

OVERCOMING BARRIERS TO PHYSICIAN VOLUNTEERISM: SUMMARY OF STATE LAWS PROVIDING REDUCED MALPRACTICE LIABILITY EXPOSURE FOR CLINICIAN VOLUNTEERS[†]

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Noting that the risk of malpractice liability poses a significant barrier to the provision of volunteer health care in this country, the author analyzes current state and federal legislative approaches designed to overcome the hurdle, including a changed standard of care for malpractice liability from simple negligence to gross negligence, governmental indemnification of volunteer providers, and state sponsored malpractice insurance. The author challenges legislators to enhance existing legislation by combining the best aspects of the varied approaches in an effort to increase delivery of medical services to those in need, while at the same time ensuring the protection of uninsured patients from malpractice.

I. INTRODUCTION

Tens of thousands of physicians, dentists, and other health care providers volunteer their time and skills to provide care to patients lacking insurance or other financial means to pay for services.¹ Physicians pro-

[†] Editor's Note: Dr. Hattis's article originally appeared in Volume 2004, Issue 1. Unfortunately, when it was first published, the appendix was not included. In order to rectify this oversight, the article, along with the appendix, are being published in this issue in their entirety. The University of Illinois Law Review apologizes to Dr. Hattis and its readers for this oversight.

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1. See CAROL K. KANE, AM. MED. ASS'N CENTER FOR HEALTH POL'Y RES., PHYSICIAN MARKETPLACE REPORT: PHYSICIAN PROVISION OF CHARITY CARE, 1988-1999 (Apr. 2002). Approximately 64.6% of physicians provided some sort of charity care in 1999. *Id.* at 1. However, most of this

vide such volunteer services in many different settings and under the sponsorship of various organizations.² One of the challenges and potential barriers to greater volunteerism among physicians is the fear of malpractice liability associated with providing such uncompensated services.

In the absence of universal entitlement to health insurance in the United States, state legislatures³ and even Congress⁴ recognize the need to help promote greater access to organized volunteer care, passing laws which in some way reduce the liability concerns of clinician volunteers in the nonemergency context. As of September 30, 2003, forty-three states plus the District of Columbia have passed some legislation in this regard.⁵ Usually, the laws either change the liability standard for malpractice in the volunteer context to make it more difficult to successfully sue a negligent volunteer clinician⁶ or in some way indemnify the clinicians for any potential liability flowing from their acts of malpractice.⁷

II. OVERVIEW OF STATE APPROACHES

Examining the realm of charitable immunity legislation reveals the individuality of state legislative responses to the issue. Although basic elements can be used as a framework for discussion, no state's legislation looks exactly like any other jurisdiction. In some instances, legislative language is transparent in its intent;⁸ in others it is more difficult to interpret.⁹

There are, however, a few summary statements that can be made. As of September 30, 2003: forty-three states and the District of Columbia have some sort of charitable immunity legislation;¹⁰ seven states have none: Alaska, California, Massachusetts, Nebraska, New Mexico, New York, and Vermont;¹¹ thirty-eight states and the District of Columbia

is done in the context of their own practice and not as part of an organized volunteer effort. *See generally id.*

2. While it is not known exactly how many organized volunteer efforts there are in the United States, it is thought that there are at least 800 free clinics operating across the fifty states, and others organized in some other form. Interview with Gayle Goldin, Technical Assistance Manager, Volunteers in Health Care, in Pawtucket, R.I. (Sept. 20, 2002).

3. *See infra* Appendix for a description of the volunteer protection laws currently on the books in the states.

4. For example, the Volunteer Protection Act of 1997 was signed on June 18, 1997, by President Clinton, and its effective date was September 16, 1997. Volunteer Protection Act of 1997, 42 U.S.C. §§ 14501–14505 (2000).

5. Paul A. Hattis & Sonya Staton, Understanding Charitable Immunity Legislation: A Volunteers in Health Care Guide 6, *available at* <http://www.volunteersinhealthcare.org/manuals/charit.imm.man.pdf> (last visited Sept. 11, 2003).

6. *See, e.g.*, ARIZ. REV. STAT. ANN. § 12-571 (West 2003); OR. REV. STAT. § 30.792 (2001); R.I. GEN. LAWS § 7-6-9 (1999).

7. *See, e.g.*, WIS. STAT. ANN. §§ 146.89(4), 895.46(1)(a) (West 1996) (stating that volunteer health care providers are treated as state employees, and thus granted indemnification).

8. *See, e.g.*, ARIZ. REV. STAT. ANN. § 12-571.

9. *See, e.g.*, R.I. GEN. LAWS § 7-6-9.

10. *See infra* Appendix.

11. *See infra* Appendix.

have legislation creating some sort of limit on liability by specifically referencing volunteer health care providers.¹² Five other jurisdictions offer protection by making reference only to volunteers generally.¹³ Twenty-one states have legislation that makes specific reference to dentists or dental care.¹⁴ Thirteen states either specifically reference or incorporate retired physicians in their charitable immunity statutes.¹⁵ Three states—Pennsylvania, West Virginia and Washington—have legislation in this area only for retired physician volunteers.¹⁶

Most states choose one of the following routes in providing charitable immunity: (1) changing the negligence standard of care (from simple negligence to gross negligence)¹⁷ or (2) indemnifying volunteer providers as if they were governmental employees (that is, extending the liability protections state employees routinely receive to volunteer providers).¹⁸ A few states combine aspects of both approaches under their laws.¹⁹

