

2003

Modernizing Local Responses to Public Health Emergencies: Bioterrorism, Epidemics, and the Model State Emergency Health Powers Act

Daniel S. Reich

Follow this and additional works at: <https://scholarship.law.edu/jchlp>

Recommended Citation

Daniel S. Reich, *Modernizing Local Responses to Public Health Emergencies: Bioterrorism, Epidemics, and the Model State Emergency Health Powers Act*, 19 J. Contemp. Health L. & Pol'y 379 (2003).
Available at: <https://scholarship.law.edu/jchlp/vol19/iss2/2>

This Article is brought to you for free and open access by CUA Law Scholarship Repository. It has been accepted for inclusion in Journal of Contemporary Health Law & Policy (1985-2015) by an authorized editor of CUA Law Scholarship Repository. For more information, please contact edinger@law.edu.

ARTICLES

MODERNIZING LOCAL RESPONSES TO PUBLIC HEALTH EMERGENCIES: BIOTERRORISM, EPIDEMICS, AND THE MODEL STATE EMERGENCY HEALTH POWERS ACT

by *Daniel S. Reich**

I. INTRODUCTION

Public health experts had been issuing clarion calls for years, warning that the American system is a house of cards that could crumble at any moment. Author Laurie Garrett lamented that “[the] twenty-first century dawned with America’s public health system in dire disarray” and

[a]s incredible as it might seem, given America’s breathtaking prosperity at the close of the 1990s, most of the problems and crises [found] in the health apparatus of central Africa, the Indian subcontinent, and former Soviet Union could also to one degree or another be found in the United States.¹

Nobel laureate Dr. Joshua Lederberg warned that the public health system “is very close to being in a shambles at this time.”² And yet, in an era of globalization, general economic prosperity, and American political, military, and economic dominance in the world, few Americans questioned the ability of the public health infrastructure to protect the nation’s public health.

All this changed in the fall of 2001, following the tragic September 11 terrorist attacks on the World Trade Center and the Pentagon and

* Associate Debevoise & Plimpton. J.D., Yale Law School, 2002; B.A., Yale College, 1998. The author wishes to thank Anita Allen, James E. Baker, W. Michael Reisman, and Mark R. Shulman, for their help in thinking through the issues discussed in this Article.

1. Laurie Garrett, *Betrayal of Trust: The Collapse of Global Public Health* 268 (2000).

2. *Id.* at 282 (quoting Dr. Joshua Lederberg).

an anthrax scare that followed soon after.³ These two events awakened Americans to the real threat of bioterrorism and the tremendous importance of a sound public health response infrastructure.⁴ When considering the need for adequate response to public health emergencies arising from bioterrorism, it became obvious that the threat was not just from acts of bioterrorism but any form of virulent contagious disease, and the debate about the public health system's preparedness quickly began to encompass response to naturally occurring infectious diseases.⁵ The threat of virulent contagious disease again became a matter of public attention both in the United States and around the world following the rapid spread of SARS (Severe Acute Respiratory Syndrome) in the spring of 2003 from China to several other countries.⁶

Underlying the debate about updating the nation's laws to allow for better public health preparedness are important questions about the proper balance between coercion, on the one hand, and leadership, on the other. While few would advocate coercion over effective leadership, it is important to distinguish between what the government *may* do and what the government *should* do. On one side of the debate are those who advocate building strong emergency powers into law — powers that would allow the state to compel citizens to undergo medical examinations, vaccinations, treatment and quarantine should the circumstances require such measures.⁷ As a group of academics,

3. Lawrence Gostin, *Law and Ethics in a Public Health Emergency; at Law*, HASTINGS CTR. REPORT, March 1, 2002, at 9. At the time of publication of this Article, the source of the anthrax attack in the United States remains a mystery. See Eric Lipton & Kirk Johnson, *The Anthrax Trail: Tracking Bioterror's Tangled Course*, N.Y. TIMES, Dec. 26, 2001, at A1.

4. Bill Miller, Study Urges Focus on Terrorism With High Fatalities, Cost, WASH. POST, Apr. 29, 2002, at A3; Larry Copeland, CDC Proposes Bioterrorism Laws, USA TODAY, Nov. 8, 2001, at 3A; Marcia Coyle, States Urged to Update Antiquated Public Health Laws, NAT'L L.J., Nov. 5, 2001, available at <http://www.law.com>.

5. Gostin, *Law and Ethics in a Public Health Emergency; at Law*, supra note 3, at 9.

6. See Dean E. Murphy, *In U.S., Fear is Spreading Faster than SARS*, April 17, 2003, N.Y. TIMES, at A1; Denise Grady, *Fear Reigns as Dangerous Mystery Illness Spreads*, April 7, 2003, N.Y. TIMES, at A1.

7. See, e.g., Cantigny Conference Series, *State Emergency Health Powers and the Bioterrorism Threat 7 (2001)* [hereinafter *State Emergency Health Powers and the Bioterrorism Threat*]; Lawrence Gostin, *YES: New Laws are Needed to Enable Federal and State Agencies to Work Together in an Emergency*, Insight on the News, Dec. 18, 2001, available at <http://www.insightmag.com/main.cfm/include/>

lawyers and government officials concluded at a recent conference on State Emergency Health Powers and the Bioterrorism Threat: "Clear, open, and lawful response by government officials is necessary for public support and preservation of our national values. Rapid determination of the appropriate balance between coercive government action and individual civil rights is critical."⁸

On the other side of the debate, those concerned primarily with preservation of civil liberties fear the formal expansion of government power. For most of those skeptics, effective leadership is the key to preserving public health. Robert Cihak and Michael Glueck note, "Human freedom is our great strength. Free people respond to leadership much more vigorously than a people held in place by power, fear and terror of their own government."⁹ The remarkable displays of civic virtue and cooperation in the aftermath of September 11 serve as strong proof of the effectiveness of leadership and the willingness of individual citizens to cooperate on behalf of the community. As health law expert George Annas has commented, "Now we know how people react, and they react really well on their own."¹⁰ This Article addresses both sides of the argument and builds on the premise that while the government should strive to exercise effective leadership in the face of a public health emergency so as to ensure maximal individual freedom of action, it is vital that the government have the legal authority to exercise compulsory powers if necessary.

detail/storyid/160392.html; Press Release, U.S. Department of Health and Human Services, Statement by HHS Secretary Tommy G. Thompson Regarding the Model Emergency Health Powers Act (Oct. 30, 2001), at <http://www.hhs.gov/news/press/2001pres/20011030.html> [hereinafter Statement by HHS Secretary Tommy G. Thompson].

8. State Emergency Health Powers and the Bioterrorism Threat, *supra* note 7, at 7.

9. Robert C. Cihak & Michael Arnold Glueck, *No: Swelling the Intrusive Reach of the States Should be Avoided*, INSIGHT ON THE NEWS, Dec. 18, 2002, available at <http://www.insightmag.com/main.cfm/include/detail/storyid/160393.html>; see also Association of American Physicians and Surgeons, *AAPS Analysis: Model Emergency Health Powers Act (MEHPA) Turns Governors into Dictators* (Dec. 3, 2001), available at <http://www.aapsonline.org/testimony/emerpowers.htm> [hereinafter *AAPS Analysis*] ("There is no evidence that force works better than leadership, which can bring out the best in citizens coming together to meet the crisis, just as firefighters, police, medical professionals, hotel owners, and other businessmen did in New York City.").

