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AN OVERVIEW OF PUBLIC HEALTH IN THE NEW
MILLENNIUM: *INDIVIDUAL LIBERTY VS. PUBLIC SAFETY*

DOROTHY PUZIO¹

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“Public health is what we, as a society, do collectively to assure the conditions for people to be healthy.”² In the abstract, the vast majority of Americans believe in

¹Dorothy Puzio is a 2004 graduate of the University of Connecticut School of Law. She is currently in private practice in Boston as a corporate and health care attorney at Brown Rudnick. She would like to extend special thanks to Professor John Day of the University of Connecticut School of Law for all of his help with and support of this article, as well as Professor Patricia McCoy.

public health and support public health goals.³ More than three and a half decades ago, this attitude prompted Congress to establish “a separate standard for coverage of children within Medicaid” in order to facilitate baby well-care.⁴ However, despite occasional preventive measures such as this, in reality, public health has been an orphan in the United States for quite some time. Much of this is due to America’s reliance on the sickness model of health, which emphasizes reactive, individual medicine as opposed to prevention in the aggregate. Absent some emergency or visible health threat, the American public has been quite complacent in its support of preventative public health, whose positive effects, unlike those of curative medicine, are largely invisible.⁵

This complacency, which began to wane as recent threats of anti-microbial resistance and the West Nile virus emerged, came to a screeching halt in 2001, with the events of September 11th and the anthrax scare.⁶ These events have catapulted public health to the forefront of homeland security,⁷ and have signaled a definite policy shift toward preparedness.⁸ As public health preparedness becomes an increasingly prominent issue on the political landscape, “the balance between public health and civil liberties, which in recent decades had been tilting more toward individual freedom, may be about to swing back.”⁹ While the tension of “freedom removed for future freedom retained”¹⁰ has been a timeless struggle in the history of democracy, the modern trend toward questioning authority figures in medicine and government has prompted a heightened awareness of the restrictions on civil liberties

²LAWRENCE O. GOSTIN, *PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT* 13 (University of California Press 2000) [hereinafter “POWER”] (citing INST. OF MED., *THE FUTURE OF PUBLIC HEALTH* 58 (1988)).

³Barry S. Levy, *Twenty-First Century Challenges for Law and Public Health*, 32 IND. L. REV. 1149, 1150 (1999).

⁴Elizabeth J. Jameson & Elizabeth Wehr, *Drafting National Health Care Reform Legislation to Protect the Health Interests of Children*, 5 STAN. L. & POL’Y REV. 152, 152 (1993).

⁵Levy, *supra* note 3, at 1150.

⁶David P. Fidler, *Lawrence O. Gostin’s Public Health Law: Power, Duty, Restraint*, 1 YALE J. HEALTH POL’Y, L. & ETHICS 303, 303 (2001) (book review) [hereinafter “Review”].

⁷Eleanor D. Kinney, *Administrative Law and the Public’s Health*, 30 J.L. MED. & ETHICS 212, 212 (2002). “The perpetration of bio-terrorism in the United States in 2001 has been singularly important in raising awareness about the national and global importance of public health.” David P. Fidler, *Introduction to Written Symposium on Public Health and International Law*, 3 CHI. J. INT’L L. 1, 3 (2002) [hereinafter “Written Symposium”].

⁸David P. Fidler, *Bioterrorism, Public Health, and International Law*, 3 CHI. J. INT’L L. 7, 10 (2002) [hereinafter “Public Health”].

⁹Liz Marlantes, *Bioterror: All the Rules Change*, CHRISTIAN SCI. MONITOR, Dec. 17, 2001, at 1. I think we may have already seen some of this pendulum swing with the 2004 presidential election. Homeland security, as an offshoot of terrorism, was among the issues of most concern in the election. See Steven Thomma & Knight Ridder, *Americans Differ on Whether President Bush Has a Mandate*, SAN JOSE MERCURY NEWS, Nov. 14, 2004, at 1.

¹⁰Carolyn D. Amadon et al., *The Erosion of Constitutional Rights in the Wake of 9/11*, 17-MAR CBA REC. 24 (2003).

that an effective public health system might require, and an increased willingness to challenge the propriety of these trade-offs.¹¹

This article explores the tensions between creating an effective public health system that would be able to respond to and protect against any public health threat, and protecting individuals against unnecessary intrusions on their civil liberties. It then considers approaches to this issue that might best strike a balance in a democratic society. While many Americans may recognize and even accept that greater security would entail some intrusion into individual rights, there is no formula for striking the appropriate balance. This article attempts to arrive at a workable framework by examining how the United States' public health system works. This includes reviewing its policy response to several recent public health threats, exposing the shortcomings of the current system, and comparing it to the approach of other democratic and non-democratic societies. Based upon this review and analysis, the article suggests an approach that might best incorporate effective techniques from a variety of alternative systems, while addressing some of the main problems of the current framework. This analysis is broken down into seven main parts.

Part I provides an introduction to public health and the essential components of an effective system. It explains why public health historically has not been high on the priority list of medical approaches to combating disease, and describes how this view of public health has evolved, particularly in recent years. Part II examines some of the shortcomings of the United States' public health system as it currently stands.

Part III introduces the central controversy between civil liberties and a strong public health system by focusing on three of the most commonly used tools of public health authorities, namely: quarantines, mandatory screening and immunization, and health information sharing, as well as their effects on liberty and freedom of movement, individual autonomy, and privacy. Part IV builds on this analysis and explores how the United States historically has struck a balance between these competing considerations by examining orders and legislation arising out of recent public health threats such as AIDS, SARS, and 9/11.

Part V investigates other approaches to resolving the tensions between public health and civil liberties by reviewing the approach advocated by one renown public health expert, Lawrence Gostin, and the response of Canadian and Singaporean societies to the threat of SARS. Part VI continues to explore alternatives, focusing solely on the Model State Emergency Health Powers Act ("MSEHPA"), developed in response to 9/11. Finally, Part VII identifies the shortcomings of MSEHPA and recommends amendments to MSEHPA that might help to strike a better balance for the American people. Addressing the criticisms and concerns voiced by the American public is an essential step toward creating a viable, stronger public health system going forward.

¹¹“Governmental power and emergency measures that people may have found necessary and acceptable during the plague years of the First World War are no longer easily supported by a citizenry sensitized to civil rights by the change in our culture that transpired during the last half of the Twentieth Century.” Deborah L. Erickson et al., *The Power to Act: Two Model State Statutes*, 30 J.L. MED. & ETHICS 57, 62 (2002).

I. BACKGROUND

Public health differs from traditional health care in several respects. Some of its distinguishing features include a focus on: “(1) the health and safety of *populations* rather than . . . individual patients; (2) [the] *prevention* of injury and disease rather than treatment[;] . . . (3) [the] relationship between *government* and the *community* rather than physician and patient; and (4) services grounded on [sic] . . . *scientific methodologies* of public health (e.g. . . . *epidemiology*) rather than personal medical services.”¹² The Institute of Medicine’s definition of public health, set forth at the beginning of this article,¹³ reinforces these distinguishing characteristics by emphasizing a mutuality of obligation lying with the government and community as a whole, and focusing on increasing the incidence of conditions that facilitate healthy living as opposed to guaranteeing health itself.¹⁴ People often fail to appreciate the benefits of public health, because the effects of prevention are usually invisible. However, a strong public health system is essential to the welfare of any society, and has accounted for approximately “twenty-five of the thirty years of increased life expectancy in the United States since the turn of the century.”¹⁵ The importance of public health to American society has been underscored by the events of September 11th, which confirmed that terrorist attacks, with the potential for biological warfare, are very real threats.¹⁶

In order to deal with catastrophes like this effectively, a public health system would have to, at a minimum, clearly articulate its objectives, and make their realization as consistent as possible with the public mores of the American people.¹⁷ It is essential to the American public that its values and priorities are reflected in the system.¹⁸ “A ‘shared understanding’ of public health’s goals [would be essential] to

¹²Lawrence O. Gostin, *Public Health Law: A Renaissance*, 30 J.L. MED. & ETHICS 136, 136 (2002) (emphasis added) [hereinafter “*Renaissance*”].

¹³“Public health is what we, as a society, do collectively to assure the conditions for people to be healthy.” POWER, *supra* note 2, at 13.

¹⁴Lawrence O. Gostin, *Conceptualizing the Field After September 11th: Foreword to a Symposium on Public Health Law*, 90 KY. L.J. 791, 794-95 (2002) [hereinafter “*September 11th*”].

¹⁵Levy, *supra* note 3, at 1150. Other things that have been positively impacted by public health include cleaner drinking water, more nutritious meals, safer workplaces, and less polluting vehicles. *Id.* at 1140.

¹⁶Carol M. Ostrom, *Bioterrorism Scare Here Adds Urgency to Conference: National Experts Discuss Coordination, Legal Rights*, SEATTLE TIMES, Apr. 7, 2002, at B1.