In addition, practically all charitable immunity legislation has qualifying conditions affecting coverage.²⁰ These conditions are usually one of the following: restrictions on the setting in which the health care can be delivered, restrictions on the type of care provided,²¹ or requirement of patient notification of liability limitations.²² Some states also place limits on the amount that can be recovered by a patient through a lawsuit.²³

III. MALPRACTICE

When a patient seeks medical care from a clinician and appears to be harmed by the treatment (or lack of it), the law provides a remedy for the patient to seek damages from that clinician.²⁴ While a bad medical result does not necessarily indicate negligent practice on the clinician's part (as even with the best of care things can go wrong), patients sometimes sue in state court for monetary damages in such circumstances.²⁵ Determining whether a clinician's actions were negligent—causation of the injury—is a question that may be put to a jury or judge after preliminary evidence is presented in court.²⁶

12. See *infra* Appendix.

13. Hattis & Staton, *supra* note 5, at 6.

14. See *infra* Appendix.

15. See *infra* Appendix.

16. 42 PA. CONS. STAT. ANN. § 8332.4 (West 2003); PA. STAT. ANN. tit. 35, § 449.47 (West 2003); WASH. REV. CODE ANN. §§ 43.70.460–470 (West 2003); W. VA. CODE ANN. § 58-13-3 (Michie 2002).

17. Hattis & Staton, *supra* note 5, at 6.

18. *Id.*

19. *Id.*

20. *Id.* at 7.

21. *Id.*

22. *Id.*

23. *Id.*

24. *Id.* at 8.

25. *Id.*

26. *Id.*

Generally, for the injured patient to win a medical malpractice case, four traditional elements must be found: (1) the existence of a duty owed to the plaintiff; (2) breach of that duty through the violation of a standard of care owed to the patient; (3) an injury to the person owed a duty; and (4) a causal connection between the violation of the standard of care and the harm.²⁷ Usually, the standard of care a physician owes a patient is one of "reasonableness."²⁸ Reasonableness is generally determined by looking at what is prudent, in view of the available knowledge and the state of medical practices at the time of the illness or injury.²⁹ There must also be proof through expert testimony that the negligence of the clinician was also the cause of the injury.³⁰ A clinician may be negligent, for example, and still not be liable, if the injury was caused by some other factor.³¹

Clinicians may be fearful of increasing their liability exposure by offering their services to patients through organized volunteer programs.³² This may be especially true for clinicians whose malpractice coverage (for negligent acts) does not apply to their volunteer activities. For example, for clinicians employed by an institution such as a hospital or medical center, malpractice coverage may be limited to patients seen in the scope of their employment.³³ These clinicians may need explicit permission to include their free clinic practice under their insurance umbrella.³⁴ This is generally more restrictive than the situation of clinicians

27. See BLACK'S LAW DICTIONARY 864 (5th ed. 1979); see also *Kosberg v. Wash. Hosp. Ctr., Inc.*, 394 F.2d 947, 949 (D.C. Cir. 1998).

28.

[T]he law places upon [a physician] the duty of possessing, that reasonable degree of learning and skill that is ordinarily possessed by physicians . . . in the locality where [one] practices, and which is ordinarily regarded by those conversant with the employment as necessary to qualify [that physician] to engage in the business of practicing medicine Upon consenting to treat a patient, it becomes [one's] duty to use reasonable care and diligence in the exercise of [one's] skill and . . . learning to accomplish the purpose for which [the physician] was employed. [A physician] is under the further obligation to use [one's] best judgment in exercising [one's] skill and applying [one's] knowledge

Pike v. Honsinger, 49 N.E. 760, 762 (N.Y. 1898).

29. See *id.*; see also KENNETH R. WING, *THE LAW AND THE PUBLIC'S HEALTH* 266-67 (4th ed. 1995).

30. See WING, *supra* note 29, at 269-70.

31. For a discussion of the role of expert testimony and issues of causation, see *id.* at 267-71.

32. It is thought that physicians caring for poor people (either in the volunteer context or for Medicaid recipients) are at greater malpractice risk than those who care for paying patients because the poor are thought to sue more. See 1 COMM. TO STUDY MED. PROF'L LIAB. & THE DELIVERY OF OBSTETRICAL CARE, INST. OF MED., *MEDICAL PROFESSIONAL LIABILITY AND THE DELIVERY OF OBSTETRICAL CARE* 63 (1989). Actually, the limited studies on the subject point to an opposite conclusion. See, e.g., David M. Studdert et. al., *Negligent Care and Malpractice Claiming Behavior in Utah and Colorado*, 38 MED. CARE 250, 250-60 (2000). ("[T]he elderly and poor are particularly likely to be among those who suffer negligence and do not sue"); see also Helen R. Burstin et. al., *Do the Poor Sue More? A Case-Control Study of Malpractice Claims and Socioeconomic Status*, 270 JAMA 1697 (1997) (abstracting a case-controlled study of malpractice claims and socioeconomic status). "Poor and uninsured patients are significantly less likely to sue for malpractice, even after controlling for the presence of medical injury." *Id.* at 1697.