10. Sharon Lerner, *Round up the Unusual Suspects*, VILLAGE VOICE, Jan. 8, 2002, at 45 (quoting George Annas). Cf. William K. Rashbaum, *Report on 9/11 Finds Flaws in Response of Police Dept.*, N.Y. TIMES, July 27, 2002, at A1.

With this framework in mind, the Article analyzes the Model State Emergency Health Powers Act (“MSEHPA”).¹¹ Part II gives a short overview of the Model Act, explains its significance, and presents some of the major general criticisms that have been leveled against it. Parts III through V analyze specific elements of the Model Act. Part III focuses on the Model Act’s provisions dealing with measures to detect and track public health emergencies, particularly reporting and tracking of private medical information. Part IV discusses the Model Act’s proposed framework for declaration of a public health emergency. Part V presents the Model Act’s provisions relating to the government’s compulsory powers over the person: first analyzing the section of the Act dealing with examination, testing, vaccine and treatment, and then doing the same for the section dealing with isolation and quarantine measures. Part VI concludes. Ultimately, this paper argues that the MSEHPA provides a strong basis from which state legislatures should begin to reconsider their public health laws and update them as necessary but that the Model Act cannot be adopted in full and must be altered so as to bolster privacy and civil liberty protections that are unjustifiably weakened to an unnecessary degree by the Model Act in its current form.

II. THE MODEL STATE EMERGENCY HEALTH POWERS ACT

The MSEHPA is a Model Act aimed at standardizing and modernizing state public health legislation across the United States in order to give officials the authority to act decisively and quickly in the event of a bioterrorist attack or major outbreak of disease.¹² Much of

11. Center for Law and the Public’s Health at Georgetown and Johns Hopkins Universities, *Model State Emergency Health Powers Act*, Dec. 21, 2001 [hereinafter MSEHPA], available at <http://www.publichealthlaw.net>. For an earlier draft of the MSEHPA, released on October 23, 2001, see Center for Law and the Public’s Health at Georgetown and Johns Hopkins Universities, *Model State Emergency Health Powers Act*, Oct. 23, 2001 [hereinafter MSEHPA Version 1 Draft] available at <http://www.publichealthlaw.net/MSEHPA/MSEHPA.pdf>. The MSEHPA was drafted by Professor Lawrence Gostin of the Center for Law and the Public’s Health at Georgetown and Johns Hopkins Universities, in a project funded by the Centers for Disease Control, in coordination with the National Governors Association, the National Conference of State Legislatures, the National Association of Attorneys General, the Association of State and Territorial Health Officials, and the National Association of City and County Health Offices. MSEHPA, *supra*, at 1.

12. Coyle, *supra* note 4.

the problem with existing public health laws is that most state public health legislation currently on the books dates to the early twentieth century, and thus predates the advances in public health sciences of the last century.¹³ One important way in which outdated legislation is insufficient is its lack of clarity. While most states have compulsory powers through which public health officials can submit individuals to examination, testing, immunization, treatment, isolation or quarantine, many of the state statutes that are the basis for these powers were drafted forty to one hundred years ago and do not articulate clear criteria for the exercise of those powers.¹⁴ In addition, the existing laws were mostly written prior to the seismic developments in the constitutional law of due process and equal protection over the last half century and consequently do not reflect current constitutional standards.¹⁵ The drafting of the MSEHPA reflects an attempt to correct these shortcomings in existing state laws.

Though the MSEHPA has been in development for several years, it has gained significant attention since the tragic events of September 11 and the anthrax scare that followed.¹⁶ On October 6, 2001, Gene Matthews, general counsel of the Centers for Disease Control and Prevention ("CDC"), asked professor of law and public health Lawrence Gostin to draft the MSEHPA.¹⁷ On October 30, 2001, Secretary of Health and Human Services ("HHS") Tommy Thompson issued a statement regarding the MSEHPA, explaining that HHS's goal is to "develop a consensus-based model legislation to assist states that are considering new emergency public health legislation."¹⁸ Thompson went on to say that "HHS is dedicated to working with state and local officials to strengthen America's capacity and ability to respond to public health emergencies. This draft Model Act is one more example of the continued work that CDC and others in the department are undertaking to strengthen our public health infrastructure on the federal, state, and local levels and protect the

13. *Id.* For a survey of communicable disease laws in the fifty states, see Lawrence Gostin et. al., *The Law and the Public's Health: A Study of Infectious Disease Law in the United States*, 99 COLUM. L. REV. 59, 101 (1999).

14. Gostin et. al., *supra* note 13, at 113.

15. Coyle, *supra* note 4.; Gostin et. al., *supra* note 13, at 105-106.

16. Gostin, *Law and Ethics in a Public Health Emergency; at Law, supra* note 3, at 9 ("Following the events of 11 September and 4 October . . . the need for law reform captured the attention of political leaders.").

17. *Id.*

18. Statement by HHS Secretary Tommy G. Thompson, *supra* note 7.

nation's health."¹⁹ Increased concern that existing public health legislation may be inadequate for the task of setting up a framework for responding to a bioterrorist attack, combined with introduction of the MSEHPA, has spurred the national government to encourage state legislatures to update existing statutes or replace them entirely with new legislation. A flurry of legislative activity has followed in almost every state.²⁰

Bills based in whole or part on the Model Act have been introduced in the legislatures of at least thirty-eight states and the District of

