10 years or so. *See* T. Jones and J. Bozeat, *A Growing Exposure: Food Contamination Claims*, INSURANCE LAW, 49 No. 5 DRI For Def. 57 (2007). That means loss or damage caused by or resulting from viruses, bacteria, or other microorganisms that cause disease, illness, or physical distress will ordinarily be excluded. Therefore, a CGL insurer may decline to defend against a lawsuit in which its insured is sued by a claimant asserting loss or damage due to a contagious disease. *See e.g. Paternoster v. Choice Hotels*, Civil Action No. 13-0662, (E.D. La., November 14, 2014. (unpublished)) (bacteria exclusion applied to coverage for claims arising out of the alleged exposure to Legionnaires' Disease at a hotel, save for those policies that contained "buy-backs" providing coverage for swimming pool and food-borne exposures).

Pollution exclusions may also exclude coverage for claims brought by those who contend they were exposed to a contagious disease due to the negligence of others. For example, in *Westport Ins. Corp. v. VN Hotel Group, LLC*, 513 Fed. Appx. 927 (11th Cir. 2013), an insurer sought declaratory judgment regarding its duty to defend and indemnify a hotel sued by a guests who claimed they contracted Legionnaires' Disease as a result of using the water in the shower or outdoor spa. One guest died as a result. The carrier asserted that coverage was precluded due to the pollutants exclusion, which, as is typical, defined pollutants as "any solid, liquid, gaseous or thermal irritant or contaminant, including smoke, vapor, soot, fumes, acids, alkalis, chemicals and waste." The Eleventh Circuit affirmed the district court's determination that Legionella bacteria was not a "pollutant" under the definition. The court's main reasoning for this holding was that there was also a separate fungi and bacteria exclusion that excluded claims due to fungi

or bacteria on buildings or structures. The court found that bacteria could not be considered within the definition of a pollutant when it was also separately categorized elsewhere in the policy.

In a similar fact scenario, the Eastern District of Pennsylvania recently found that a CGL policy excluded coverage for claims related to bacterial infections allegedly caused by medical spa visits. *Sentinel Ins. Co., Ltd. v. Monarch Med Spa, Inc.*, 2015 WL 1954199 (E.D. Pa., April 30, 2015). The claimants, one of whom died, alleged they were infected with Group A Streptococcus bacteria during liposuction surgery. The CGL policy in this case had a more expansive fungi and bacteria exclusion, which the court found clearly applied to exclude coverage for these claims. Likewise, the court also found that the policy's professional services exclusion[4] barred claims arising out of infections caused when healthcare workers allowed contaminated materials to come in contact with the claimants' open wounds during surgery.

Likely to apply in a third-party claim for damages due to disease will be the professional liability or errors & omissions insurance held by health care workers. Such provides coverage for losses due to the provision of professional services. Health care employees are most often sued in this capacity due to the failure to follow the standard of care.

B. **Directors and Officers (D&O) Insurance**

D&O insurance provides liability protection for managerial employees faced with claims that financial loss resulted from their actions. For example, if a business such as a hospital chain is faced with avoidance of their services due to poor publicity about its ability to care for Ebola patients, the shareholders may sue the managers for their financial losses. The liability arises from the oversight provided or policies implemented by the managers of the business. Most D&O policies exclude coverage for bodily injury claims, but it may not always exclude coverage for damages flowing from bodily injury claims if financial loss to the business results.

It is possible that individuals other than those personally sickened, e.g., shareholders in companies adversely affected by an outbreak, may make claims against companies or their executives based on allegations that management's acts or omissions caused such claimants to suffer financial losses. Directors' and Officers' policies may respond to such a claim. Although most D&O policies contain exclusions for claims alleging bodily injury, claims for financial damages are insured under D&O insurance. In most cases, the bodily injury exclusions should not come into play in financial claims — although some broadly written exclusions may prove problematic. As with commercial coverage, policyholders must give notice to their insurance company when they become aware of such claims, before the policy and/or reporting period for their current D&O coverage expires.