33. Hattis & Staton, *supra* note 5, at 8.

34. *Id.*

in private practice, whose insurance coverage usually follows them no matter where within the state they are practicing their approved specialty.³⁵

IV. STATE APPROACHES: CHANGING THE NEGLIGENCE STANDARD OF CARE

The most common approach to charitable immunity legislation is changing the standard of care owed by the volunteer clinician to the patient.³⁶ As of September 30, 2003, thirty-six states and the District of Columbia have enacted legislation that changes the standard of care from negligence to a more egregious level of practice, usually referred to as “gross negligence” (sometimes also called a “willful or wanton” or “reckless” standard).³⁷ Under this standard of care, an injured person must often show that the volunteer had a conscious indifference to the consequences of his or her actions.³⁸ This is not an easy standard to prove.³⁹ The context for this approach comes from state legislative changes that made it more difficult to sue a health care provider who stops and offers aid at the scene of an accident.⁴⁰

When states enact such standard of care changes, they can do so through a law that applies to all volunteers⁴¹—not strictly limited to the medical care context—or pass specific laws targeted toward physicians and other health care providers providing charitable health care ser-

35. *Id.*

36. *See infra* Appendix.

37. *See infra* Appendix. While state definitions for the term differ, a typical one is the Illinois statute, which defines “willful and wanton conduct” as follows:

“Willful and wanton conduct” as used in this [Local Governmental and Governmental Employees Tort Immunity] Act means a course of action which shows an actual or deliberate intention to cause harm or which, if not intentional, shows an utter indifference to or conscious disregard for the safety of others or their property.

745 ILL. COMP. STAT. 10/210 (2002).

38. *See generally* RESTATEMENT (SECOND) OF TORTS § 500 (1965) (defining reckless disregard of safety).

39. *Id.* § cmt. g (comparing negligence and recklessness).

40. *See, e.g.,* WING, *supra* note 29, at 297 n.6 (providing a critical view of these so-called “Good Samaritan” laws). There has not been an evidentiary base for creating such laws based on a flurry of malpractice lawsuits. *Id.* at 298 n.6.

41. An example of a typical statute that focuses on volunteer providers in general and changes the standard of care (not all states use identical language in their statutes) is Rhode Island’s legislation:

Exemption from liability—Notwithstanding any other provisions of this chapter:

(a) No person serving without compensation as a volunteer, director, officer, or trustee of a non-profit corporation, including a corporation qualified as a tax exempt corporation under § 501(c) of the United States Internal Revenue Code, 26 U.S.C. §501(c), or of an unincorporated non-profit organization or an unincorporated public charitable institution qualified as a tax exempt organization under § 501(c) of the United States Internal Revenue Code, is liable to any person based solely on his or her conduct in the execution of the office or duty unless the conduct of the director, officer, trustee, or volunteer regarding the person asserting the liability constituted malicious, willful, or wanton misconduct.

R.I. GEN. LAWS. § 7-6-9 (1999).

vices.⁴² The recent trend has been to pass laws specific to health care providers as a way to encourage more charitable health care delivery.⁴³ In those states that have statutes both for volunteers generally and health care providers specifically,⁴⁴ the operative statute for determining the volunteer clinician liability is the one focused on health care providers.⁴⁵

V. STATE APPROACHES: INDEMNIFYING THE VOLUNTEER AS A PUBLIC EMPLOYEE

The second common approach is to indemnify volunteer clinicians by providing liability protection through use of the same mechanism available to compensate for injuries caused by negligent acts of government employees. Under such an approach, the state limits recovery for malpractice-related injuries resulting from the care of volunteer clinicians to the state tort claims act mechanism.⁴⁶ As of September 30, 2003, ten states—Florida, Iowa, Kansas, Louisiana, Missouri, Nevada, Oregon, Tennessee, Virginia, and Wisconsin—have adopted some aspect of this approach for their clinician volunteers.⁴⁷ Seven of these states—Iowa, Louisiana, Missouri, Nevada, Oregon, Virginia, and Wisconsin—raise the standard of care, as well as offer indemnification to qualifying clinician volunteers.⁴⁸

Usually, the legislation specifies certain conditions—such as the setting in which the care is delivered or a formal agreement between the clinician provider and the state—that must be met for state tort claims act coverage to be extended to the volunteer clinician.⁴⁹ As long as these conditions are met, the state tort claims act affords protection to the vol-

42. An example of a typical statute that focuses on health care providers and changes the standard of care is Arizona's legislation:

Qualified Immunity for Health Professionals

A health professional . . . who provides medical or dental treatment within the scope of the health professional's certificate or license at a nonprofit clinic where neither the professional nor the clinic receives compensation for any treatment provided at the clinic is not liable in a medical malpractice action, unless such health professional was grossly negligent.

ARIZ. REV. STAT. § 12-571 (2003).

43. Hattis & Staton, *supra* note 5, at 9.

44. See *infra* notes 46–68 and accompanying text (discussing states' approaches).

45. It is important to note, however, that as legally constructed, these state laws are not a guarantee against malpractice litigation, nor do they assure early dismissal of a lawsuit. What they can do—and this is not insignificant—is set the “bar” for winning a malpractice case high enough so as to make it more unlikely that lawyers would advise their clients to pursue malpractice litigation against a volunteer clinician.

46. See, e.g., FLA. STAT. ANN. § 766.1115(2) (West 2003) (identifying legislative intent to provide sovereign immunity).

47. See *infra* Appendix.

48. See *infra* Appendix. In Oregon, state university physician employees who volunteer their medical services at sites outside of their normal scope of employment are extended state tort claims act protection, as are retired physicians who care for patients that are referred to them by county health officers. OR. REV. STAT. §§ 30.268, 302 (2001). Oregon legislation also raises the standard of care to gross negligence for other clinician volunteers. *Id.* § 30.792.