19. *Id.*

20. According to a record of state legislative activity kept by the authors of the MSEHPA, bills based in whole or part on the Model Act have been introduced in Alabama (2003 H.B. 335), Arizona (2002 S.B. 1400; 2002 H.B. 2044), California (2002 A.B. 1763; 2003 A.B. 206), Connecticut (2002 H.B. 5286; 2003 S.B. 245; 2003 S.B. 247; 2003 S.B. 248; 2003 S.B. 404; 2003 S.B. 406; 2003 S.B. 412), Delaware (2001 H.B. 377), District of Columbia (DC B14-0373; DC A14-380) Florida (2002 S.B. 1262; 2002 S.B. 1264; 2002 H.B. 1579), Georgia (2002 S.B. 385), Hawaii (2001 H.B. 2521; 2001 S.B. 2779), Idaho (2002 H.B. 517), Illinois (2001 S.B. 1529; 2001 H.B. 3809; 2003 H.B. 6; 2003 H.B. 691), Kansas (2002 S.B. 597), Kentucky (2002 H.B. 88; 2002 H.B. 370), Maine (2001 H.P. 1656; 2002 L.D. 2164), Maryland (2002 S.B. 234; 2002 H.B. 296; 2002 H.B. 303), Massachusetts (2001 S.B. 2173; 2001 S.B. 2194; 2001 S.B. 2; 2003 S.B. 597), Minnesota (2001 H.F. 2619; 2002 S.F. 2669; 2002 H.F. 3031), Mississippi (2002 H.B. 1348; 2002 S.B. 2737), Missouri (2002 S.B. 712; 2002 H.B. 1771; 2002 S.B. 1000; 2002 S.B. 854; 2002 S.B. 1280), Nebraska (2002 L.B. 1224), New Hampshire (2001 H.B. 1478), New Jersey (2002 S.B. 1042; 2002 S.B. 1223; 2002 A.B. 1746; 2002 A.B. 1773), New Mexico (2002 H.B. 195; 2003 H.B. 231; 2003 S.B. 194), New York (2001 AB. 9508; 2001 S.B. 5841; 2003 A.B. 6321), North Carolina (2002 H.B. 1508; 2002 S.B. 1166), Ohio (2002 S.B. 296; 2003 S.B. 6), Oklahoma (2002 H.B. 2765; 2002 S.B. 1659; 2003 H.B. 1467), Pennsylvania (2001 H.B. 2261; 2001 H.B. 2371; 2001 S.B. 1338; 2002 H.B. 2928; 2002 S.B. 1569; 2003 S.B. 206), Rhode Island (2001 H.B. 7357; 2001 H.B. 7563; 2001 S.B. 2865; 2002 H.B. 7305; 2002 S.B. 2304; 2003 H.B. 5747; 2003 S.B. 318), South Carolina (2002 H.B. 4416), South Dakota (2002 H.B. 1303, 1304), Tennessee (2001 S.B. 2392; 2001 H.B. 2271), Texas (2003 S.B. 399), Utah (2002 H.B. 231), Vermont (2001 S.B. 298), Virginia (2001 H.B. 882), Washington (2001 H.B. 2854), Wisconsin (2001 A.B. 849, 850), and Wyoming (2002 S.F. 67; 2003 S.F. 11). See Center for Law and the Public's Health, *The Model State Emergency Health Powers Act State Legislative Activity*, March 24, 2003, available at <http://www.publichealthlaw.net> [hereinafter *MSEHPA State Legislative Activity*]. See also American Legislative Exchange Council, *ALEC Opposes the Model State Emergency Health Powers Act*, at <http://www.alec.org> (last visited April 18, 2003) (tracking legislation related to the MSEHPA in the states).

Columbia.²¹ As of March 2003, twenty-one states and the District of Columbia have already enacted legislation based on the Model Act.²²

The MSEHPA has come under heavy criticism on multiple fronts and is the subject of vigorous debate. Standing in opposition to proponents of the statute, such as Lawrence Gostin and Tommy Thompson, are groups and individuals who fear the MSEHPA does not provide sufficient protections to guarantee the privacy and civil liberties of individuals. The American Legislative Exchange Council (“ALEC”), a non-partisan group of state legislators, has criticized the Model Act for unnecessarily intruding on civil liberties and for granting too much coercive power to health officials and governors.²³ George Annas of Boston University School of Law, has also spoken out against the MSEHPA, criticizing the Model Act for giving “tremendous powers to unnamed and unaccountable public health officials to order people examined, treated, vaccinated or quarantined and do it with immunity unless acting with willful malice.”²⁴ At the core of the debate over the MSEHPA between advocates of the Model Act and its critics is the tension between public health and civil liberties.

No state is required to adopt the Model Act and it is unlikely that the Model Act will be adopted in its entirety by any state. However, it is certain that many states will draw from the model in revising or overhauling their public health statutes.²⁵ As states continue to use the MSEHPA as a starting point for reconsideration of state public health

21. See discussion, *supra* note 20.

22. See *MSEHPA State Legislative Activity*, *supra* note 20. Legislation enacted includes: Arizona (2002 H.B. 1400; 2002 H.B. 2044), Delaware (2002 H.B. 377), District of Columbia (DC B14-0373; DC A14-380), Florida (2002 S.B. 1262), Georgia (2002 S.B. 385), Hawaii (2002 H.B. 2521), Louisiana (2002 H.B. 91), Maine (2002 L.D. 2164), Maryland (2002 S.B. 234; 2002 H.B. 303), Minnesota (2002 H.F. 3031), Missouri (2002 S.B. 712), New Hampshire (2002 H.B. 1478), New Mexico (2002 H.B. 195; 2003 H.B. 231 (pending Governor’s expected signature)), North Carolina (2002 H.B. 1508; 2002 S.B. 1166), Pennsylvania (2002 S.B. 1569), South Carolina (2002 H.B. 4416), South Dakota (2002 H.B. 1303; 2002 H.B. 1304), Tennessee (2002 S.B. 2392), Utah (2002 H.B. 231), Vermont (2002 S.B. 298), Wisconsin (2001 A.B. 850), and Wyoming (2003 S.F. 11). *Id.*

23. American Legislative Exchange Council, Issue Alert, *Model State Emergency Health Powers Act*, Nov. 8, 2001, available at <http://www.alec.org>; Michael L. Betsch, *Bio-terror Response Plan Would Invade Civil Liberties*, *Says Critic*, CNSNEWS.COM, Dec. 11, 2001, at <http://www.cnsnews.com/Nation/archive/2000112/NAT20011211a.html>.

24. Coyle, *supra* note 4 (quoting George Annas).

25. See Copeland, *supra* note 4, at 3A (quoting John Thomasian of the National Governors Association).

powers, it is worth analyzing the strengths and weaknesses of this Model Act while state legislators are still in the process of reviewing and debating its provisions.

III. MEASURES TO DETECT AND TRACK PUBLIC HEALTH EMERGENCIES

Section 301 of the Model Act deals with mandatory reporting of diseases and other health conditions.²⁶ This section calls for health care workers to “report all cases of persons who harbor any illness or health condition that may be potential causes of a public health emergency.”²⁷ The list of reportable illnesses is to be identified by the state’s public health authority.²⁸ Furthermore, the model requires that pharmacists report unusual prescription activity or unusual trends in pharmacy visits.²⁹ Included in the list of information to be reported are the specific illness; the patient’s name, date of birth, sex, race, occupation and current home and work addresses; the name and address of the health care workers filing the report; and “any other information needed to locate the patient for follow-up.”³⁰ Finally, section 301 requires similar reporting requirements of veterinarians and persons caring for animals in the case of animals “having or suspected of having any diseases that may be potential causes of a public health emergency.”³¹

Section 302 of the Model Act charges the public health authority with responsibility for identifying cases of illness or health condition that may signal an impending public health emergency.³² To carry out this task, the public health authority is expected to use information reported in accordance with section 301 in order to “identify all individuals thought to have been exposed to an illness or health condition that may be a potential cause of a public health

26. MSEHPA, *supra* note 11, § 301.

27. *Id.* §301(a). The list of health care workers includes health care providers, coroners, medical examiners, as well as in- and out-of-state medical laboratories. *Id.* §301(a), (e). For a detailed discussion of the jurisdictional problem relating to out-of-state laboratories, see LAWRENCE O. GOSTIN, PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT 119 (2000).

28. MSEHPA, *supra* note 11, § 301(a)

29. *Id.* § 301(b).

30. *Id.* § 301(c).

31. *Id.* § 301(d).