¹⁷See James F. Childress et al., *Public Health Ethics: Mapping the Terrain*, 30 J.L. MED. & ETHICS 170, 172 (2002).

¹⁸This can be accomplished in more than one fashion. A public health system can be developed according to what is known of society’s values. The sharp division in social values between the more liberal and more conservative factions in the United States at the present time, however, makes this a difficult task. In the alternative, since some of these values are contradictory and may lead to an ineffective system, getting the public’s support for a system may require some more adroit advertising.

avoiding ‘mass pandemonium.’”¹⁹ Likewise, public health, by its very nature, requires an investment in and support of preparedness.²⁰

Historically, however, public health has not been high on the priority list of medical interventions for the American people. As a field of legal analysis, for example, it has largely been ignored due to its “broad, diffuse scope and immense complexity.”²¹ Moreover, the American public tends to be results-oriented in its view of medical care, valuing tangibility and immediacy of consequences over prevention, and, therefore, has focused on a sickness model of medicine that favors curative medicine rather than prevention. As a result, resources are disproportionately allocated to support the former endeavor.

These conditions have led to a situation where there seems to be a “‘virtually bottomless purse for treating illness’ by medical means and [only a] paucity of public provisions to prevent it or ensure the conditions for which people can be healthy.”²² The reason for this disparity is tied to the public’s perception of need.

[I]n the absence of real or perceived crises, most media and public attention tends to focus considerably more on the individual flesh-and-blood stories of medical care than on public health topics that concern ‘the commons,’ such as health promotion and disease prevention, to which it is generally difficult to attach specific faces.²³

Therefore, while most people have historically supported a high level of public health, at least in the abstract, “fewer [have been] eager to pay for it, and many [have been] positively opposed to changing their own activities to promote it.”²⁴ Until now.

Although the pendulum has swung quite heavily in favor of individual rights in recent decades,²⁵ “[m]any Americans have come to rethink the role of government and the importance of the public health safety system.”²⁶ September 11th and the

¹⁹Ostrom, *supra* note 16.

²⁰ “[P]revention through preparation is essential.” James G. Hodge, Jr., *Bioterrorism Law and Policy: Critical Choices in Public Health*, 30 J.L. MED. & ETHICS 254, 254 (2002).

²¹Review, *supra* note 6, at 304.

²²Bernard M. Dickens, *A Tool For Teaching and Scholarship: A Review of Lawrence Gostin’s Public Health Law: Power, Duty, Restraint*, 30 J.L. MED. & ETHICS 162, 168 (2002) (book review).

²³Marshall B. Kapp, *Lawrence Gostin’s Public Health Law: Power, Duty, Restraint*, 22 J. LEGAL MED. 581, 581 (2001) (book review).

²⁴Dickens, *supra* note 22, at 168.

²⁵The HIV epidemic has sharpened the timeless tension between public health and civil liberties, and “[t]o many, . . . the pendulum has swung decidedly in favor of civil liberties” in recent decades. Lawrence O. Gostin & James G. Hodge, Jr., *The “Names Debate”: The Case for National HIV Reporting in the United States*, 61 ALB. L. REV. 679, 682 (1998) [hereinafter “Names Debate”].

²⁶*September 11th*, *supra* note 14, at 793. With respect to confidence in government, a poll of ninety-nine Americans taken after 9/11 indicated that approximately fifty-eight percent either had a great deal or quite a lot of confidence in the United States government’s ability to protect its citizens from future terrorist attacks, while only ten had very little. Similarly,

subsequent anthrax scare have illustrated the importance of rapidly detecting and reacting to the threats of bio-terrorism and infectious disease.²⁷ Even more significantly, these disasters have made it clear that individuals acting alone cannot effectively protect against many public health threats to their well-being.²⁸

Accordingly, “[i]n the aftermath of anthrax [and 9/11] . . . [w]e may witness a shift from a weak national commitment to public health to a strong effort on homeland security, in which public health plays an important part.”²⁹ There seems to be a renewed enthusiasm for preparedness and a greater support for governmental efforts to safeguard security. American attitudes concerning public health have already been evolving. One of the best indicators of the public’s stance on any issue is political action.³⁰ Since 9/11, legislators in Washington DC have illustrated their dedication to the cause of public health as a matter of national security by passing several bio-terrorism bills.³¹ Among these is the Public Health Threats and Emergencies Act, which set aside over \$500 million for bio-terrorism preparedness in 2001.³² Even on the state level, public health values, such as individual freedom yielding to the public good,³³ are being increasingly reflected in legislation.³⁴ Public

ninety-one of one-hundred-and-one believed the government could protect the liberties of Americans while ten thought it could not. See Blendon, NPR/Kaiser Family Foundation/Kennedy School of Government Civil Liberties, at http://www.npr.org/programs/specials/poll/civil_liberties/civil_liberties_static_results_2.html [hereinafter “Blendon”]. With respect to feelings about public health, a RobertWood Johnson Foundation national survey conducted October 20-30, 2002 found that three-fourths of Americans are concerned about the strain on America’s public health system, and most support increasing federal funding for public health, even through higher taxes. RobertWood Johnson Foundation, *How Public Health has Changed Since 9-11*, at http://www.rwjf.org/portfolios/features/feature_detail.jsp?featureID=50&type=3&iaid=141 (last visited Dec. 19, 2005) [hereinafter “RobertWood”].

²⁷*September 11th*, *supra* note 14, at 792. “A recent national poll suggests that 70 percent of the public believes a subsequent biological or chemical attack on the United States will occur in the next year.” Hodge, *supra* note 20, at 256.

²⁸*September 11th*, *supra* note 14, at 793.

²⁹*Public Health*, *supra* note 8, at 23.

³⁰While some political action is admittedly prompted by intense pressure from a small but notable group of influential members of the public, my less cynical belief is that much political action is still an outgrowth of widespread public opinion and insistence.

³¹*Public Health*, *supra* note 8, at 11. “On January 10, 2002, President Bush signed into law a \$2.9 billion bioterrorism appropriations bill.” *Id.*

³²Hodge, *supra* note 20, at 254.

³³20 N.Y. JUR. 2D *Constitutional Law* § 215 (2003).

³⁴Many states are considering and adopting variations of the Model State Emergency Health Powers Act, which is described *infra* Part VI. “For the first time in a half-century, authorities are considering the legality and practicality of extreme measures, such as requiring the public to be tested for diseases or seizing property.” Marlantes, *supra* note 9.

health and the seemingly necessary intrusion on civil liberties may slowly be climbing the ladder of prominence in the lives of the American people.³⁵

II. WEAKNESSES OF THE PUBLIC HEALTH SYSTEM IN THE UNITED STATES

With renewed attention being focused on public health, it is becoming increasingly clearer that the United States' system, as it currently stands, needs more than tweaking; it needs an entirely new conceptual foundation. The first major problem with the public health system in the United States is one of capacity. For example, in Washington, the Board of Health found that only thirty percent of its counties had isolation protocols in place in their hospitals, and even fewer had self-contained air systems sufficient to isolate contagious patients.³⁶ As a whole, "[s]tate and local agencies [across the United States] have inadequate and incomplete surveillance capacity, antiquated data systems, technologically inferior laboratories, and an under-trained, under-qualified workforce."³⁷ Much of these "glaring deficiencies in the public health infrastructure"³⁸ are due to grossly inadequate funding and a lack of strong public support for the cause, which, according to respected surveys,³⁹ is only now beginning to change.⁴⁰

The second major problem with the public health infrastructure in the United States is legal. Lawrence Gostin has identified three main problems with public health laws as a whole, namely: (1) antiquity, (2) multiple layers of law, and (3) inconsistency among the states and territories.⁴¹

A. Problem of Antiquity

Much of public health law was enacted in the late nineteenth and early to mid-twentieth century, predating significant advancements in scientific understanding and constitutional law.⁴² As a result, "[t]hese laws often do not reflect contemporary scientific understandings of injury and disease . . . or legal norms for protection of individual rights."⁴³ Instead, today's public health laws reflect a mindset that existed, in some cases, one hundred years earlier. For example, many state quarantine laws do not afford individuals any sort of due process, whether in the

³⁵Americans are generally notably concerned that the public health system provide preventive measures like immunizations, health education, and chronic disease prevention. "[A]t least seven in 10 people say that each of these is a *very important* activity." See RobertWood, *supra* note 26.

³⁶Ostrom, *supra* note 16.

³⁷*September 11th*, *supra* note 14, at 796.

³⁸*Id.*

³⁹See, e.g., RobertWood, *supra* note 26.

⁴⁰*September 11th*, *supra* note 14, at 796. "Before the recent infusion of federal funds, the government allocated only approximately one percent of all health dollars to traditional public health services." *Id.* at 797. See RobertWood, *supra* note 26.