49. See *infra* Appendix (outlining volunteer protection laws of the various states).

unteer clinicians by indemnifying them as if they were state employees.⁵⁰ In most of these “indemnity” states, a legal defense fund has been created to cover legal defense costs, as well as monetary damages.⁵¹ Often, statutes of this type will cap the total compensation that can be paid for claims; the range for the above noted seven states varies from \$250,000⁵² to \$1,000,000.⁵³ These statutes also exempt the state from punitive damages (that is, damages awarded in excess of normal compensation to punish a defendant for a serious wrong).⁵⁴

Wisconsin provides an example of an indemnity approach. Under state law, volunteer clinicians working under the auspices of a nonprofit agency are designated “state agents of the department of health and family services.”⁵⁵ As such, the clinicians are covered under the state tort claims act.⁵⁶ This requires the state government to pay damages for any valid malpractice claim against a volunteer clinician that arose in the volunteer practice context and was a service covered under the act, as well as to pay for legal defense costs.⁵⁷

VI. OTHER STATE APPROACHES

A few states, rather than enacting legislation that extends some degree of immunity to volunteer clinicians, provide a mechanism for purchasing malpractice insurance.⁵⁸ In a recently enacted provision in Minnesota,⁵⁹ the state licensing boards must purchase malpractice insurance for uncovered volunteer clinicians and pass on liability costs through increases in licensing fees. In Connecticut,⁶⁰ legislation authorizes the Department of Public Health to purchase liability insurance for free clinics, if it chooses to do so. Kentucky⁶¹ legislation makes monies available to free clinics, so that they may purchase insurance for providers working at their facilities. In both cases, providers must not receive compensation for any of the health care services. In addition, Kentucky requires insurers writing medical malpractice insurance to make such insurance available, with the same limits of coverage as for private practice, to charitable health care facilities in their state; the state covers the cost of the premium within certain dollar limits.⁶²

50. Hattis & Staton, *supra* note 5, at 11.

51. *Id.*

52. OR. REV. STAT. § 30.270(1)(b).

53. MO. REV. STAT. § 105.711(2)(3)(c) (2003).

54. OR. REV. STAT. § 30.270(2); WIS. STAT. ANN. § 893.82(6) (West 2002).

55. WIS. STAT. ANN. § 146.89(4).

56. *Id.*

57. *Id.* § 895.46(1)(a).

58. *See, e.g.*, MINN. STAT. ANN. § 214.40(7) (West 2003).

59. *Id.*

60. CONN. GEN. STAT. ANN. § 19a-17m (West 2003).

61. KY. REV. STAT. ANN. § 304.40-075 (Michie 2002).

62. *Id.*

Tennessee⁶³ mandates that malpractice insurance sold in the state cannot exclude coverage to any provider who voluntarily provides health care services. Under this legislation, local governments also have the option to indemnify volunteers providing care under their auspices. In Washington,⁶⁴ state legislation grants the Department of Health the right to establish a program to purchase malpractice insurance for retired primary care clinicians who volunteer at community clinics, although there is no legislation pertaining to non-retired physician volunteers.

Several states have legislation that is not easily categorized. In Hawaii, for example, individuals are immune from liability if they provide volunteer care under the auspices of a nonprofit or governmental organization that has total assets under \$50,000 or that carries malpractice insurance of at least \$200,000 per occurrence⁶⁵—in which case the injured party can sue the volunteer clinician's sponsoring organization.⁶⁶ In Delaware⁶⁷ and North Carolina,⁶⁸ if neither the free clinic nor the volunteer clinician carries malpractice insurance covering care at the clinic, a suit may go forward only in cases of gross negligence.

VII. QUALIFYING THE GRANTING OF IMMUNITY

Whether states change the operative standard of care, offer state tort claim act coverage to clinician volunteers,⁶⁹ or provide payment for liability insurance,⁷⁰ they usually do not do so without creating some limitations or qualifications.⁷¹ As detailed below, among the most common constraints are the setting in which care is delivered, the services that are covered, and specific requirements regarding notice to patients on liability limitations.⁷² These limitations are discussed below.

A. *Restriction to Certain Settings*

Thirty-two states and the District of Columbia⁷³ specifically reference the settings where volunteer care is delivered in order to qualify for charitable immunity protection. While states differ in the settings they specify, some of the most common are: (1) free clinics;⁷⁴ (2) community

63. TENN. CODE ANN. § 63-6-707 (2000).

64. WASH. REV. CODE § 43.70.460 (2002).

65. HAW. REV. STAT. § 662D-2(a)(3)(A) (2001).

66. *Id.* § 662D-2(b).

67. DEL. CODE ANN. tit. 10, § 8135(b) (2001).

68. N.C. GEN. STAT. § 90-21.16 (2001)

69. *See supra* notes 46–57 and accompanying text.

70. *See supra* notes 58–64 and accompanying text.

71. *See supra* notes 65–68 and accompanying text.

72. There may be additional limitations as well, for example, by specifying income limits of patients that are eligible for care under the program. *See, e.g.*, FLA. STAT. ch. 766.1115(3)(d)(3)–(4) (2002).

73. *See infra* Appendix.