32. *Id.* § 302.

emergency.”³³ Once these individuals are identified, section 302 further authorizes the public health authority to “counsel and interview” them to obtain information that will assist in identifying exposed individuals and determining the source of the health threat.³⁴ Information to be collected includes the name and address of “any person from whom the illness or health condition may have been contracted and to whom the illness or health condition may have spread.”³⁵ The public health authority is further authorized to “close, evacuate, or decontaminate any facility or decontaminate or destroy any material,” which the authority “reasonably suspects” may endanger the public health.³⁶ Finally, the public health authority is required to share information with the state public safety authorities, tribal authorities and federal health and public safety authorities.³⁷ Public safety authorities and other state and local government agencies are also required to share information with the public health authority.³⁸ In an attempt to protect the privacy interests of the individuals involved, the Model Act restricts the information to be shared between authorities to “information necessary for the treatment, control, investigation, and prevention of a public health emergency.”³⁹

The reporting requirements of the MSEHPA have drawn a great deal of criticism from privacy advocates. Janlori Goldman, Director of the Health Privacy Project at Georgetown, has commented that “[t]here is very little in this Model Act that either builds protections in for privacy or civil liberties.”⁴⁰ Similarly, Jennifer King, Director of ALEC’s Health and Human Services Task Force, complained that “[t]here are almost no privacy protections in this bill at all.”⁴¹ Indeed, the privacy implications of the Model Act’s reporting requirements are serious and deserve serious consideration.⁴²

33. *Id.* § 302(a).

34. *Id.* § 302(b).

35. *Id.*

36. *Id.* § 302(c).

37. *Id.* § 303(b).

38. *Id.* § 303(a).

39. *Id.* § 303(c).

40. Drew Clark, *Privacy: Bioterrorism Plan Sparks Outcry Over Privacy; Infringement*, NAT’L J. TECH. DAILY, Feb. 6, 2002, LEXIS, Nexis, News Group File (quoting Janlori Goldman).

41. *Id.* (quoting Jennifer King).

42. The discussion in this Part focuses exclusively on the data reporting provisions of the Model Act. Any state legislation dealing with protected health information will also have to comply with the medical privacy regulation of the

The central question underlying any public health reporting requirement is where the appropriate balance lies between an individual's legitimate expectation of privacy and the public health benefits to society as a whole. Collection of health information is one of the fundamental responsibilities of any public health system.⁴³ After all, health data is absolutely necessary for state health authorities to "identify health risks, inform the public, [and] intervene" to prevent the spread of disease.⁴⁴ The problem with collection of health data is that it may involve extremely intimate information about a person's life and, if made public, could seriously affect a person's professional and personal life, including job prospects, immigration status or access to insurance.⁴⁵ The sensitive personal health data collected for the benefit of public health surveillance is especially vulnerable in a world where electronic records and linked computer databases are used with increasing frequency.⁴⁶ In addition, it is important to recognize that protection of privacy is beneficial to the public health, for people are more likely to come forward for testing, counseling and treatment if they know that their privacy will be maintained.⁴⁷ For these reasons, it is essential that individual privacy be protected to the greatest extent possible even as state health authorities collect the health information that is so vital to the public health. Ultimately, both the state and the individual will have to make some concessions for the system to work. Some degree of privacy will have to be forsaken in the interest of the

Health Insurance Portability and Accountability Act of 1996 (HIPAA). 45 C.F.R. pts. 160, 164 (2003). For an excellent overview of the HIPAA regulations and their impact on the proposed rules of the MSEHPA, see Peter P. Swire & Lauren B. Steinfeld, *Modern Studies in Privacy Law: National Health Information Privacy Regulations Under HIPAA: Security and Privacy After September 11: The Health Care Example*, 86 MINN. L. REV. 1515, 1534-1540 (2002)

43. GOSTIN, *supra* note 27, at 113.

44. *Id.* at 115. See also Raymond J. Baxter et. al., Is the U.S. Public Health System Ready for Bioterrorism? An Assessment of the U.S. Public Health Infrastructure and its Capacity for Infectious Disease Surveillance, 2 YALE J. HEALTH POL'Y L. & ETHICS 1 (2001) (arguing that the key features of public health surveillance are information collection and reporting, the orderly consolidation and evaluation of the data and prompt dissemination of results to relevant health authorities).

45. GOSTIN, *supra* note 27, at 115.

46. Patricia I. Carter, Health Information Privacy: Can Congress Protect Confidential Medical Information in the "Information Age"?, 25 WM. MITCHELL L. REV. 223 (1999); James G. Hodge, Jr. et al., Legal Issues Concerning Electronic Health Information, 282 JAMA 1466 (1999).

47. GOSTIN, *supra* note 27, at 132; Hodge, Jr. et al., *supra* note 46, at 1470.

public health, and, at the same time, health data collection will have to be less efficient than it otherwise could be if we are to allow the individual to maintain some semblance of privacy.

While the mandatory reporting of medical records raises serious constitutional questions relating to privacy,⁴⁸ it is clear that mandatory reporting of health information is constitutional so long as privacy is adequately protected. In *Whalen v. Roe*,⁴⁹ the Supreme Court's most important case addressing the constitutionality of medical reporting requirements, a unanimous Court upheld a New York State statute requiring that the state health authority maintain a centralized computer file containing the names and addresses of all persons who obtained certain controlled substances pursuant to a doctor's prescription.⁵⁰ While the Court acknowledged that there exists a constitutionally protected "zone of privacy" that includes an individual's "interest in avoiding disclosure of personal matters" and "the interest in independence in making certain kinds of important decisions," it concluded that the New York program "does not, on its face, pose a sufficiently grievous threat to either interest to establish a constitutional violation."⁵¹ While the Court did recognize that there is a serious potential "threat to privacy implicit in the accumulation of vast amounts of personal information in computerized data banks or other massive government files," it found that the provisions of the statute in this instance adequately protected privacy by limiting access to the lists and building in protection from disclosures.⁵² In a concurring opinion, Justice William S. Brennan made a point of the fact that "[t]he information disclosed by the physician under this program is made available only to a small number of public health officials with a legitimate interest in the information."⁵³ Brennan went on to explain that "broad dissemination by state officials of such information" would clearly violate constitutionally protected privacy rights, and thus would

48. For the Supreme Court's most important considerations of the concept of a constitutional right to privacy, see *Roe v. Wade*, 410 U.S. 113, 152-153 (1973) (stating that the "right of privacy" is founded in the Fourteenth Amendment's concept of personal liberty); and *Griswold v. Connecticut*, 381 U.S. 479, 483 (1965) (stating that "[T]he First Amendment has a penumbra where privacy is protected from governmental intrusion.").

49. 429 U.S. 589 (1977).

50. *Id.* at 591.

51. *Id.* at 598-600.

52. *Id.* at 600-01, 605.

53. *Id.* at 606 (Brennan, J., concurring).

only be justified by “compelling state interests.”⁵⁴ The *Whalen* decision thus makes it clear that mandatory reporting of diseases is constitutional as long as the collected information is subject to adequate safeguards and procedures for protection of the patient’s privacy. One should also bear in mind Brennan’s emphasis on the importance of limiting access to the collected data to a very limited group of public health officials. Nevertheless, the case does evince the weight accorded by the Court to the government’s interest in acquiring and using information as long as these requirements are met.⁵⁵

Neither the Constitution nor the courts provide clear guidance on the proper approach to balancing the individual’s legitimate expectation of privacy and the larger societal interests of guaranteeing the public health. However, *Whalen* sets down a basic balancing test that requires local data collection policies to provide adequate privacy protections. Thus, one must balance the potential harm inflicted on the community by not reporting a condition that has potentially dangerous public health implications against the harm inflicted by violating privacy.