⁴¹See POWER, *supra* note 2, at 317-19.

⁴²*Id.* at 317.

⁴³*Renaissance*, *supra* note 12, at 137.

form of a right to challenge a governmental action, or a hearing, for the deprivation of liberty associated with quarantines.⁴⁴

B. Problem of Multiple Layers of Law

While most public health laws have not undergone substantial revision since their enactment, they have been amended over the years to respond to specific health threats.⁴⁵ This piecemeal legislation has created a system where public health officials are accorded different levels of authority according to varying scales of criteria that change with the type of disease.⁴⁶ This disparate structure creates confusion in the understanding and application of the law to contemporary health threats.⁴⁷ Additionally, it leads to occasionally absurd results, such as a Massachusetts law maintaining the penalty for resisting a quarantine order at ten dollars.⁴⁸

C. Problem of Inconsistency

“Public health laws remain fragmented not only within states but among them.”⁴⁹ Each of the states’ health codes has evolved independently; accordingly, they exhibit profound variations among them, both in structure and in substance.⁵⁰ Since state borders are artificial boundaries when it comes to disease, these differences become problematic when trying to launch a coordinated response to a widespread threat.

D. Problem of Lack of Authority

Finally, many of the state officials who have been charged with scrutinizing public health laws across the nation in an effort to better prepare their states for the future have cited a fourth, more fundamental legal obstacle to a stronger public health system. They argue that even a nationally coordinated response would be insufficient to develop an effective public health system because there is a fundamental “lack [of] adequate authority to combat a major bio-terror event.”⁵¹ Due to its civil liberties implications, it is this issue, more than any other, which has engendered controversy in the search for a more effective system.⁵² This article will

⁴⁴Ceci Connolly, *Bush Smallpox Inoculation Plan Near Standstill: Medical Professionals Cite Possible Side Effects, Uncertainty of Threat*, WASHINGTON POST, Feb. 24, 2003, at A06, available at <http://www.Washingtonpost.com/ac2/wp-dyn?pagename=article&node=Feb23¬Found=true> (last visited Dec. 19, 2005).

⁴⁵See *Renaissance*, *supra* note 12, at 137.

⁴⁶See *POWER*, *supra* note 2, at 318.

⁴⁷*Id.* at 319.

⁴⁸*Marlantes*, *supra* note 9.

⁴⁹*POWER*, *supra* note 2, at 319.

⁵⁰*Id.*

⁵¹*Marlantes*, *supra* note 9. This lack of authority is due to a multitude of factors, which include, among other things, federalism and overly burdensome privacy statutes.

⁵²Another controversial aspect, which is more practical than legal, is cost. After all, creating a more effective public health system costs money, and people do not like to give

focus on the tension between *greater* authority and the necessary intrusion into civil liberties that it occasions.

III. PUBLIC HEALTH VS. CIVIL LIBERTIES TENSIONS

Adequately addressing the identified weaknesses of the United States' public health system will involve some friction with individual rights.⁵³ For example affording public health officials an expansion of authority, will, of necessity, intrude on the protection of civil liberties. More governmental power almost invariably corresponds to less individual liberty; “[i]t is not a new equation.”⁵⁴ Likewise, some of the most popular and commonly used public health measures around the world—namely quarantines, mandatory screening and immunization, and health information sharing—all intrude upon civil liberties to one extent or another.

Notwithstanding the utility of these tools, and despite their potential value to rebuilding our nation's public health system, “the shaping of public health policy and practice should never occur without careful consideration of the burden such policies would have for the rights of individuals.”⁵⁵ In order to fully understand the implications of the tensions between public health measures and civil liberties, which some are calling the greatest dilemma now facing the nation,⁵⁶ it is useful to take a closer look at each of the following three responses, (1) quarantines, (2) mandatory screening and immunization, and (3) health information sharing, individually, in order to balance their usefulness against the burdens they impose. Only then can their place in modern United States' policy be assessed.

A. Quarantines

The modern definition of quarantine is “[a] restriction of the activities of *healthy* persons who have been *exposed* to a *communicable* disease, *during* its period of *communicability*, to *prevent* disease *transmission* during the incubation period *if* infection should occur.”⁵⁷ The quarantine, as a tool of public health, has a long history dating all the way back to the Bible's Leviticus 13,⁵⁸ which discusses

money to government programs without seeing results. As mentioned earlier in this paper, *see infra* page 1, the results of prevention are often invisible.

⁵³Even New York's jurisprudence acknowledges that “[t]he right to preserve the public health, to protect the public morals, and to provide for the public safety, may interfere to some extent with both liberty and property.” 20 N.Y. JUR. 2D *Constitutional Law* § 207 (2003).

⁵⁴Amadon et al., *supra* note 10.

⁵⁵Ronald Bayer, *Tom Stoddard, Public Health, and Civil Liberties: A Remembrance*, 72 N.Y.U. L. REV. 1034, 1036 (1997). This is important not just because it is the right thing to do, but because the public's buy-in is essential.

⁵⁶*See* Marlantes, *supra* note 9.

⁵⁷POWER, *supra* note 2, at 210 (emphasis added). Compare the definition of quarantine to that of isolation, which is “the separation, for the period of communicability, of *known infected persons* in such places and under such conditions as to prevent or limit the transmission of the infectious agent.” *Id.* (emphasis added). The distinction between the two is frequently not recognized, leading many to use the terms interchangeably.

⁵⁸Declan McCullagh, *Something's in the Air: Liberties in the Face of SARS and Other Infectious Diseases*, REASON, Aug. 1, 2003, at 33.

isolation in the context of leprosy.⁵⁹ Its primary function is to combat contagious disease, and countries across the globe have used it, in varying degrees of severity, as a method of self-preservation. In the fifteenth century, for example, the British government used quarantines to fight the bubonic plague.⁶⁰ Likewise, at various times in history, both Bedloe's and Ellis Islands of New York were sites of quarantines.⁶¹

Despite their widespread use, quarantines are controversial because of their intrusion into valued individual rights. Quarantines not only impact general liberty, by hindering the freedom of mobility within society, but also personal autonomy, by substituting the judgment of public health officials, acting as an extension of the government, for that of individuals.⁶² Moreover, such measures tend to breed fear and blame among the people in a community, frequently leading to the unjust shunning of marginalized individuals and unpopular social groups.⁶³ Overreaction, particularly when it is prejudicial, is a daunting area of concern for those questioning the propriety of such measures in a democratic society.⁶⁴ On the other hand, "having the ability to act forcefully to stop an epidemic could prove indispensable"⁶⁵ to saving people's lives and preserving the social infrastructure necessary for maintaining public order. And while limiting a person's freedom of movement, for example, should not be taken lightly, there do not seem to be many alternatives in the case of highly infectious communicable diseases.⁶⁶

While the public's view of quarantines seems mixed following 9/11, which confirmed the possibility of future bio-terrorism, quarantines have historically engendered significant resistance and controversy.⁶⁷ Moreover, unlike many Asian countries like Singapore and China, where the governments are authoritarian and the expectation of civil liberties is much lower, quarantines have never been widely used in the United States.⁶⁸ Renewed consideration of this measure, therefore, raises a

⁵⁹*Leviticus* 13:4 (King James).

⁶⁰McCullagh, *supra* note 58.

⁶¹*Id.*

⁶²POWER, *supra* note 2, at 219.

⁶³*Id.* at 208. In 1892, the New York City Port Authority quarantined a ship of immigrants from Europe by forcing poor passengers to remain sequestered below the deck in unsanitary conditions. Fifty-eight of the sequestered passengers perished on the vessel. Marlantes, *supra* note 9.

⁶⁴McCullagh, *supra* note 58.

⁶⁵Stephen Smith, *US Allows for SARS Quarantines Health Officials Say None are Planned Yet*, THE BOSTON GLOBE, Apr. 5, 2003, at A2.

⁶⁶McCullagh, *supra* note 58.

⁶⁷Marlantes, *supra* note 9.

⁶⁸"Although quarantines have been applied on occasion in limited circumstances, broad quarantines have never been used in the United States" Lorena Matei, *Quarantine Revision and the Model State Emergency Health Powers Act: "Laws for the Common Good,"* 18 SANTA CLARA COMPUTER & HIGH TECH. L.J. 433, 435 (2002).

host of “political and ethical questions in a mobile society”⁶⁹ that extend beyond intrusions into civil liberties. These deserve attention before any significant policy decisions are made.⁷⁰

B. Mandatory Screening and Immunization

“Laws mandating immunization first appeared [in the United States] in the early nineteenth century.”⁷¹ Like quarantines, mandatory immunizations are aimed at combating infectious disease, only through prevention. Vaccinations are currently among the most cost-effective and widely used preventive measures against disease.⁷² Similarly, “[d]isease screening is one of the most basic tools of modern public health and preventive medicine . . . [with] a long and distinguished history in efforts to control epidemics of infectious diseases and targeting treatment for chronic diseases.”⁷³ Screening involves the medical testing of a defined population, and is undertaken for broader public health purposes than mere diagnosis.⁷⁴ Despite their utility, both of these public health measures, immunization and screening, have long sparked popular resistance and controversy from the public, with attitudes ranging from sharp suspicion to appreciative enthusiasm.⁷⁵

The root of the discord stems from the underlying observation that “[t]he power of government to compel individuals to receive approved materials into their bodies and to surrender materials from their bodies is necessary from a public health perspective, and necessarily objectionable from a civil liberties perspective.”⁷⁶ Both of these interventions, mandatory immunization and screening, impact rights to personal autonomy and privacy; however, they also provide a tremendous benefit.