74. *See, e.g.*, N.C. GEN. STAT. § 90-21.16 (2001).

health centers or other nonprofit clinics;⁷⁵ or (3) other special care sites designated or established by “sponsoring organizations” to help facilitate the provision of volunteer care to persons who cannot afford to pay.⁷⁶ It appears that such limitations are added so that physicians in private practice, as well as those working in entities such as hospitals or ambulatory surgical centers, are excluded from protection—even when care is provided without any expectation of payment. A possible explanation is that generally, physicians working in these settings are covered by malpractice insurance.⁷⁷ Furthermore, there could be some concern that if reduced liability exposure was extended to volunteer care provided in these settings, then it may lead to providers designating patients whom they injure through their care as “charitable cases” after the fact, in order to protect themselves from malpractice liability.⁷⁸ Georgia and Florida are exceptions. In Georgia, protection extends to hospitals, as well as to care provided in other nonprofit organizational sites.⁷⁹ In Florida, hospitals can be included as practice sites if there is a formal agreement with providers in such settings to participate in designated volunteer care programs.⁸⁰

B. Restriction to Specific Medical Care Services

A few states limit the scope of services covered under volunteer medical care practice.⁸¹ There appears to be a clear intent that the sort of services considered for charitable immunity are preventative and primary care. Some states, such as Connecticut, limit the scope of practice to primary care.⁸² In the District of Columbia, the limitation on liability applies only to the activities of physicians and nurses working in obstetrics and gynecology in free clinic settings.⁸³ Other states specifically enumerate what health services are (or are not) covered under their reduced liability scheme. For example, in Wisconsin, the nonprofit agency using clinician volunteers may only provide diagnostic tests, health education, and information about available health care resources, office visits, patient advocacy, prescriptions, dental services, and referrals to health care specialists.⁸⁴ In Missouri, abortion services are specifically excluded from coverage under its charitable immunity legislation.⁸⁵

75. See, e.g., ARIZ. REV. STAT. § 12-571 (2003).

76. See, e.g., GA. CODE ANN. § 51-1-29.1 (2000).

77. Hattis & Staton, *supra* note 5, at 14.

78. *Id.*; see also *infra* Appendix.

79. GA. CODE ANN. § 51-1-29.1.

80. FLA. STAT. ch. 766.1115(3)(d)(3)–(4) (1997).

81. See *infra* Appendix.

82. CONN. GEN. STAT. § 19a-17m(a) (1997).

83. D.C. CODE ANN. § 7-402(a) (2000).

84. WIS. STAT. ANN. § 146.89(3)(b) (West 1997).

85. MO. REV. STAT. § 105.711.2(3)(d) (1997).

States often exclude surgical treatment, general anesthesia, or other more complex or invasive kinds of medical care.⁸⁶ The concern is that this sort of medical care often poses greater risks to the patient, and if injury results from negligent care, then patients need to be compensated.⁸⁷ Although services such as hospital or ambulatory surgery are excluded from charitable immunity legislation in a few states, protection is afforded to providers who deliver follow-up care to a patient (including in a hospital) upon referral from the free clinic.⁸⁸

C. Requirement to Notify Patients of Liability Limitation

Sixteen states and the District of Columbia⁸⁹ require that the non-profit agency or clinic using volunteers give notice to patients that there is a limit on the liability for health care services provided. In many states, this requires written notice.⁹⁰ In Florida, for example, each patient or legal representative is given written notice concerning the terms of the treatment and the limits on liability.⁹¹ Some states require that all clinics post such a notice, often in a “conspicuous place.”⁹² Arkansas⁹³ and Texas⁹⁴ require that patients sign a written statement acknowledging their understanding of the health care provider’s limit on liability. The District of Columbia requires that the written statement be signed and “witnessed by 2 persons,” where the “parties agree to the rendering of the health care or treatment.”⁹⁵ In other states, the requirement about notice is less clear. For example, in Montana, patients must be given notice that “under state law the medical practitioner . . . cannot be held legally liable for ordinary negligence if the medical practitioner . . . does not have malpractice insurance.”⁹⁶ It would appear that oral notice would suffice.⁹⁷

VIII. LIMITING REMUNERATION

In practically every state that relies upon state tort claims acts⁹⁸ to protect volunteer clinicians, efforts are made to impose specific limita-

86. Hattis & Staton, *supra* note 5, at 15.

87. *Id.*

88. *See, e.g.*, 745 ILL. COMP. STAT. 49/30(d) (2002).

89. *See infra* Appendix.

90. *See infra* notes 91–95 and accompanying text.

91. FLA. STAT. ch. 766.1115(5) (1997).

92. *Id.*

93. ARK. CODE ANN. § 16-6-201(b)(2)(B) (Michie 1999).

94. TEX. CIV. PRAC. & REM. CODE ANN. §§ 84.001–.007, 109.004 (Vernon 2003).

95. D.C. CODE ANN. § 7-402(b) (2001).

96. MONT. CODE ANN. § 27-1-736(1) (2002).

97. *Id.* (failing to require written notification).

98. The federal, state, and local governments are not amenable to actions in tort except in cases in which they have consented to be sued. 28 U.S.C.A. § 2680 (2003). Like the federal government, which has waved its immunity under certain cases under the Federal Tort Claims Act, 28 U.S.C.

tions on recovery of damages by plaintiffs. The limitations vary from state to state.⁹⁹ Limits to recovery also occur in a few states in which the change of standard to “gross negligence” has been legislated.¹⁰⁰

Sometimes the limits are different depending on the services provided. For example, Missouri has different limits of recovery for volunteer obstetrical services than for volunteer primary care services.¹⁰¹ As mentioned previously, under state tort claim acts, plaintiffs usually cannot recover punitive damages.¹⁰² Some states, such as South Carolina, also specifically preclude any recovery of interest that would ordinarily accrue from the time of injury to the date of the award.¹⁰³

IX. RETIRED PHYSICIANS

As of September 30, 2003, thirteen states have passed legislation that affects in some way the liability exposure of retired volunteer physicians.¹⁰⁴ In some of these states, the legislatures have enacted slightly different laws affecting retired physicians as compared to active physician volunteers. For example, Mississippi requires a written or oral agreement between the retired physician and the sponsoring clinic that services are being provided for free;¹⁰⁵ for volunteers still active in practice, the law stipulates that they and their patients must each sign a written agreement that details not only that the service is free, but that certain limits to liability for malpractice are operative.¹⁰⁶ In Maine, both retired and active volunteers receive the protection of a gross negligence standard.¹⁰⁷

Finally, a few states have reduced liability statutes that have special provisions for retired physicians. As noted previously, Washington provides for a state program that pays for malpractice insurance for retired physician volunteers who practice primary care at community clinics; it has no liability reduction program for non-retired volunteers.¹⁰⁸ In Ore-

§§ 1346(b), 2674 (2000), most states have also waived government immunity to various degrees. See BLACK'S LAW DICTIONARY 613 (6th ed. 1990).