Unfortunately, the MSEHPA does not seem to strike the appropriate balance between privacy and public health. Even when one recognizes the need for deference to public health considerations, this Model Act goes too far in stripping the patient of his or her privacy. As previously discussed, the list of information to be reported includes the patient’s name, date of birth, sex, race, occupation, addresses and the catch-all “any other information needed to locate the patient for follow-up.”⁵⁶ First of all, there is no reason that the private information about the patient needs to be forwarded to the state public health authorities. Instead, a two-step approach could be adopted. It would certainly be possible for each report to have a case number that would be linked to a patient file in the hospital or doctor’s office. Should the state public health authorities wish to follow up on the report, they could contact the reporting health care worker and get the necessary personal information about the individual. While the categories of sex, race and occupation may help identify some epidemiological trends, it is by no means clear that the interest served by reporting these elements of the patient’s identity is strong enough to justify reporting these items of personal information. Finally, the catch-all phrase is much too broad and leaves too much discretion in

54. *Id.*

55. GOSTIN, *supra* note 27, at 133.

56. MSEHPA, *supra* note 11, § 301(c); *see also* text accompanying *supra* note 30.

the hands of the reporting health care worker to decide what kinds of personal information should be reported. While there is clearly a need for some intrusion of the individual's privacy for the sake of the common good, the detailed personal information required by the Model Act seems to go well beyond the minimum requirement necessary for adequate preservation of the public health.

Another problematic aspect of the Model Act is its grant of authority to the public health authority to "counsel and interview" individuals identified via the state's reporting methods. On its face, this policy allowing for what amounts to an involuntary interrogation seems to be a violation of the Fourth Amendment guarantee of the "right of the people to be secure in their persons . . . against unreasonable searches and seizures."⁵⁷ The reported medical information would likely constitute "probable cause" for a warrant, and there is no reason that the "counsel and interview" interrogation should not be subject to the same procedural requirements of Fourth Amendment criminal procedure and thus subject to issue of a warrant by a judge.⁵⁸ There is a strong argument to be made that collection of the name and address of any person with whom the interviewee had contact, as provided for in section 302(b), would also violate the patient's Fourth Amendment rights. An exception might be made in a situation where a public health emergency has been declared,⁵⁹ but absent a declared state of emergency there is no reason "counsel and interview" should be allowed where no warrant has been issued. Ultimately, this type of information gathering should be subject to judicial review similar to that which exists for issuance of a warrant.

Moreover, the information-sharing provisions of the Model Act are overbroad. Section 303 requires that public health authorities and public safety authorities exchange relevant information.⁶⁰ Surely exchange of protected health information is necessary, but the language of section 303 does not adopt a high enough threshold for triggering such information exchange. The public safety authority or

57. U.S. Const. amend. IV.

58. See generally *Arizona v. Hicks*, 480 U.S. 321 (1987); *United States v. Ross*, 456 U.S. 798 (1982); *Michigan v. Tyler*, 436 U.S. 499 (1978); *Marshall v. Barlow's, Inc.*, 436 U.S. 307 (1978).

59. For examples of exceptions to the warrant requirement in emergency situations, see *Tyler*, 436 U.S. 499 (allowing exception to warrant requirement when there is a burning fire), and *North American Cold Storage Co. v. City of Chicago*, 211 U.S. 306 (1908) (allowing exception to warrant requirement in a case involving contaminated food).

60. See discussion in text accompanying *supra* notes 37-39.

any other government agency is required to report any illness, health condition, unusual cluster, or suspicious event “that may be the cause of a public health emergency.”⁶¹ It is unclear why, at the very least, this trigger is not subject to a reasonableness requirement. After all, the trigger for the public health authority to report a case of reportable illness or health condition to public safety authorities is in fact contingent on a “reasonable belie[f]” that the case in question was potentially caused by bioterrorism,⁶² which does seem fair. Further, while section 303(c) does limit the sharing of information to “information necessary for the treatment, control, investigation, and prevention of a public health emergency,”⁶³ this broad safeguard needs to be strengthened with more specification of what constitutes necessary information for these purposes. Another important safeguard in this context would be requiring that the sharing of information not only be limited to necessary information, but that its distribution be limited to necessary individuals within the state’s public health and public safety authorities.

Section 607 deals with access to protected health information of persons who have participated in compulsory testing, treatment, vaccination, isolation or quarantine programs adopted during a public health emergency, and limits access to “those persons having a legitimate need to acquire or use the information” for treatment, epidemiologic research or investigation of the cause of transmission.⁶⁴ Section 607 also requires that, subject to certain clearly defined exceptions, “protected health information held by the public health authority shall not be disclosed without individual written, specific informed consent.”⁶⁵ However, the information currently reported under section 301 is not subject to such a specific consent requirement. The model act should adopt a more limited reporting requirement under sections 301 as previously suggested,⁶⁶ and apply a specific consent requirement like that in section 607(b) to protected health information not reported under a more limited version of section 301. If one adopts this Article’s suggested two-step approach to release of protected health information,⁶⁷ such a specific consent requirement for the release of protected health information not reported under the first

61. MSEHPA, *supra* note 11, § 303(a).

62. *Id.* § 303(b).

63. *Id.* § 303(c).

64. *Id.* § 607(a).

65. *Id.* § 607(b).

66. *See* text following *supra* note 56.

67. *See* text following *supra* note 56.

step could be effective and workable. The non-personal information indicating potential of a public health emergency could be released without consent under a more limited version of section 301, while release of personal information used in investigating the source and spread of an illness or health condition would be predicated on a specific consent requirement similar to that which exists in section 607. Should the patient refuse specific consent, then the Model Act could authorize the public health authority to obtain the protected health information pursuant to a court order.⁶⁸

In addition to the privacy concerns raised by the Model Act's proposed reporting requirements, it is important to consider the deficiencies of the current state reporting systems and whether the MSEHPA does anything to address these. An article in the American Medical Association publication *American Medical News* highlighted some of the most significant problems plaguing the current state reporting mechanisms.⁶⁹ These include the following complaints: (1) each state has its own reporting mechanism and its own lists of reportable diseases;⁷⁰ (2) health care workers have trouble keeping track of the long list of reportable diseases; (3) reporting procedures are cumbersome and inefficient; and (4) reporting times vary widely, ranging from one day to more than a year, with the average falling between two and three weeks.⁷¹ At the very least, the MSEHPA should seek to correct these known deficiencies of the current web of individualized state reporting systems.

The very fact that the Model Act has been drafted and is being considered in a large number of state legislatures should help in the effort to standardize state reporting mechanisms. The Model Act requires that reportable illnesses and conditions will include, but not be limited to, biological agents enumerated in 42 C.F.R. § 72, app. A,

68. See, e.g., MSEHPA, *supra* note 11, § 607(b)(4) (authorizing disclosures of protected health information "pursuant to a court order to avert a clear danger to an individual or the public health").

69. Victoria Stagg Elliott, *Public Health Reporting Flaws Spell Trouble*, AM. MED. NEWS, Apr. 22/29, 2002, available at http://www.amaassn.org/scipubs/amnews/pick_02/hll20422.htm.