With respect to immunization, using it as a form of prevention is almost always less costly, physically as well as financially, than treating an illness on a case-by-case basis after it develops and has the opportunity to spread. This is particularly

⁶⁹*Id.*

⁷⁰While a quarantine is inherently intrusive, there are ways of limiting the extent of its intrusion into civil liberties by regulating aspects of its scope and length.

⁷¹POWER, *supra* note 2, at 181.

⁷²*Id.* at 180. Just last year, the state of Illinois added chickenpox to its list of required immunizations for children in school and/or daycare, bringing the total number of required vaccinations to nine. See Kevin McDermott, *Chickenpox Vaccine Will be Required; Children Entering Kindergarten or Day Care are Affected*, ST. LOUIS POST-DISPATCH, Apr. 11, 2002, at B1.

⁷³POWER, *supra* note 2, at 187 (quoting the INST. OF MEDICINE, *supra* note 2).

⁷⁴*Id.* at 188.

⁷⁵See Marlantes, *supra* note 9 for commentary identifying some of the greatest successes and failures in the history of immunizations. One of the most prominent recent illustrations of this resistance was the public’s reaction to President Bush’s smallpox vaccination program. “Although the federal government . . . shipped 274,000 doses of vaccine to states since the program began Jan. 24, 2003 hundreds of hospitals, a half-dozen major unions and even some public health departments . . . refused to participate . . . [T]he vast majority of medical professions remain[ed] unconvinced that the threat of a smallpox attack [was] serious enough to administer a vaccine known for its serious side effects.” Connolly, *supra* note 44.

⁷⁶Dickens, *supra* note 22, at 167.

true for ailments, such as chickenpox, which are very common and tend to be concentrated in a certain segment of the population.⁷⁷ On the other hand, forcibly injecting a pathogen into one's body is a very intimate form of bodily intrusion that is frequently objectionable from a religious, as well as a privacy, standpoint. Additionally, the measure involves a level of risk that, in some cases, could be considerable, and may result in major bodily harm and/or even death.⁷⁸ While there is no guaranteed constitutional protection against this, it is becoming less of an issue as all state immunization laws now excuse children who are *known* to be more susceptible to having an adverse reaction, and most states make exceptions for those articulating sincere religious objections.⁷⁹

Mandatory screening, for its part, also plays an important role in promoting public health. Modern public health is grounded in the scientific foundation of epidemiology, which, in turn, is based on studies of the prevalence and character of disease in various populations. The primary justification for such an intrusive measure is society's interest in health and safety.⁸⁰ However, the benefits of screening depend on several variables, which include, among other things, the reliability of the particular test and the frequency of its false positive results.⁸¹ These must be weighed against some of the primary objections, which include a veritable violation of bodily integrity and privacy, as well as possible stigmatization.⁸²

C. Health Information Sharing

"[T]he amount of personal medical information that is routinely disclosed [in American society] has become enormous."⁸³ Such records invariably contain sensitive information concerning everything from a person's behavior and genetic

⁷⁷The underlying impetus for mandatory immunization is really an externality principle. It is not as much for the individual child's benefit (though this is also a consideration), as it is for the broader public good. When children are vaccinated, it provides great benefits to all those they come into contact with. This is a positive externality.

⁷⁸In 1954, a faulty batch of the new polio vaccine resulted in the paralysis of 200 hundred young children. Marlantes, *supra* note 9.

⁷⁹POWER, *supra* note 2, at 181. This illustrates one way in which the government has struck a balance between this particular public health intrusion and civil liberties.

⁸⁰*See id.* at 196. The knowledge obtained from screenings helps to educate officials about the characteristics and transmission of a given disease. This, in turn, aids officials in developing preventive strategies.

⁸¹*See id.* at 189.

⁸²*See id.* at 188. This issue is particularly salient with respect to HIV screening of newborns since "determining the HIV status of [a] newborn automatically establishes the HIV status of the mother." Linda Farber Post, Note, *Unblinded Mandatory HIV Screening of Newborns: Care or Coercion?*, 16 CARDOZO L. REV. 169, 173 (1994). As with all public health measures, however, there are ways of minimizing the level of intrusiveness by adopting, for example, strict privacy guidelines regulating the use and dispersion of such information.

⁸³Eric Wymore, *It's 1998, Do You Know Where Your Medical Records Are? Medical Record Privacy After the Implementation of the Health Insurance Portability and Accountability Act of 1996*, 19 HAMLINE J. PUB. L. & POL'Y 553, 554 (1998).

profile to their socio-economic status.⁸⁴ This free flow of information has many positive aspects. From a public health perspective, information concerning demographics, public benefit eligibility, current health status, and lifestyle choices is all very helpful for developing strategies to promote public health.⁸⁵ Additionally, access by insurers helps them to combat fraud in the industry and access by employers can help to ensure “the accommodation and safety of workers, as required by the Americans with Disabilities Act and the Occupational Safety and Health Act.”⁸⁶ On the other hand, health information sharing also has very serious privacy implications, and privacy seems to be an issue of some concern to the American people.

In 1996, the public’s interest in the privacy of health information prompted the government to enact the Health Insurance Portability and Accountability Act (“HIPAA”), which was intended to facilitate access to health insurance and combat fraud in the health care industry while establishing more stringent privacy safeguards to protect electronic exchanges of health information.⁸⁷ Then in 1999, a Wall Street Journal poll revealed that the issue most feared by Americans in the upcoming century was “erosion of personal privacy.”⁸⁸ It received twenty-nine percent of the vote with no other issue scoring more than twenty-three percent.⁸⁹ While the September 11th attacks on America shifted that focus somewhat, it remains an issue of concern.⁹⁰ And there is some indication that this concern over privacy may not be unfounded. Public health officials have admitted that HIPAA has loopholes,⁹¹ and many hospitals simply do not have sufficient safeguards in place to guarantee privacy.⁹² Moreover, mishandling confidential medical information could have dire consequences for individuals, which range from embarrassment and loss of self-esteem to loss of employment and/or insurance.⁹³ Striking a balance is a delicate procedure that is very tough to do.

⁸⁴POWER, *supra* note 2, at 131.

⁸⁵*Id.* Names-based AIDS reporting is one example of a successful health information sharing campaign that helped to determine the disease’s cause and effect on those affected. *Names Debate*, *supra* note 25, at 698.

⁸⁶Wymore, *supra* note 83, at 555.

⁸⁷See *id.* at 566-73 for a more detailed discussion of HIPAA.

⁸⁸Peter P. Swire & Lauren B. Steinfeld, *Security and Privacy After September 11: The Health Care Example*, 86 MINN. L. REV. 1515, 1515 (2002).

⁸⁹*Id.*

⁹⁰See *id.* at 1515-516.

⁹¹Among some of the exceptions to the rule for patient permission before disclosure of medical records are national priorities purposes, national emergencies, and compliance with court orders. See *id.* at 1530-533.

⁹²Avram Goldstein, *A Behind-the-Scenes Force for Privacy; For Leader of D.C.-Based Project, Protecting Confidentiality of Medical Records is ‘Lifelong Endeavor,’* WASH. POST, Apr. 28, 2003, at A21.

⁹³POWER, *supra* note 2, at 131.

Reviewing the tensions between public health and civil liberties inherent in quarantines, mandatory screening and immunization, and health information sharing, makes it clear that there is much to consider when balancing these values. It is difficult to predict how the American public would react to the implementation of these measures, with much depending on the context of the situation. On the one hand, there are many historical examples of Americans sacrificing for the greater good in times of war, for example.⁹⁴ Similarly, there are many limitations on individual rights that society has agreed to enforce in the name of public health, such as seat belt requirements.⁹⁵ On the other hand, “overreaction is [always] a threat whenever governments face an apparent crisis;”⁹⁶ authority can be carefully used or wildly abused.⁹⁷ Additionally, the American public is living in an age of increasingly extensive civil liberties and is much more willing to challenge attempts at curtailing these freedoms. To be effective, a public health system would have to appreciate these realities.