[4] It is unclear why the insured did not have professional liability (malpractice) coverage given the nature of its practice. Ordinarily, professional liability insurance would provide a defense and indemnity to claims that involve bacterial or other types of infection provide the exposure arose as the result of the performance of professional services.

II. PROPERTY INSURANCE

It is unlikely that most property insurance policies would respond to loss or damage caused by a contagious disease as property insurance policies require physical loss or damage to covered property (buildings, structures or contents) to trigger coverage as the result of a covered (i.e. non-excluded) cause of loss. As described by the Third Circuit in *Port Auth. of New York & New Jersey v. Affiliated FM Ins. Co.*, 311 F.3d 226, 235 (3d Cir. 2002) (citation omitted):

> In ordinary parlance and widely accepted definition, physical damage to property means "a distinct, demonstrable, and physical alteration" of its structure. Fire, water, smoke and impact from another object are typical examples of physical damage from an outside source that may demonstrably alter the components of a building and trigger coverage. Physical damage to a building as an entity by sources unnoticeable to the naked eye must meet a higher threshold.

See also Universal Image Prods., Inc. v. Fed. Ins. Co., 475 F. App'x 569, 575 (6th Cir. 2012) (insured may have suffered a large inconvenience as a result of the mold and bacterial contamination but there was no "tangible damage" to insured property as a result); *but see W. Fire Ins. Co. v. First Presbyterian Church*, 165 Colo. 34, 437 P.2d 52, 55 (1968) (holding that the policyholder suffered "direct physical loss" when "the accumulation of gasoline around and under the [building caused] the premises to become so infiltrated and saturated as to be uninhabitable, making further use of the building highly dangerous").

The question of whether the presence of Ebola constitutes physical loss or damage has not yet been litigated. However, even if it did, most property policies provide exclusions for loss or damage caused by bacterial contamination. *See HoneyBaked Foods, Inc. v. Affiliated FM Ins. Co.*, 757 F. Supp. 2d 738, 747-48 (N.D. Ohio 2010) ("The presence of listeria on HoneyBaked's food products plainly renders the products unfit for consumption, and as such meets the ordinary, unambiguous definition "contamination").

Property insurance policies also provide coverage for the financial risks associated with insured property damage. Clearly the potential for a pandemic to interfere with the business of an insured's suppliers or customers creates a significant financial risk. Should the widespread loss or damage be the result of an insured event like a flood or an earthquake, a business can purchase insurance in the form of contingent business income coverage to insure against the impact to its supply chain or its market. The insurance market has responded to the increased risk of business interruption from communicable diseases by offering new coverages. They include coverages for loss of business income caused by pandemic, communicable, infectious or contagious disease, both for interruption of the insured's business or their suppliers or customers. See *How Will Insurance Respond to Ebola-Related Events?* WILLIS CLIENT ADVISORY ALERT, October 2014. Another product that an insured could purchase would be for decontamination of the insured's product or property. Many food service or food manufacturers may wish to purchase such a product to protect against the contamination of their products against contagious diseases, resulting in the loss of inventory or stock. It is important to be mindful that many property policies also exclude damages caused by "pollutants." What is

considered a pollutant varies state-by-state, but they usually consist of non-microbial components. David J. Dybdahl, *Insurance Coverage for Losses Arising from the Ebola Virus*, IRMI.com (December 2014).

Many property policies also include civil authority coverage, which insures income losses that occur when business is suspended due to government order. This coverage ordinarily requires physical damage to property caused by a covered cause of loss, such that it would likely not apply during a pandemic.

III. THE FUTURE

Manuscript insurers, such as those affiliated with the London market, have specifically crafted policies to cover losses related to pandemics or contagious diseases. *See* Logan Payne, *Ebola Outbreak: Risk Management and Insurance Considerations*, LOCKTON GLOBAL (August 2014). As discussed above, some insurers are specifically tailoring coverage for business income to include losses both for suspension of business without property damage and suspension of a dependent property's business.