70. See *id.* For a survey of the various infectious disease reporting requirements of U.S. states and territories and the substantial differences between them, see Sandra Roush et al., *Mandatory Reporting of Diseases and Conditions by Health Care Professionals and Laboratories*, 282 JAMA 164 (1999). For the most recent survey of state reporting requirements, see Council of State and Territorial Epidemiologists, *Nationally Notifiable Disease Survey* (May 2001), available at <http://www.cste.org/Surveys/NNDSSresults.htm>.

71. See Elliott, *supra* note 69.

as well as “any illnesses or health conditions identified by the public health authority.”⁷² So while every state will be able to add any conditions that are particular to it (such as those that are only found in certain regions of the country), widespread adoption of this provision would significantly help standardize the list of diseases and conditions that require reporting, thereby decreasing the confusion felt by health care workers and filling in gaps in current national reporting. The Model Act may also help alleviate the problem of cumbersome and inefficient reporting methods with its requirement that reports “be made electronically or in writing within [twenty-four (24) hours] to the public health authority.”⁷³ The possibility of electronic reporting may help to correct some of the cumbersome aspects of existing reporting methods. Electronic reporting also has the advantage of allowing for proper safeguards to be built into a central database so as to limit access to information to those who need it. Furthermore, the twenty-four hour requirement, if enforced, would certainly correct the current lack of timely reporting. Thus, it does seem that the MSEHPA addresses some of the most significant shortcomings of the current reporting system and may help to correct them.

IV. DECLARING A STATE OF PUBLIC HEALTH EMERGENCY

The MSEHPA provides that the governor may declare a state of public health emergency in any of the following circumstances:⁷⁴

A “public health emergency” is an occurrence or imminent threat of an illness or health condition that:

- (1) is believed to be caused by any of the following: (i) bioterrorism; (ii) the appearance of a novel or previously controlled or eradicated infectious agent or biological toxin; (iii) [a natural disaster;]; (iv) [a chemical attack or accidental release; or] (v) [a nuclear attack or accident]; and
- (2) poses a high probability of any of the following harms: (i) a large number of deaths in the affected population; (ii) a large number of serious or long-term disabilities in the affected population; or (iii) widespread exposure to an infectious or toxic

72. MSEHPA, *supra* note 11, § 301(a).

73. *Id.* § 301(c) (brackets in original).

74. *Id.* § 401 (authorizing the governor to declare a public health emergency upon the occurrence of a “public health emergency” as defined in § 104(m)).

agent that poses a significant risk of substantial future harm to a large number of people in the affected population.⁷⁵

Adopting this broad definition of a “public health emergency,” the Model Act authorizes the governor to declare a state of emergency either in the event of a bioterrorist attack or upon the discovery of a particularly virulent virus or disease, when either scenario involves a threat that poses a “high probability” of leading to a large number of deaths, causing serious or long term disability to the population, or widely exposing the population to an infectious agent that is likely to cause large-scale infection.

Once a state of public health emergency is declared, the governor’s scope of authority includes the power to: (1) suspend any statutory provisions regulating the conduct of state business to the extent that strict compliance with these provisions would “prevent, hinder, or delay necessary action (including emergency purchases)” by the state’s public health authority in responding to the emergency; (2) utilize all available state and local resources as “reasonably necessary” to respond to the emergency; (3) mobilize the state’s National Guard units; (4) coordinate with other states; and (5) seek aid from the federal government.⁷⁶ In the state of public health emergency, the public health authority is charged with coordinating the state’s response to the emergency and has “primary jurisdiction, responsibility, and authority” for planning and executing this response, for coordinating between state and local authorities and for collaborating with federal authorities.⁷⁷

The Model Act authorizes the governor to declare a state of public health emergency without consulting anyone “when the situation calls for prompt and timely action.”⁷⁸ In order to declare a state of public health emergency, the governor must issue an executive order that specifies:

- (a) the nature of the public health emergency,
- (b) the political subdivision(s) or geographic area(s) subject to the declaration,
- (c) the conditions that have brought about the public health emergency,
- (d) the duration of the state of the public health emergency, if less than thirty (30) days, and

75. *Id.* § 104(m) (italics and brackets in original).

76. MSEHPA, *supra* note 11, § 403(a).

77. *Id.* § 403(b).

78. *Id.* § 401.

(e) the primary public health authority responding to the emergency.⁷⁹

While the governor has the executive authority to decide whether a state of public health emergency should be declared, he is required by the model statute to declare the nature and cause of the emergency and identify the specific area to which it applies. Moreover, the governor must clearly state the duration of the emergency, which can last no longer than thirty days unless the governor takes action to renew the executive order.⁸⁰ The governor is required to terminate the state of emergency by executive order upon finding that the circumstances no longer pose a “high probability” of large-scale death, disability or widespread infection.⁸¹ Furthermore, the state of emergency shall be terminated automatically after thirty days and can only be renewed by issuance of a new executive order.⁸² Any renewal secured in this way shall likewise terminate after thirty days unless it is formally renewed by executive order.⁸³

The only check against the governor’s power to declare a state of public health emergency is a provision empowering the state legislature to terminate the state of emergency by a majority vote in both chambers.⁸⁴ While this check is certainly important, an even more effective check on the governor’s authority would be to require approval by majority vote of the state legislature to renew the state of emergency after the first thirty-day period elapses. With the broad grant of powers that follows from the declaration of a state of emergency, it seems that, at the very least, the state legislature should actively be involved in granting the governor the authority to invoke such broad powers. This is the logic of a check on executive power that underlies the War Powers Act, which requires Congressional approval for prolonging a state of war declared by the President beyond sixty days,⁸⁵ and the same logic should be extended to the exercise of

79. *Id.* § 402.

80. *Id.*; *see also id.* § 405(b) (stating that “the declaration of a state of public health emergency shall be terminated automatically after thirty (30) days unless renewed by the Governor under the same standards and procedures set forth in [Article IV].”).

81. *Id.* § 405(a).

82. *Id.* § 405(b). For exact text of § 405(b), *see supra* note 80.

83. *Id.*

84. *Id.* § 405(c).

85. The War Powers Resolution, 50 U.S.C. § 1544 (2002), Pub. L. No. 93-148, § 5, 87 Stat. 555, 556 (1973). For a thorough academic consideration of the

executive power in the states with regard to public health emergencies. At a minimum, the MSEHPA should follow the example of federal law on termination of national emergencies, which stipulates that “[n]ot later than six months after a national emergency is declared, and not later than the end of each six-month period thereafter that such emergency continues, each House of Congress shall meet to consider a vote on a joint resolution to determine whether that emergency shall be terminated.”⁸⁶ A six-month period is too long to allow a public health emergency to continue unchecked, but the general principle of legislative review of the executive’s declaration of a state of emergency applies. Applying this approach, the governor’s executive power to declare a state of public health emergency can be effectively narrowed by either requiring that both houses of the state legislature actively vote to renew the state of emergency beyond thirty days, or alternatively, the act could require, rather than just allow, that each house of the state legislature shall meet to consider a vote on a joint resolution to determine whether the state of public health emergency should be terminated.