99. See *infra* note 101 and accompanying text; see also *supra* notes 47–48 and accompanying text.

100. For example, the states of California, Colorado, Indiana, Montana, and Utah have caps on noneconomic damages for malpractice claims. CAL. CIV. CODE § 333.2 (West 1997); COLO. REV. STAT. ANN. § 13-64-302 (West 1997); IND. CODE ANN. § 34-18-14-3 (West 1999); MONT. CODE ANN. § 25-9-411; UTAH CODE ANN. § 78-14-7.1 (2002). Their damage cap limits would apply to malpractice cases where there is a finding of gross negligence. See, e.g., MONT. CODE ANN. § 27-1736.

101. MO. REV. STAT. § 105.711.2(3)(c)–(d) (1997).

102. See *supra* note 54 and accompanying text.

103. S.C. CODE ANN. § 15-78-120(5)(b) (Law. Co-op. Supp. 2002).

104. Some states, as an additional incentive to promote volunteerism, have statutes that reduce the licensing fee for retired physicians who, at no charge, only care for the poor and medically needy. See, e.g., W. VA. CODE ANN. § 30-3-10a (Michie 2002).

105. MISS. CODE ANN. § 73-25-38(2) (2000).

106. *Id.* § 73-25-38(1).

107. ME. REV. STAT. ANN. tit. 24, § 2904(2) (West 2003).

108. WASH. REV. CODE ANN. § 43.70.460 (West 1998).

gon, a retired physician caring for patients referred from a county health officer has liability limits of recovery equal to those of persons who work for a “public body.”¹⁰⁹ In New Hampshire, immunity for retired physicians extends only to health education in public forums or to individual educational consultations, so long as they are not considered diagnostic or treatment advice.¹¹⁰ Pennsylvania’s legislation specifically targets for protection from liability, retired physicians, dentists, and other health professionals who volunteer in “approved clinics;” so long as there is a posting of this reduced standard of liability in a “conspicuous place” of the clinic.¹¹¹

X. FEDERAL LEGISLATION

While malpractice and tort law have been used primarily by states to extend charitable immunity to volunteers, this is not an area that Congress has completely ignored. In 1996, as part of the Health Insurance Portability and Accountability Act, Congress amended the Public Health Service Act to make certain qualified clinician volunteers working at free clinics employees of the U.S. Public Health Service and, hence, covered for malpractice liability by the federal government.¹¹² The law, however, has never gone into effect because Congress has not appropriated funds to cover the costs of providing federal coverage to these clinician volunteers.¹¹³

In 1997, Congress passed the Volunteer Protection Act (VPA).¹¹⁴ The law provides all volunteers, including clinician volunteers, of non-profit organizations and government entities with protection from liability for certain harms caused by their acts or omissions while serving as volunteers.¹¹⁵ As with practically all such state laws, volunteers who qualify for the VPA’s protection are shielded from harm caused by simple negligence, so long as it is within the scope of the volunteer’s duties.¹¹⁶ As with most state laws attempting to reduce volunteer liability, the law does not prevent people from bringing lawsuits nor does it provide for defense cost reimbursement to volunteers.¹¹⁷ As of July 1, 2002, only one federal district court has had an opportunity to apply the law¹¹⁸ and posit that under the correct factual circumstances, the federal law is

109. OR. REV. STAT. § 30.302 (2001).

110. N.H. REV. STAT. ANN. § 329:25-a (2003).

111. 35 PA. CONS. STAT. ANN. § 449.47 (West 2003).

112. Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, § 194, 110 Stat. 1936, 1988-91 (1996).

113. Hattis & Staton, *supra* note 5, at 18.

114. Pub. L. No. 105-19, 111 Stat. 218 (codified at 42 U.S.C. §§ 14501-14505 (2000)).

115. *Id.*

116. 42 U.S.C. § 14503(a) (2000).

117. *See generally* 42 U.S.C.A. §§ 14501-14506 (West 1997).

118. *See Momans v. St. Johns Northwestern Military Acad., Inc.*, No. 99-C8510, 2000 WL 33976543, at *5 (N.D. Ill. Apr. 20, 2000).

legitimate and can be applied to help defendants gain some immunity for malpractice liability.