IV. THE UNITED STATES’ METHOD OF HANDLING THESE TENSIONS

Recognizing the trade-offs inherent in various public health measures, it is useful to examine how the United States has handled these tensions by reviewing legislation arising out of several of the most dire public health crises in recent years, namely: (1) the HIV/AIDS pandemic, (2) 9/11, and (3) SARS.

A. HIV/AIDS

Legislation arising out of the HIV/AIDS pandemic, which is targeted at stopping its spread, has taken on several forms including case reporting, partner notification, and criminal penalties for knowingly exposing others to the virus.⁹⁸ While each of these plays a part in the fight against HIV/AIDS in many states, efforts have concentrated primarily on case reporting, which involves monitoring individuals infected with the disease.⁹⁹ Whereas AIDS reporting received widespread support, even from the infected community, from the moment of its implementation, HIV

⁹⁴Col. Thomas W. McShane, *Life, Liberty and the Pursuit of Security*, 23-DEC PA. LAW. 46, 46 (2001). This was particularly true during World War II and the Cold War.

⁹⁵Georges Benjamin, Wilfredo Lopez & Angela Zoe Monson, *Partners in Public Health Law: Elected Officials, Health Directors, and Attorneys*, 30 J.L. MED. & ETHICS 17, 21 (2002). Other limitations include motorcycle helmet wearing requirements and no smoking laws. *Id.*

⁹⁶McCullagh, *supra* note 58.

⁹⁷*Id.* This potential for overreaction was realized during the recent anthrax scare when several female employees of Michigan State University “were made to strip naked and stand in a plastic wading pool to be decontaminated with a chlorine-bleach solution” after receiving a suspicious letter. Marlantes, *supra* note 9.

⁹⁸Mark Hansen, *Can the Law Stop AIDS? Through Penalties and Reporting Requirements, Lawmakers Appear Determined to Regulate the Disease Out of Existence*, 84 A.B.A.J. 26 (1998).

⁹⁹*Id.* HIV reporting is very similar in process to AIDS reporting. It involves physicians and laboratories reporting evidence of HIV infection to local health officials who then forward that information to the Centers for Disease Control. *Names Debate, supra* note 25, at 706.

positive status reporting was met with considerable resistance.¹⁰⁰ This is largely due to the stigma attached to the designation of “HIV positive” that stays with often non-symptomatic infected individuals for the rest of their lives, which, with modern treatment techniques, could be quite long.¹⁰¹ Legislation mandating HIV reporting is now widespread¹⁰² and enjoys broad-based support,¹⁰³ with the only real debate centered on whether reporting should be names-based or done through a code system.¹⁰⁴

As exemplified by the HIV/AIDS legislation, the United States Government responded to this threat by striking the balance on the side of greater governmental intervention. It considered the benefits of HIV surveillance, which include assistance in targeting preventive services and facilitating access to counseling, education, treatment, and voluntary partner notification services early-on,¹⁰⁵ to outweigh the adverse effects of potential stigmatization if a leak of information were to occur. However, the government has not fully heeded United States Representative Thomas Coburn’s (R-OK) admonition that “it is time to stop treating AIDS like a civil rights issue and start treating it like the public health crisis that it is.”¹⁰⁶ The government’s recognition of victims’ interest in privacy is the motivating factor behind its efforts to explore alternative options to the names-based reporting system that is now in place throughout most of the country.¹⁰⁷

B. 9/11

On October 26, 2001, less than six weeks after the devastating events of September 11th, President George W. Bush signed into law the USA Patriot Act, which was designed to increase governmental powers of investigation and enforcement so as to combat all modes of terrorism, including bio-terrorism.¹⁰⁸ “[T]he USA Patriot Act [is], by all measures, one of the most sweeping and

¹⁰⁰*Names Debate*, *supra* note 25, at 696-97.

¹⁰¹*See id.* at 698-99.

¹⁰²*Id.* at 705. “[A] majority of states have [now] implemented HIV reporting.” *Id.*

¹⁰³Hansen, *supra* note 98.

¹⁰⁴*Names Debate*, *supra* note 25, at 736-37.

¹⁰⁵*Id.* at 714-15.

¹⁰⁶Hansen, *supra* note 98. In fact, Rep. Thomas Coburn has advocated a bill permitting, among other things, doctors and funeral homes to deny treatment to patients who are not tested first, and requiring sex offenders to be tested within forty-eight hours of formally being charged with a crime. *Id.*

¹⁰⁷Despite its original promise as an alternative, the non-named unique identifier code system that has been implemented in several states has proven to be more costly and less effective than the names-based system. According to a study promulgated by the states of Maryland and Texas along with the Centers for Disease Control, the code system had “low rates of completeness in reporting, . . . difficulty in conducting follow-up on specific cases, and the absence of behavioral risk data.” *Names Debate*, *supra* note 25, at 740.

¹⁰⁸Lisa Finnegan Abdolian & Harold Takooshian, *The USA Patriot Act: Civil Liberties, the Media, and Public Opinion*, 30 *FORDHAM URB. L.J.* 1429, 1429 (2003).

controversial acts in United States history.”¹⁰⁹ Its provisions include, among other things, increased surveillance and wiretap authority, greater sharing of intelligence among independent agencies, diminished due process for immigrants, and criminal sanctions for the new crime of domestic terrorism.¹¹⁰ With respect to public health specifically, it calls for an expansion of information sharing to facilitate a response to bio-terror attacks, a grant program to support preparedness, upgrading surveillance epidemiology, improving public health laboratories, and enhancing training of healthcare professionals likely to be the first responders to bio-terrorist plagues.¹¹¹ It was passed by an overwhelming majority of the federal government and without public debate at a time where “even a member of Congress would provoke cries of heresy by questioning the President’s request for additional powers to catch the evil-doers.”¹¹²

The Patriot Act unequivocally tips the scales in favor of governmental power and intervention, “many would argue at the expense of individual liberties.”¹¹³ Nevertheless, despite the ease with which elected officials allowed provisions formally declared by Congress to be too pro-surveillance to become law,¹¹⁴ the American public is not yet ready to treat the Constitution like a rough draft.¹¹⁵ It is true that there is mixed public sentiment over the sacrifice of individual liberties for national security, as there generally is with respect to any topic of major concern;¹¹⁶ however, “[o]rganizations across the political spectrum, from village councils to national advocacy groups, are [increasingly] going on record opposing this newest potential assault on Americans’ civil liberties.”¹¹⁷ Some of the most controversial surveillance provisions of the Act were set to sunset in 2004.¹¹⁸ The key was to replace these provisions with less extreme measures focused on the *common* objectives of security and privacy, which were not necessarily antagonistic.¹¹⁹

¹⁰⁹*Id.*

¹¹⁰*Id.* at 1430-431. The definition of domestic terrorism includes “dangerous acts that ‘appear to be intended . . . to influence the policy of government by intimidation or coercion.’” *Id.* at 1430 (quoting from USA Patriot Act of 2001, Pub. L. No. 107-56 § 802, 115 Stat. 272, 376 (2001)).

¹¹¹USA Patriot Act of 2001, Pub. L. No. 107-56 § 802, 115 Stat. 272, 376 (2001).

¹¹²Abdolian & Takooshian, *supra* note 108, at 1437.

¹¹³*Id.* at 1429.

¹¹⁴Swire & Steinfeld, *supra* note 88, at 1516.

¹¹⁵William E. Gibson, *The Key to America’s Security: Should the United States Adopt Israel’s Aggressive Approach to Ensure Homeland Security?*, SUN-SENTINEL, Aug. 24, 2003, at 1F.

¹¹⁶As an example of the extent of mixed feelings, while some members of Congress are rallying for greater protection of civil liberties, others have suggested modeling the United States’ national security policy after Israel’s system, which takes an aggressive approach toward terrorism. *See id.*

¹¹⁷Matt Larson, *Strange Bedfellows: What the ACLU and the NRA Have in Common*, INST. FOR PUB. AFFAIRS, Sept. 1, 2003, at 6.

¹¹⁸Swire & Steinfeld, *supra* note 88, at 1517.

¹¹⁹*See id.* at 1523.

C. SARS

On April 4, 2003, “President Bush signed an executive order . . . allowing health authorities to forcibly quarantine people potentially infected with severe acute respiratory syndrome [SARS], the mystery ailment that killed at least 84 people and infected more than 2,300 on five continents since it first appeared in China during November, 2002.”¹²⁰ It has been two decades since the nation’s list of infectious diseases justifying forcible quarantine was last amended;¹²¹ “almost all quarantines in recent decades had been voluntary.”¹²² Violations of the order carry the penalty of a fine of up to \$1000 and one year in prison.¹²³ While public health officials clearly have the authority to quarantine, none are anticipated in the immediate future.¹²⁴

Allowing forcible quarantines certainly gives the government tremendous power at the expense of personal autonomy. As discussed earlier,¹²⁵ such a broad grant presents dangers of civil liberties violations particularly where, as here, the disease seems primarily concentrated in a particular subset of the population.¹²⁶ However, the legislative response may not be as unbalanced as it superficially may appear considering SARS is a veritable weapon of mass destruction.¹²⁷ After all, “[i]t only takes one individual not complying to cause a real problem.”¹²⁸ But it certainly lacks the specificity of guidelines that is necessary to safeguard against civil liberties violations.