It is worth noting that the original October 2001 draft of the MSEHPA had a much broader definition of “public health emergency,”⁸⁷ which was then seriously narrowed in the most recent draft of December 21, 2001 in response to widespread criticism of the original definition.⁸⁸ Nevertheless, even after the definition of “public health emergency” was narrowed, the scope of what is considered an

effectiveness of the War Powers Act, *see* John Hart Ely, *Suppose Congress Wanted a War Powers Act that Worked*, 88 COLUM. L. REV. 1379 (1988).

86. 50 U.S.C. § 1622(b) (2002).

87. MSEHPA Version 1 Draft, *supra* note 11, § 104(l) (defining “public health emergency” as “an occurrence or imminent threat of an illness or health condition, caused by bioterrorism, epidemic or pandemic disease, or novel and highly fatal infectious agent or biological toxin, that poses a substantial risk of a significant number of human fatalities or incidents of permanent or long-term disability. Such illness or health condition includes, but is not limited to, an illness or health condition resulting from a natural disaster.”).

88. *See, e.g.,* Wendy E. Permet & Wendy K. Mariner, *A Health Act That Jeopardizes Public Health*, BOSTON GLOBE, Dec. 1, 2001, at A15 (“The definition of an emergency is extremely broad and seemingly without review, raising troubling constitutional questions. . . . Read literally, the Model Act allows the declaration of an emergency, triggering all its coercive powers, every flu season.”); *AAPS Analysis, supra* note 9 (“Under this Act, any Governor could appoint himself dictator by declaring a ‘public health emergency.’ . . . What is a public health emergency? It is whatever the Governor decides it should be.”).

emergency continues to elicit a great deal of criticism.⁸⁹ While the criticism of the Model Act's emergency powers provision is understandable given the deep-rooted fear of abuse of power by executives in our country, there are certainly circumstances where the executive may have a legitimate need to invoke emergency powers.⁹⁰ As Alexander Hamilton wrote in the Federalist Number 36, "[t]here are certain emergencies of nations in which expedients that in the ordinary state of things ought to be forborne become essential to the public weal. And the government, from the possibility of such emergencies, ought ever to have the option of making use of them."⁹¹ While the federal government and all states already consider threats to the public health to be a legitimate basis for declaration of a state of emergency,⁹² many of the current laws are antiquated and do require reconsideration. National emergency tends to be associated with national security, and before September 11, few people linked public health and national security in their minds. Unfortunately, it took an anthrax scare in the fall of 2001 to make the general population aware that threats to the public health are real and may indeed rise to the level of threats to the national security.⁹³ Thus, it is important to

89. See, e.g., Jennifer King, *Power Grab: The States in a State of Emergency, The Model Emergency Health Powers Act*, ALEC ISSUE ANALYSIS (American Legislative Exchange Council, Washington, D.C.), Jan. 2002, at 1-2, available at <http://www.alec.org> (stating that "powers granted under the MEHPA are duplicative and unnecessary" and that the "vagueness of the language and lack of definitions of key terms [in the MSEHPA] leaves too many questions unanswered"); Robert Cihak & Michael Glueck, *CDC Proposal Overreaches*, USA TODAY, Jan. 3, 2002, at 10A (arguing against the MSEHPA, with one of the grounds for objection being that the governor can declare a public health emergency without consulting public-health officials so long as he declares that "a potentially fatal threat could exist").

90. For a superb overview of the philosophical underpinning and historical development of emergency powers doctrine, and modern scholarship on the questions that follow from this doctrine, see Jules Lobel, Comment, *Emergency Power and the Decline of Liberalism*, 98 YALE L.J. 1385 (1989).

91. THE FEDERALIST NO. 36, at 223 (Alexander Hamilton) (Clinton Rossiter ed., 1961).

92. For an overview of federal and state grants of emergency powers to the executive, see Lobel, *supra* note 90, at 1408-1409 fn.117-120.

93. See Gerberding, Hughes & Koplan, *Bioterrorism Preparedness and Response: Clinicians and Public Health Agencies as Essential Partners*, 287 JAMA 898 (2002); Leonard Cole, *When Smallpox Failed*, N.Y. TIMES, Dec. 2, 2001, § 4, at 5; Lawrence Altman, *Plan for Smallpox Rules Out Mass Vaccination*, N.Y. TIMES, Nov. 27, 2001, at B7; Sheryl Gay Stolberg, *He Routed Smallpox, Now Tackles*

recognize the very real dangers that public health emergencies pose and that there is a need to plan for effective response well in advance of such emergencies.⁹⁴

Large scale public health threats, be they the result of bioterrorist attack or an outgrowth of a naturally occurring epidemic, require extraordinary measures by the government. Use of quarantine, travel restrictions and the commandeering of private resources such as hospitals and pharmacies become measures citizens may be willing to bear in order to protect their own health and to limit the exacerbation of an already acute problem. At such tense moments, it is important that our laws permit flexibility of response for fear that they otherwise might be ignored altogether or adhered to with disastrous consequences.

This Article proceeds from the assumption that planning for all exigencies within the framework of law is preferable to planning for extralegal responses in the face of necessity. When the pressure on the system is too great, emergency powers help maintain proper equilibrium. The tension between the need for vigorous adherence to our laws in even the most trying of times and the need to relax them when necessity dictates has been constant throughout the history of the United States. As Professor Jules Lobel has written, “[a] fundamental tension exists in any constitutional order between the basic premise of government constrained by law and the perceived need for unfettered, discretionary power to confront dire emergencies and crisis.”⁹⁵

Emergency powers are not to be invoked lightly, for they pull at the Constitution and force tremendous strain upon the governmental structures. Nevertheless, necessity sometimes requires that the civil liberties of the individual give way to the greater good and that the wise system of checks and balances built into the Constitution be relaxed. This is the underlying logic of states of emergency—they are the release valves that enable laws to be as robust as they are in normal circumstances. Without emergency powers, the law may end up being

Bioterror, N.Y. TIMES, Nov. 18, 2001, §1B, at 1; Judith Miller, U.S. Set to Retain Smallpox Stocks, N.Y. TIMES, Nov. 16, 2001, at A1; Sheryl Gay Stolberg & Judith Miller, Bioterror Role an Uneasy Fit for the C.D.C., N.Y. TIMES, Nov. 11, 2001, §1A, at 1; Sheryl Gay Stolberg, Struggling to Reach a Consensus on Preparations for Bioterrorism, N.Y. TIMES, Nov. 5, 2001, at B1; Lawrence Altman, U.S. Sets Up Plan to Fight Smallpox in Case of Attack, N.Y. TIMES, Nov. 4, 2001, § 1A, at 1.

94. Dr. Jeffrey Koplan, Director of the Centers for Disease Control, Address, *Building Infrastructure to Protect the Public's Health*, Sept. 21, 2001, available at <http://www.phppo.cdc.gov/documents/koplanastho.pdf>

95. Lobel, *supra* note 90, at 1386.

disregarded altogether; or, as Oliver Cromwell would have had it: “[n]ecessity hath no law.”⁹⁶ Some of the opponents of the MSEHPA have expressed similar sentiments to those of Cromwell, rejecting the idea that the law should incorporate a degree of flexibility that would allow adaptation to even the most trying circumstance and accepting that the law may have to be disregarded if necessity should so require. For example, MSEHPA critics Robert Cihak and Michael Glueck have argued that “government officials throughout the ages have bent the law in response to unprecedented circumstances; we’re sure officials would be so inclined and adept if a real need arose. In the meantime, expanded state government ‘emergency’ powers likely would be abused more often than appropriately used.”⁹⁷ While the arguments in favor of building emergency powers into law are powerful, they inevitably give individuals pause and require that Americans pay heed to the rational fears of skeptics.