However, insurers have also moved to protect themselves quickly when a new outbreak occurs. Some insurers moved to place Ebola exclusions after the outbreak last year, for example. *See* C. Cohn, R. Naidu and A. Das, *Some Insurers Exclude Ebola; Others Offer New Products*, INSURANCE JOURNAL (Oct. 23, 2014).

Some nongovernmental organizations are also drawing together plans to pay money to qualifying countries at the moment of a major disease outbreak, rather than raising money after the fact to respond. Alex Whiting, *New pandemic insurance to prevent crises through early payouts*, REUTERS (March 26, 2015). The World Bank, African Union and a consortium of aid agencies and private sector experts started designing the "insurance schemes" earlier this year. The schemes would pay money to qualifying countries as soon as disease breaks out with the intention of preventing international crises. To qualify, countries would have to develop rigorous contingency plans to ensure the payouts would quickly reach the most vulnerable in a crisis.

D. Jay Davis, Jr.

Practice Group Chair

Direct Dial: (843) 720-5406

Direct Fax: (843) 579-1355

E-mail: jdavis@ycrlaw.com

Jay is a partner in the law firm of Young Clement Rivers, LLP. Jay is chair of the firm's Professional and Medical Liability section and the firm's Business Litigation practice group. He serves also on its Management committee. He practices primarily Professional Liability, Medical Malpractice, Legal Malpractice, Nursing Home and Assisted Living, Business, and Real Estate litigation. He is a member of the South Carolina State Bar, the Fourth Circuit Court of Appeals, the United States District Court for the District of South Carolina, the Charleston County Bar Association, the American Bar Association, the South Carolina Defense Trial Attorneys Association and the Defense Research Institute.

Jay is rated AV® Preeminent TM Peer Review Rated by Martindale Hubbell in the areas of litigation, Medical malpractice and Professional Liability. Jay has also been selected as a member of *Super Lawyers*® in the areas of Professional Liability defense. Jay is a member of the American Board of Trial Advocates ("ABOTA"). He is also a member of the Federation of Defense and Corporate Counsel ("FDCC").

Jay also serves as the FDCC liaison to the Medical Liability Committee of the Defense Research Institute ("DRI"). He serves on the South Carolina State Bar Association Committee for Professional Liability. He is a past member of the Executive Board of the South Carolina Defense Trial Attorneys Association. He is a member of the American Bar Association's section on Business Law. Jay has served as an adjunct professor of law at the Charleston School of Law where he taught litigation. He has also been certified by the South Carolina Supreme Court Commission on Alternative Dispute Resolution as a civil mediator. He has been selected to the *Super Lawyers*® Business Edition.

Jay grew up in Charleston and graduated from Porter Gaud School in 1984. He earned his Bachelor of Arts degree from the University of Georgia in 1988. He earned a Master's Degree from the College of Charleston in 1993. In 1996, Jay graduated cum laude from the University of South Carolina School of Law. He was admitted to the South Carolina Bar that same year.

Jay has also been a frequent speaker and presenter on issues related to litigation and insurance defense including medical malpractice, trial techniques, cross examination, risk management, lender liability, and professional malpractice issues. He has presented to the South Carolina Medical Association, The South Carolina Hospital Association, the Medical University of South Carolina, Roper Hospital, Palmetto Richland Hospital, The South Carolina Dental Association, the South Carolina Neurological Association, and the South Carolina Defense Trial Attorneys Association. He has also served as a lecturer on behalf of the National Business Institute on Medical Malpractice and Real estate liability issues.

He is a member of the American Law Firm Association's Professional Liability Steering Committee. He is a past vice-chair for the Young Lawyers Subcommittee of the Toxic Tort Committee of the Defense Research Institute. Jay has published articles in the South Carolina Law Review, The Professional Lawyer, For the Defense: The Magazine for Insurance and Corporate Counsel, the Federation of Regulatory Council Quarterly Journal of Insurance Law and Regulation, and The Defense Line.