V. ALTERNATIVE APPROACHES TO RESOLVING THESE TENSIONS

As a whole, the U.S. government’s reaction to each of the recent public health threats was to augment its authority to take measures entailing the sacrifice of individual freedoms. This was accomplished reactively, in piecemeal fashion, as a response to whatever threat was endangering the public’s health at a specific time. Notably, several of these measures provided the officials charged with enforcing

¹²⁰Smith, *supra* note 65.

¹²¹*Id.* Other diseases on the list include cholera and the plague. See Exec. Order No. 13,295, 68 Fed. Reg. 17,255, 17,255 (Apr. 4, 2003).

¹²²Smith, *supra* note 65.

¹²³McCullagh, *supra* note 58.

¹²⁴Smith, *supra* note 65. “Public health experts are in wide agreement that U.S. officials would always attempt voluntary isolation and quarantine” in the first instance. Ceci Connolly, *Laws Not Up to SARS Epidemic: Quarantining the Infected and the Exposed May Trample Civil Liberties*, WASHINGTON POST, Apr. 26, 2003, at A1 [hereinafter, *Civil Liberties*].

¹²⁵See Part III.A, *supra*.

¹²⁶I do not mean to suggest that the Asian population is more susceptible to SARS, only that they are more likely to be discriminated against because of the disease’s origination in Asia, and the popular impression that Asian people are more likely to be carriers, at least in the short term.

¹²⁷Nicholas D. Kristof, *Civil Liberties? If They’re Really Sick, Lock ‘Em Up*, THE INTERNATIONAL HERALD TRIBUNE, May 3, 2003, at 6. Also, health officials already quarantine tuberculosis patients on a regular basis. *Civil Liberties*, *supra* note 124.

¹²⁸*Civil Liberties*, *supra* note 124.

them little guidance regarding their use, thereby leaving them open to the possibility of ready abuse.¹²⁹ This course of action, with all of its benefits and faults, represents the way the United States has dealt with the tensions between public health and civil rights infringements in recent years. Before considering ways of improving upon this system, it is important to recognize that there are alternative approaches, such as those implemented internationally by countries like Singapore and Canada, and those advocated by public health experts like Lawrence Gostin. Assessing these alternative approaches for their efficacy in striking a balance in the face of similar public health threats, such as SARS, provides a useful tool with which to more critically evaluate the U.S. system.

A. *Singapore: A Non-Democratic Alternative*

The nation of Singapore provides a good illustration of the general approach of non-democratic societies, which are not charged with the task of protecting individual rights, to assaults on public health. When SARS hit the shores of Singapore in the spring of 2003, the government responded swiftly, definitively, and authoritatively. It immediately implemented aggressive quarantines¹³⁰ with punishments for breaking them ranging from fines to imprisonment and the threat of public identification.¹³¹ There was also electronic surveillance of those in isolation through the use of web cameras and electronic tracking bracelets.¹³² “SARS patients were allowed no visitors, and schools were closed.”¹³³ Even foreign visitors were forced to pass through a thermal scanner that, depending on the reading, could result in their being quarantined for up to ten days.¹³⁴ The government’s approach to the problem was dictatorial and heavy-handed, but nonetheless very honest, proactive, and effective for combating the disease.¹³⁵

Singapore’s “single-minded determination to take whatever steps necessary to stop the spread of the disease, with scant regard for such individual liberties as the

¹²⁹In fact, there have been numerous reports of civil rights violations against detainees being held in New York City holding facilities in the aftermath of 9/11. The “Justice Department inspector general’s report reviewing the detention . . . [found] that these individuals, some 760, were denied assistance of counsel, routinely denied basic information about why they were being held and detained excessively long – on average for three months.” *Brandon Mayfield Case*, THE JOURNAL NEWS, May 26, 2004, at 6B.

¹³⁰McCullagh, *supra* note 58. After the government got word of several potential cases of SARS at the popular Pasir Panjang Wholesale Market, it forcibly quarantined nearly 2,000 people who had worked at the market between April 5th and 19th. *Id.*

¹³¹Paul Jacob, *Draconian? Singapore is Just Doing What it Needs to Fight SARS*, STRAITS TIMES, May 3, 2003, at 1. “Singapore announced that it intends to open a camp for any of the 2,500 people under home quarantine who disobey.” *Civil Liberties*, *supra* note 124.

¹³²McCullagh, *supra* note 58.

¹³³Kristof, *supra* note 127.

¹³⁴*Id.*

¹³⁵Singapore has been “one of the few countries where those in charge have been quick and just as upfront with the bitter news as they have been with the determination to fight off the effects of the virus by any means necessary.” Jacob, *supra* note 131. This openness and proactive response stands in direct contrast to China’s approach, which was wide-scale denial.

right to travel and associate freely . . . may have spared it the worst.”¹³⁶ Despite its having experienced the third-worst outbreak of SARS in the world, Singapore’s death rate was comparably low,¹³⁷ and notably lower than the less severe outbreak that hit North America.¹³⁸ The lesson from the SARS outbreak in Singapore seems to be that compromising on certain civil liberties can enable more effective management of public health risks.¹³⁹ However unpopular this lesson may be, particularly in a democratic nation like the United States, it presents an unmistakable and powerful message that should have some bearing on the shaping of United States policy in this regard.¹⁴⁰

B. Canada: A Democratic Approach

Canada’s reaction to SARS was very different from the authoritarian response of Singapore. SARS first appeared in Toronto in February 2003 when an elderly Toronto woman returned from a visit to Hong Kong infected with the disease, and passed it on to her family.¹⁴¹ After several misdiagnoses and hospital transfers that facilitated broad exposure to the deadly illness, it was properly identified as SARS, prompting the government to take action.¹⁴²

By comparison to Singapore’s approach, Canada’s reaction was sluggish and relatively mild-mannered. The first quarantines were voluntary in nature, though officials did have the authority to request police escorts for dangerous dissenters.¹⁴³ It was several weeks, if not months, after SARS hit that Canadian officials began to quarantine more aggressively by “cordoning off entire buildings containing infected patients.”¹⁴⁴ This eventually escalated to the point where hospitals were closed and anyone having had contact with SARS patients was quarantined.¹⁴⁵ Even the Catholic Church began stepping in and asking worshippers to “refrain from kissing icons, dipping their hands in holy water or sharing Communion wine.”¹⁴⁶

In the opinion of some medical professionals, Canada’s slow yet gradually intensifying response to SARS was at least partly responsible for the magnitude of

¹³⁶McCullagh, *supra* note 58.

¹³⁷It was approximately fifteen percent. *Id.*

¹³⁸*Id.*

¹³⁹Kristof, *supra* note 127.

¹⁴⁰It is important to note, however, that while an authoritarian, heavy-handed central government has some advantages with respect to public health because of its ability to disseminate information quickly and control its citizenry, it will not necessarily fare better than a democratic society if, for example, it decides to hide information or misrepresent it to the public. Much will depend, as always, on how the power is exercised.

¹⁴¹Michael D. Lemonick & Alice Park, *The Truth About SARS*, TIME, May 5, 2003, at 48.

¹⁴²*Id.*

¹⁴³Jacob, *supra* note 131.

¹⁴⁴*Civil Liberties*, *supra* note 124.

¹⁴⁵Phil Thomas & Lorraine Fraser, *Exiles Fleeing Hong Kong ‘Pose Threat to Health in Britain,’* SUNDAY TELEGRAPH, Apr. 6, 2003, at 17.

¹⁴⁶Lemonick & Park, *supra* note 141.

the infection in its country.¹⁴⁷ This resulted in its having a higher death rate than some of the harder hit Asian countries.¹⁴⁸ Another likely cause was the lack of communication among public health officials across the country.¹⁴⁹ The fact that Canada has a federal system, like the United States, complicated matters with respect to coordination and communication. This coordination, however, was not a problem for the centralized government of Singapore. Overall, Canada's approach was less effective in controlling the illness, but also generated little strife concerning civil rights violations because the infringements were made only where clearly necessary.¹⁵⁰

C. Lawrence Gostin: The Approach of a Public Health Expert

Lawrence Gostin, a renowned Professor of Law at Georgetown University Law Center and Professor of Public Health at Johns Hopkins Bloomberg School of Public Health, is a leading expert and one of the foremost respected voices in the area of public health. Through his book, *Public Health Law: Duty, Power Restraint*,¹⁵¹ Gostin sets forth a framework for what he envisions would be an effective public health system in the United States. While a general framework does not provide the same benefit of detailed review as a specific strategy, it is useful for illustrating reasonable alternative approaches that have a chance of succeeding in the U.S. democratic system.