Under the VPA, properly licensed volunteer clinicians acting within their scope of duties in nonprofit or governmental organizations are protected from liability for simple negligence, so long as the alleged misconduct does not fall into certain categories of exclusion (e.g., a crime of violence or hate; a sexual offense or civil rights violation; or an act committed under the influence of alcohol).¹¹⁹ Even in situations in which the volunteer can be held liable, e.g., was grossly negligent, the VPA greatly limits the circumstances in which punitive damages can be awarded to those cases with clear and convincing evidence of willful or criminal conduct.¹²⁰ It also restricts the amount of noneconomic damages, i.e., pain and suffering, to the proportion of the volunteer's contributory responsibility for the resultant harm.¹²¹ If a fact finder determines the volunteer is responsible for twenty percent of the harm done, then noneconomic damages can equal no more than twenty percent of the awarded damages.¹²² The VPA, however, does not place any limits on the amount of economic damages, e.g., medical expenses, lost wages, awarded to a person injured as a result of a volunteer's gross negligence.¹²³

The statute allows states, if they so choose, to impose further limitations on liability.¹²⁴ Accordingly, state laws could: (1) require volunteer programs to adhere to risk management procedures; (2) create vicarious liability on the part of the sponsoring volunteer program (that is, make the volunteer program liable for a volunteer's negligent acts); (3) make the liability limitation inapplicable if a suit is brought by state or local government; or (4) make the liability limitation apply only if the sponsoring organization provides a financially secure source of recovery for harms caused by volunteers.¹²⁵

While the VPA preempts any state law offering fewer protections, states can go beyond the VPA's protections through passage of state laws.¹²⁶ Interestingly, there is a provision of the VPA that permits individual states to pass specific legislation that would make the VPA provisions inapplicable in the specific circumstance where all parties to a lawsuit are residents of that state.¹²⁷ If a state passes such a provision, then only its laws and not the VPA would govern. As of July 1, 2002, no state has chosen to opt out of the VPA protections.

119. 42 U.S.C. § 14503(f).

120. *Id.* § 14503(e).

121. *Id.* § 14504(b).

122. *Id.*

123. *See id.* § 14503.

124. *Id.* § 14503(d).

125. *Id.*

126. *Id.* § 14502(a).

127. *Id.* § 14502(b).

XI. FUTURE POLICY DIRECTION

More than forty-one million people in this country lack health insurance,¹²⁸ with no prospect of federal legislation extending coverage to this population on the horizon. As such, providing medical and dental care for the uninsured remains a key policy issue. In many communities, one component of the safety net for the uninsured includes primary and specialty care provided by volunteer clinicians. In order to support this spirit of volunteerism and increase the amount of volunteer services, the federal government and most states have enacted legislation to reduce liability risks or, in a few instances, help to provide malpractice insurance for clinicians.

Legislators drafting legislation to support clinician volunteerism face several challenges: creating a climate that encourages volunteerism, addressing the concerns of volunteer clinicians regarding malpractice litigation, ensuring that patients seen by volunteer clinicians retain rights to compensation for acts of negligence, and avoiding the perception that volunteer liability protection legislation permits a lesser standard of health care for the uninsured. The pivotal issue becomes how to balance the need to allay the fears of clinicians willing to provide free services with the rights of individuals receiving those services to be compensated for their injuries.

From a policy perspective, efforts to reduce the liability risk of volunteers comes at a potential price to persons injured by their negligent acts, unless some secure source of recovery for an injury is in place. State legislation that makes the volunteer's sponsoring organization responsible for providing a financially secure source of recovery—such as an insurance policy or shared risk pool arrangement—may offer one alternative that addresses the liability concerns of volunteers, while allowing for injured patients to be compensated for their injuries. There is a downside, however, to this approach. If it becomes unaffordable for the sponsoring organization to arrange for such a secure financial arrangement, then the underlying volunteer activity may not be able to go forward if the expectation is full indemnification for health care volunteers. One way of reducing the financial burden for some charitable endeavors is the route taken by those states that set aside government funds to subsidize malpractice insurance costs or fund a risk pool to reimburse injured parties (i.e., those “indemnity” states).¹²⁹

Any legislator looking to introduce or amend volunteer protection legislation should make a careful assessment of all these factors in order to create laws that best meet the needs of his or her constituents. As noted previously, the VPA, while creating a base level of volunteer pro-

128. U.S. CENSUS BUREAU, CURRENT POPULATION SURVEY, (Sept. 30, 2002), available at <http://www.census.gov/hhes/hlthins/hlthin01/hlth01asc.html> (last visited Sept. 11, 2003).

129. See *supra* notes 46–68 and accompanying text.

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tection, specifically allows states to pass laws that condition their grant of volunteer immunity on the existence of a financially secure source of recovery available to persons injured by the negligent acts of volunteers. In the interest of fairness for all involved, states might be wise to follow-up on this legislative suggestion in a manner that incorporates the concerns of both clinician and patient.

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State	State Statute	Change of standard of care or reckless	Indemnity approach	Legislation specifically references health care providers	Legislation references dentists or dental care	Legislation references retired physicians	References certain health care settings	Limitation with respect to certain services	Prior notice of liability limitation to patients
COLORADO	COLO. REV. STAT. § 13-21-115.5 (1997).	•		•			•		•
CONN-ECTICUT	CONN. GEN. STAT. §§ 19(a)-17(m)-(n) (1997).			•	•	•	•	•	•
DELAWARE	DEL. CODE ANN. tit. 10, §§ 8133, 8135 (1999).	•		•			•		
DISTRICT OF COLUMBIA	D. C. CODE ANN. §§ 7-402, 29-599.15 (2001).	•		•			•		•
FLORIDA	FLA. STAT. ch. 766.1115, 768.13(1)-(2), 768.28, 768.1355 (1997).		•	•			•		•
GEORGIA	GA. CODE ANN. §§ 51-1-20, 51-1- 20.1, 51-1-29.1 (2000).	•		•	•		•		•