While in law school, Jay was a member of the Order of the Coif, Order of the Wig and Robe, an editor for the South Carolina Law Review, a member of the South Carolina Moot Court Bar, and listed in the Who's Who of American Law Students. Jay also served as the Associate Editor for the South Carolina Law Review Symposium on the "Restatement (Third) of Unfair Competition."

Jay has been active in community organizations in the Charleston area. He has been appointed to the First Citizens Bank advisory board. He is a member of the Board of Directors of Charleston Day School. He is a past member of the Board of Directors of the South Carolina Maritime Foundation, the Low Country Children's Museum, American Heart Association Heart Ball Executive Leadership Team, and the Charleston Metro Chamber of Commerce Board of Economic Advisers. He has served on the Communities in Schools Board of Directors, as a United Way Account Executive, as a member of the Youth Service Charleston Advisory Council, is a graduate of Leadership Charleston, and as a Junior Achievement Volunteer. He is an active member of St. Philips Episcopal Church and a former member of the Vestry. Jay is a member of the Clergy Society, Widows and Orphans Society, and the Charleston Club.

Richard D. Gable, Jr. | Partner | 215.405.9191 | rgable@butler.legal

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Rich Gable is a commercial litigator with a wealth of experience representing insurance carriers in property insurance disputes, including complex first-party coverage matters and claims of bad faith. He also handles large loss commercial property subrogation matters, third-party insurance coverage disputes and environmental liability insurance claims. He is often engaged to provide coverage and claims handling advice early in the claims adjustment process to avoid or eliminate costly litigation to his insurer clients. In addition to insurers, Rich has experience defending other financial institutions from claims of fraud, unfair trade practices and violations of various other consumer protection statutes.

Rich is a past Chair of the American Bar Association, Tort Trial and Insurance Practice Section, Property Insurance Law Committee and has been recognized as a Pennsylvania Super Lawyer in the area of Insurance Coverage every year since 2011. He maintains an "AV Preeminent" peer review rating with Martindale-Hubbell.

Rich received a Bachelor of Science in Commerce from the University of Virginia and graduated from Villanova University School of Law. Following law school, Rich served as Captain in the U.S. Army Judge Advocate General's Corps where he tried numerous felony courts-martial as both a military prosecutor and criminal defense attorney. While in the Army he also served as a Special Assistant United States Attorney in the office of the United States Attorney for the Eastern District of Virginia. He began his civil litigation career as an associate and later partner with the firm of Hecker Brown Sherry and Johnson LLP. From 2006 until 2012 he was a Director with the firm Gibbons, P.C., resident in their Philadelphia office.

Rich is admitted to the state bars of New Jersey and Pennsylvania; the Federal District of New Jersey; the Eastern, Middle and Western Districts of Pennsylvania and the Third Circuit Court of Appeals. He has also been admitted to practice pro hac vice in many other states including Maryland, Virginia and New York.

Rich is a frequent author and speaker in the area of property insurance and property insurance litigation. Some of his publications include “Don’t Leave Money on the Table: Pursuing Recovery for Large Uninsured Losses,” The Metropolitan Corporate Counsel, June 2011; Chapter 7 (“Experts”) and Section 11.09 (“Damages”) of the Property Insurance Litigator’s Handbook, American Bar Association, 2007, 2013. His speaking engagements include: “Ethical Considerations in Settlement and Mediation of a Complex Commercial Fire Claim,” with Jay Levin and Hon. David Strawbridge at the ABA Property Insurance Law Committee Mid-Year Meeting, May 2015; “Evaluating Coverage for Property Insurance Claims Arising From Multiple Causes of Loss” at the Property Loss Research Bureau’s 2010 and 2011 Claims Conferences; “Appraisal Strategies That Work,” presented with Jonathan C. Held at the DRI Insurance Coverage and Practice Symposium, December 2009; and “Managing and Adjusting Builder’s Risk Claims,” presented with Andrew S. Granzow at the ABA Property Insurance Law Committee Mid-Year Meeting, May 2009.