At the heart of his book is support for model legislation that reflects the three principles of duty, power, and restraint.¹⁵² More specifically, Gostin asserts that such a law should impose affirmative obligations on government to promote health within the population, and give public health authorities sufficient power to regulate actions for the benefit of the community without permitting "overreaching in the name of public health."¹⁵³ In order to achieve this appropriate balance of power, Gostin provides an evaluative framework that can be systematically applied to all of the

¹⁴⁷*Civil Liberties*, *supra* note 124. There is some evidence that suggests that Canada's initially sluggish reaction to SARS may have been influenced by policy-makers' concern for the economy. After all, "[t]ourism is the No. 1 industry worldwide, with 2001 revenues of more than \$463 billion," and the World Health Organization's advisory warning against nonessential travel to Toronto was met with outrage. "[Canadian officials] claimed that the advisory was unwarranted . . . and would ruin their already slumping tourism business." Jill Schensul, *SARS and the Speed of Life*, TRAVEL, May 4, 2003, at 1.

¹⁴⁸Singapore's death rate was only 15% whereas Canada's was estimated at 17.5%. McCullaugh, *supra* note 58.

¹⁴⁹One of Toronto's disease experts had no way of getting information about the spread of SARS to Canada's national health agency after regular working hours. Rob Stein, *SARS Exposed World's Weak Spots: Experts Welcome Hotline for Public Health Emergencies*, *New Powers for WHO*, WASHINGTON POST, June 15, 2003, at A27.

¹⁵⁰Another problem associated with the difficulty of communication was the reluctance of policymakers to accurately characterize the magnitude of the problem for fear of the adverse economic impact it could have on tourism.

¹⁵¹*See generally* POWER, *supra* note 2.

¹⁵²*September 11th*, *supra* note 14, at 801.

¹⁵³*Id.* at 801-02.

various sources of public health threats. It involves the following five steps: (1) identifying existing public health risks, (2) demonstrating a particular public health measure's effectiveness at reducing the risk, (3) assessing the economic costs of such an endeavor, (4) similarly assessing the degree of burden it would impose on individuals, and (5) weighing these two to assess the overall fairness of the policy.¹⁵⁴

Overall, Gostin's approach seems to advocate "a carefully constrained and narrowly delineated interventionist role for government" whenever intervention and civil liberties come into conflict.¹⁵⁵ He does not think that public health and individual rights can always coexist.¹⁵⁶ On the other hand, he also contends that the exercise of civil liberties is only possible with security;¹⁵⁷ therefore, almost paradoxically, some sacrifice of liberty must be made in order to gain it. After all, "individuals, acting alone, cannot safeguard their own health and safety, even with full access to the sophisticated technologies of modern science and medicine."¹⁵⁸ In light of this, Gostin proposes that the relevant question is not "whether liberty-limiting power is ever legitimate . . . [but] what circumstance must exist to justify [a particular] level of [governmental] authority."¹⁵⁹ While Gostin may not specifically delineate where society should draw the line to balance these often opposing forces, he advocates, at the very least, a process with greater consistency and detail in approach than what the U.S. system has thus far exemplified, particularly in recent years.¹⁶⁰

VI. A FOURTH ALTERNATIVE: THE MODEL STATE EMERGENCY HEALTH POWERS ACT

Yet another alternative to the U.S. system that responded to the threats of HIV/AIDS, 9/11, and SARS is embodied in model legislation called the Model State Emergency Health Powers Act (MSEHPA). This model bill was drafted in the Fall of 2001 by the Center for Law and the Public's Health at Georgetown and Johns Hopkins Universities in response to 9/11.¹⁶¹ Because of some perceived ambiguity in

¹⁵⁴See the chart in POWER, *supra* note 2, at 92.

¹⁵⁵Kapp, *supra* note 23, at 585.

¹⁵⁶Review, *supra* note 6, at 309.

¹⁵⁷September 11th, *supra* note 14, at 801-02.

¹⁵⁸*Id.* at 793.

¹⁵⁹Lawrence O. Gostin, *When Terrorism Threatens Health: How Far Are Limitations On Personal And Economic Liberties Justified?*, 55 FLA. L. REV. 1105, 1109 (2003) [hereinafter "*Limitations*"]. In this paper, Gostin goes on to explain that both ends of the political spectrum support liberty-limiting government involvement with respect to public health in certain circumstances.

¹⁶⁰See Julia F. Costich, *Lawrence Gostin's Public Health Law: Power, Duty, Restraint*, 90 KY. L.J. 1083, 1088 (2002) (book review). In very general terms, Gostin seems to be advocating the creation and acceptance of a *process* that reflects the values and interests of the American people, more than any specific approach to the problem. People's support for a process with which to combat public health threats lends some legitimacy to necessary government action in this area, while simultaneously serving as an important check on that action.

¹⁶¹Erickson et al., *supra* note 11, at 57.

the scope of the Commerce Clause, as compared to states' police power, it was drafted as a *state* bill, and incorporates some of Gostin's theory because he contributed greatly to its drafting.¹⁶² Moreover, it signals the first major shift in U.S. public health policy away from the sickness model of health and toward preparedness.

Very generally, MSEHPA "provides a modern framework for effective identification and response to emerging health threats."¹⁶³ It is not meant to be adopted in draft form by every state but, instead, is intended to be used as a template.¹⁶⁴ Any state adopting some version of this model legislation would assume the responsibility of safeguarding its citizens' public health and security, and providing the tools with which to accomplish it.¹⁶⁵ Among the powers that it grants to officials in times of health crises are the power to declare a public health emergency, the power to quarantine without a court order, the power to take and/or condemn property as needed for the care and treatment of individuals, and the power to force health workers to help out or risk losing their licenses.¹⁶⁶

While these are very expansive grants of authority, they are not exercised in a vacuum. The model act is also concerned with the protection of civil liberties.¹⁶⁷ A more detailed review of some of its main provisions reveals how it strikes a balance between the breadth of these powers and individual rights.

First, while a state governor has full and sole discretion to declare a state of emergency, which triggers a host of other powers,¹⁶⁸ the designation automatically terminates after thirty days unless specifically renewed, and can be overruled by a majority vote in both chambers of a state's legislature.¹⁶⁹ Second, to issue a

¹⁶²See Marlantes, *supra* note 9. This raises the question: why did the drafters design a model state bill as opposed to a federal one? It would seem that a central federal system would be more adept at handling major public health disasters where unity of action and responsiveness are crucial. The answer to that is broader authority. Various public health measures, such as vaccinations, for example, have traditionally fallen within the ambit of states' police powers, which are thought to be more extensive than the powers of the federal government in the public health area. Accordingly, they allow states to legislate more broadly, making them better empowered to respond to public health emergencies. Telephone Interview with James G. Hodge, Jr., J.D., LL.M, Executive Director, Center for Law and the Public's Health at Georgetown and Johns Hopkins Universities (Nov. 9, 2004).

¹⁶³Lawrence O. Gostin, *When Terrorism Threatens Health: How Far are Limitations on Personal and Economic Liberties Justified?*, 28-SPG ADMIN. & REG. L. NEWS 6, 25 (2003) [hereinafter "*Terrorism*"].

¹⁶⁴Julie Bruce, *Bioterrorism Meets Privacy: An Analysis of the Model State Emergency Health Powers Act and the HIPAA Privacy Rule*, 12 ANNALS HEALTH L. 75, 78 (2003).

¹⁶⁵Matei, *supra* note 68, at 437.

¹⁶⁶Kristin Choo, *Controversial Cure: Proposed CDC Model Act on Bioterrorism Seeks to Clarify State Enforcement Powers*, 88 A.B.A.J. 20 (2002).

¹⁶⁷Matei, *supra* note 68, at 439.

¹⁶⁸"The effect of a declaration of a public health emergency is great. Once an emergency is declared, the disaster response mechanisms . . . are activated . . . [and] [t]he governor has broad powers during the emergency." Bruce, *supra* note 164, at 80.