State	State Statute	Change of standard to willful, wanton or reckless	Indemnity approach	Legislation specifically references health care providers	Legislation references dentists or dental care	Legislation references retired physicians	References certain health care settings	Limitation with respect to certain services	Prior notice of liability limitation to patients
HAWAII	HAW. REV. STAT. §§ 662D-3, 328C-2 (2000).	•							
IDAHO	IDAHO CODE § 6-1605 (Michie 1998).	•							
ILLINOIS	745 ILL. COMP. STAT. ANN. 49/20, 30 (West 2002).	•		•	•		•		•
INDIANA	IND. CODE ANN. §§ 34-30-13-1 to -2, 36-1-14.2-3 (West 1997).	•		•			•		
IOWA	IOWA CODE ANN. §§ 135.24, 613.19, 669.24 (West 1998).	•	•	•	•		•	•	
KANSAS	KAN. STAT. ANN. §§ 75-6102, 6115, 6117, 6120 (1997).		•	•			•		

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State	State Statute	Change of standard to wanton or reckless	Indemnity approach	Legislation specifically references health care providers	Legislation references dentists or dental care	Legislation references retired physicians	References certain health care settings	Limitation with respect to certain services	Prior notice of liability limitation to patients
KENTUCKY	KY. REV. STAT. ANN. §§ 216.940 to -943, -945, 304.40-075 (Michie 2002).			•			•	•	
LOUISIANA	LA. REV. STAT. ANN. §§ 9:2799.5, 40:1299.39 (West 2001).	•	•	•	•		•		•
MAINE	ME. REV. STAT. ANN. tit. 24, § 2904 (West 2000).	•		•	•	•	•		
MARYLAND	MD. CODE ANN., CTS. & JUD. PROC. § 5-407, -606 (Michie 2002).	•		•			•		
MASSACHUSETTS	No statute.								
MICHIGAN	MICH. COMP. LAWS ANN. §§ 450.2209, 333.16277 (West 2003).	•		•			•	•	•

State	State Statute	Change of standard to wanton or reckless	Indemnity approach	Legislation specifically references health care providers	Legislation references dentists or dental care	Legislation references retired physicians	References certain health care settings	Limitation with respect to certain services	Prior notice of liability limitation to patients
MINNESOTA	MINN. STAT. ANN. § 214.40 (West 2003).			•	•		•	•	
MISSISSIPPI	MISS. CODE ANN. §§ 73-25-38, 75-74-8, 95-9-1 (1994).	•		•		•	•		•
MISSOURI	MO. ANN. STAT. §§ 105.711, 537.118 (West 2000 & Supp. 2003).	•	•	•	•		•	•	
MONTANA	MONT. CODE ANN. § 27-1-732, -736 (2001).	•		•	•		•		•
NEBRASKA	No statute.								
NEVADA	NEV. REV. STAT. ANN. 41.485, 428.095 (Michie 2002).	•	•	•	•				

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State	State Statute	Change of standard to willful, wanton or reckless	Indemnity approach	Legislation specifically references health care providers	Legislation references dentists or dental care	Legislation references retired physicians	References certain health care settings	Limitation with respect to certain services	Prior notice of liability limitation to patients
NEW HAMPSHIRE	N.H. REV. STAT. ANN. §§ 329:25(a); 508-17 (1997 & 2003).	•		•		•	•		
NEW JERSEY	N.J. STAT. ANN. § 2A:53A-7 to -7.1 (West 2000).	•							
NEW MEXICO	No statute.								
NEW YORK	No statute.								
NORTH CAROLINA	N.C. GEN. STAT. §§ 1-539.10 to -539.11, 90-21.16 (2001).	•		•		•	•		
NORTH DAKOTA	N.D. CENT. CODE §§ 32-03.1-01 to -02.3 (1996 & Supp. 2001).	•		•			•		

State	State Statute	Change of standard to wanton or reckless	Indemnity approach	Legislation specifically references health care providers	Legislation references dentists or dental care	Legislation references retired physicians	References certain health care settings	Limitation with respect to certain services	Prior notice of liability limitation to patients
OHIO	OHIO REV. CODE ANN. §§ 473.295, 2305.234, 4715.42, (Anderson 2001 & 2003).	•		•	•	•	•	•	•
OKLAHOMA	OKLA. STAT. ANN. tit. 51, § 152; tit. 76, § 31 (West 2000 & 2001).	•							
OREGON	OR. REV. STAT. §§ 30.268, .302, .792 (2001).	•	•	•		•	•		
PENN- SYLVANIA	PA. STAT. ANN. tit. 35, § 449.47 (West 2003); 42 PA. CONS. STAT. ANN. § 8332.4 (West 2003).	•		•	•	•	•		•
RHODE IS- LAND	R.I. GEN. LAWS § 7-6-9 (2002).	•							

State	State Statute	Change of standard to willful, wanton or reckless	Indemnity approach	Legislation specifically references health care providers	Legislation references dentists or dental care	Legislation references retired physicians	References certain health care settings	Limitation with respect to certain services	Prior notice of liability limitation to patients
VIRGINIA	V.A. CODE ANN. §§ 32.1-127.3, 54.1-106 (West 2003).	•	•	•	•		•		
WASHINGTON	WASH. REV. CODE ANN. §§ 43.70.460-470 (West 2003).			•	•	•	•	•	
WEST VIRGINIA	W. VA. CODE §§ 30-3-10a, 30-14-12b (2002).	•		•		•	•		
WISCONSIN	WIS. STAT. ANN. §§ 146.89, 181.0670 (West 2002).	•	•	•	•			•	
WYOMING	WYO. STAT. ANN. §§ 1-1-125, 1-1-129, 33-15-131, 33-26-601 (West 2002).	•		•	•	•	•	•	•