¹⁶⁹Matei, *supra* note 68, at 438-39.

quarantine, a written, ex parte court order authorizing it must be obtained beforehand unless “a delay . . . would pose an immediate threat to the public health.”¹⁷⁰ However, even in cases where a delay *is* dangerous, a court order must be obtained within ten days afterward.¹⁷¹ Third, with respect to confiscation of property for the good of public health, MSEHPA requires the state to “pay ‘just compensation’ to the owners of any facilities or materials that are lawfully taken or appropriated by a public health authority for its temporary or permanent use during a state of public health emergency.”¹⁷² Finally, although the public health authority has the power to forcibly elicit the help of healthcare providers and negotiate their rates with the threat of otherwise revoking their medical licenses, it balances this intrusion by holding them harmless from liability except in cases of gross negligence or willful misconduct.¹⁷³

MSEHPA has many other provisions that, in similar fashion, attempt to balance the more expansive authority of the government for protecting the public’s health with more detailed measures guarding individual rights. “[V]irtually every state has used MSEHPA as a checklist of powers...for responding to . . . public health emergencies . . . [and] [a]t least 20 . . . have adopted the Model Act in whole or in part.”¹⁷⁴ However, the model legislation has also generated much controversy, with some of the nation’s largest and most influential states, namely: California, New York, and Texas, all spurning it.¹⁷⁵ This controversy is testament that, while MSEHPA is invaluable for its identification of the difficult trade-offs inherent in public health, if not for its overall approach to the problem in the United States, there is room for improvement.

VII. SOME REFLECTIONS ON POSSIBLE IMPROVEMENTS TO MSEHPA

In Chinese, the word “crisis” is comprised of two symbols: danger and opportunity.¹⁷⁶ Applying this logic to the MSEHPA, the model legislation aimed at public health crises, every weakness identified in the act is an opportunity for improvement. Therefore, the best way to expand upon the solid foundation of the act is to review and address its greatest criticisms.

One of the most dangerous and troubling aspects of the legislation is its ambiguity in explaining some of the most controversial grants of authority, like the ability to quarantine.¹⁷⁷ Language such as “[t]he public health authority may . . . establish and maintain places of isolation and quarantine, and set rules and make orders . . . [f]ailure to obey these rules, orders, or provisions shall constitute a

¹⁷⁰Bruce, *supra* note 164, at 86.

¹⁷¹*Id.*

¹⁷²*Id.* at 84.

¹⁷³*Id.* at 88.

¹⁷⁴*Terrorism*, *supra* note 163, at 6. Every state modifies the act according to its own constitution and public values.

¹⁷⁵See Kristof, *supra* note 127.

¹⁷⁶Levy, *supra* note 3, at 1152.

¹⁷⁷See Matei, *supra* note 68, at 442.

misdemeanor,”¹⁷⁸ does not explain how far officials should go in keeping people out of the quarantined area, if parents could be kept from children,¹⁷⁹ or any other practical details about the provision’s implementation that might better guard against abuses. Another problem is the lack of recourse for the public against public health officials in times of crisis except under extreme circumstances,¹⁸⁰ i.e. in cases of “gross negligence” or “willful misconduct”, both of which are high thresholds.¹⁸¹ This point is particularly disturbing in light of the fact that individuals may be forcibly receiving medical treatment they do not want. Yet another weakness in the legislation is that it hinges upon an identification and declaration of a public health emergency. However, this “establishes an artificial distinction between the functioning of the public health system during a bio-terrorist attack and the day-to-day functioning of the system,¹⁸² because public health crises do not often involve a single cataclysmic event.¹⁸³ Instead, the early stages of a crisis, like a bio-terrorist attack, “mimic fairly ordinary public health situations in which illnesses that initially seem routine strike a small number of people.”¹⁸⁴

Accordingly, attempts at more effective and enduring reform should begin with a framework for addressing these problematic issues. One of the best ways to resolve the problem of ambiguity is to provide a set of guidelines, like those accompanying the tax code, to better explain the provisions of the model law in their application to various life situations. While states can choose to accept, reject, or modify provisions according to their own constitutions, the guidelines should be a national instrument that provides the public with some semblance of uniformity and reasonable expectations a standard that could serve as a point of comparison when investigating potential abuses of power. Additionally, choosing one public health threat, such as a bio-terror attack for example, and examining its implications on each of the Model Act’s provisions would be useful as a general gauge of what to expect and what measures are unreasonable in light of the severity of the threat.

With respect to the problem of liability, would it be better to promote a sense of fairness and accountability by lowering the threshold, with some qualifications, to bring it in line with peacetime notions of legal actionability? Instead of drawing the line at gross negligence, what if MSEHPA should allow suits for negligence that would exist absent a public health emergency? Lawsuits for negligence should only be promulgated against individual officials if they are working in their areas of expertise and should take into account the exigencies of a public health emergency. Otherwise, if healthcare providers are being forced to temporarily provide medical services outside their areas of expertise due to the exigencies of the emergency and

¹⁷⁸Model State Emergency Health Powers Act (Dec. 21, 2001), *available at* <http://www.publichealthlaw.net>.

¹⁷⁹Matei, *supra* note 68, at 442.

¹⁸⁰Bruce, *supra* note 164, at 91.

¹⁸¹Matei, *supra* note 68, at 446.

¹⁸²Choo, *supra* note 166.

¹⁸³*Civil Liberties*, *supra* note 124.

¹⁸⁴Choo, *supra* note 166.

negligent harm results, liability should be directed toward the government.¹⁸⁵ For example, a medical lab technician who is asked to administer vaccines during a public health crisis and who would not otherwise be working in such a capacity but for the government's request, should not be held individually liable for negligent vaccine administration. Instead, liability should rest with the government. This guarantees medical professionals some degree of protection, which, in turn, would likely make healthcare providers more willing to help out, while also ensuring some form of accountability to the public, which "is indispensable for engendering and sustaining public trust, as well as for expressing justice."¹⁸⁶

Finally, a good way to approach the problem of delayed public health responses in the absence of cataclysmic events that trigger a state of emergency declaration is to restructure the provision. Since health officials are the most likely to detect a public health threat, and in the best position to contain one, they should have certain of the emergency powers, like the authority to quarantine, for example, in the first instance. Within forty-eight hours of exercising such powers, the health officials should have to justify their actions to an appointed commission and the governor,¹⁸⁷ who would then either release the individuals and investigate the actions taken, or declare a public health emergency. Abuses could be curbed through publicity for incorrect decisions and professional consequences for officials who should have known better. Governors would have the incentive to review potential threats immediately,¹⁸⁸ and the longest infringement on personal autonomy without a priori review, would be forty-eight hours.

In addition to improving upon these identified weaknesses, there are several other strategic steps that would likely strengthen the public health system. The first is to have a nationwide or, if feasible, international notification system for public health emergencies. Logistically, such a system could operate via an on-line bulletin board that every health official would be obligated to check on an hourly basis. Details about a public health threat, both medical and demographic, would be posted on the computer, as well as the medical facility of origination, so that practitioners with questions could obtain more information. The purpose of such a system would be to disburse information about a public health threat to the largest number of health officials in the shortest amount of time possible. It would greatly facilitate preparedness, as well as a quick and coordinated national and international response to the particular threat.¹⁸⁹

¹⁸⁵This could happen if, for example, state officials were to waive license requirements for practicing and/or use medical professionals in one field to fill other positions as well.

¹⁸⁶Childress et al., *supra* note 17, at 174.

¹⁸⁷I think the governor and an appointed commission are a better choice for this job than the judiciary because the former are accountable to the public. Since they are likely to promote the interests of the public, they are probably a better check on the health officials' power than the judiciary. Also, placing some of this power in the hands of the governor is more in line with the structure of the MSEHPA.

¹⁸⁸This incentive stems from the desire not to tread on civil liberties without need, especially in light of media attention that would be paid to mistakes.

¹⁸⁹It is generally true that full information about the existence of a potential public health emergency could easily start a panic among members of the public. However, my proposal limits access to this information to public health officials whose very responsibility is to react

The second stratagem is an education campaign instructing the public on how the public health response system operates, and what mechanisms are in place for their protection. This would put any misgivings they might have about civil rights infringements in the broader context of protecting public welfare. Moreover, the openness of the government with respect to its plan of action would help to maintain public trust, which is "central to controlling any outbreak."¹⁹⁰ After all, "it takes a society - an informed and educated society - to practice public health."¹⁹¹ In the end, the public's belief in the fairness of the system will go a long way, and could change their view of objectionable provisions from being unjust assaults on civil liberties to mere differences of opinion.

VIII. CONCLUSION

As the United States moves forward in this new millennium, it is likely to encounter many more public health threats than those faced in recent decades. However daunting these assaults may be, the key to an effective response is preparedness. While security almost invariably comes at a price, Americans historically have been willing to accept reasonable restraints on liberty so long as they were accompanied by a well-articulated need and a general consensus for action.¹⁹² Using the lessons learned from recent threats to educate the public about the importance of preventive initiatives for potentially less visible threats in the future is an essential part of developing a more effective public health system. The suggestions for preparedness outlined in this paper, which include education and public accountability, are a definite though not decisive step in the direction of balancing the scale of individual rights and public protection.

calmly and quickly to it. While there is always the possibility of an information leak to the media and/or public, the price of non-preparedness is too high a price to warrant a more limited flow of information.

¹⁹⁰Marlantes, *supra* note 9.

¹⁹¹Levy, *supra* note 3, at 1159.

¹⁹²McShane, *supra* note 94, at 47.