The concerns expressed regarding broad grants of authority are natural and reasonable responses to the corrupting nature of power, but the wisest approach is to properly tailor emergency powers and the circumstances that trigger them rather than to do away with them altogether. While the MSEHPA could benefit from further narrowing on the procedural latitude given the governor invoking a public health emergency, the broad definition of triggering events listed under the definition of “public health emergency” in the Model Act is not as problematic as some critics of the law argue. Precisely because these powers may need to be invoked in circumstances that have not yet been contemplated, the definition meant to encompass them must be broad. However, because the list of events triggering an emergency is broad, it is crucial that greater safeguards be placed on the executive in the form of relatively prompt review of the governor’s declaration of a state of emergency by the legislature.

V. SPECIAL POWERS DURING A STATE OF PUBLIC HEALTH EMERGENCY—PROTECTION OF PERSONS

This Part discusses compulsory medical examination, testing, vaccination and treatment, as well isolation and quarantine. These issues raise complex and troubling constitutional questions that force us to seriously consider where the outer limits of civil liberties

96. *Id.* (quoting Oliver Cromwell).

97. Cihak & Glueck, *supra* note 9.

protections lie and to determine the proper balance between an individual's liberty interests and the community's public health interests.

A. Compulsory medical examinations, testing, vaccination, and treatment

Sections 602 and 603 of the MSEHPA lay out the contours of the state's authority to administer compulsory medical examinations, tests, vaccinations and/or treatments during a state of public health emergency. Section 602 authorizes the public health authority to "perform physical examinations and/or tests as necessary for the diagnosis or treatment of individuals."⁹⁸ Section 603 gives the public health authority the ability to "exercise . . . emergency powers over persons . . . [t]o vaccinate persons as protection against infectious disease and to prevent the spread of contagious disease or possibly contagious disease."⁹⁹ Based on this provision, the public health authority may exercise its authority to adopt a regime of forced vaccination. Section 603 also serves as the basis for the public health authority to "exercise . . . emergency powers over persons . . . to treat persons exposed to or infected with disease," including forced treatment where necessary.¹⁰⁰ The one limitation on the public health authority's ability to compel examinations, testing, vaccination and/or treatment is that such measures cannot be of a nature that they would be "reasonably likely to lead to serious harm to the affected individual."¹⁰¹ Thus, the Model Act allows for compulsory physical examination, testing, vaccination and medical treatment so long as the state's action is not likely to lead to serious harm under a reasonableness standard.

Questions of compulsory examination, testing, vaccination and treatment once again raise concerns regarding the proper balance between individual liberties and collective public health interests.¹⁰² There is no question that compulsory examination, vaccination and treatment are serious violations of bodily integrity that deprive

98. MSEHPA, *supra* note 11, § 602.

99. *Id.* § 603.

100. *Id.* § 603(b).

101. *Id.* §§ 602(b), 603(a)(2), 603(b)(2).

102. See discussion in text accompanying *supra* notes 48-55.

subjected individuals of some degree of liberty.¹⁰³ The individual has a constitutional right to refuse treatment based on the concept of bodily integrity.¹⁰⁴ This right to refuse treatment is also rooted in the common law.¹⁰⁵ While the Supreme Court has repeatedly affirmed a right of bodily integrity, it has also held that this right is not absolute.¹⁰⁶

As Justice Tom C. Clark stated in *Breithaupt v. Abram*: “[a]s against the right of an individual that his person be held inviolable . . . must be set the interests of society.”¹⁰⁷ Likewise, Gostin points out that compulsory measures may be necessary in order to satisfy one or more of the state’s interests in preserving public health in the case of a public health emergency. Gostin then identifies three distinct state interests.¹⁰⁸ First, the state has an interest in preserving the lives of infected persons.¹⁰⁹ Second, the state has an interest in preventing harm to others.¹¹⁰ Third, the state has an interest in preserving the effectiveness of drug-based therapies for infectious diseases.¹¹¹ For the purposes of our discussion, these three state interests provide a useful guide to the societal interests that must be weighed against those of the individual.

Balancing individual liberty interests against the state’s communal interests, the Supreme Court has often tolerated restrictions of individual liberty in order to further state interests.¹¹² While forcing

103. See, e.g., *Washington v. Harper*, 494 U.S. 210, 229 (1990) (stating that “The forcible injection of medication into a nonconsenting person’s body represents a substantial interference with that person’s liberty.”).

104. GOSTIN, *supra* note 27, at 217-19 (discussing the constitutional right to refuse treatment) (citing *Riggins v. Nevada*, 504 U.S. 127 (1992) (holding that in compelling physical examination and treatment, the state must demonstrate an “overriding justification and determination of medical appropriateness”); *Rivers v. Katz*, 495 N.E.2d 337, 343 (N.Y. 1986) (holding that, under the New York State Constitution, individuals have the right to “control the course of their medical treatment”)).

105. See, e.g., *In re Storar*, 420 N.E.2d 64, 70 (N.Y. 1981) (stating that, at common law, every competent adult has a “right to determine what should be done with his own body”) (cited in GOSTIN, *supra* note 27, at 217-218).

106. *Mills v. Rogers*, 457 U.S. 291, 299 (1982) (cited in GOSTIN, *supra* note 27, at 219).

107. *Breithaupt v. Abram*, 352 U.S. 432, 439 (1957).

108. GOSTIN, *supra* note 27, at 219-220.

109. *Id.*

110. *Id.* at 220.

111. *Id.* at 221.

112. See *Cruzan v. Director, Mo. Dep’t of Health*, 497 U.S. 261 (1990); *National Treasury Employees Union v. Ron Raab*, 489 U.S. 656 (1989); *Washington v. Harper*, 494 U.S. 210 (1990)) (all cases cited in GOSTIN, *supra* note 27, at 219).

treatment upon an unwilling competent adult in order to preserve that person's own life has been held a violation of the person's right to refuse treatment,¹¹³ courts are willing to allow compulsory treatment where the person poses a danger to others.¹¹⁴ However, compulsory treatment may be held unconstitutional where the person did not pose a danger to others or the treatment was not medically appropriate.¹¹⁵ In the case of forced vaccination, the Supreme Court has found that vaccination is a constitutional exercise of the state's police powers due to its crucial importance for execution of the state's obligation to protect communal public health.¹¹⁶ Nevertheless, the state must implement forced vaccination schemes in a reasonable manner, so that the state cannot force an individual to be vaccinated if it is clear that the individual to be vaccinated would have an adverse reaction¹¹⁷—a requirement which clearly informed the drafting of sections 602(b), 603(a)(2) and 603(b)(2) of the Model Act.¹¹⁸ Thus, the state can only compel medical examination or treatment where the individual poses a significant risk of transmission, and the treatment has clear medical benefits.¹¹⁹

In order to enforce the examination and testing provisions in section 602, the public health authority is authorized to isolate or quarantine “any person whose refusal of medical examination or testing results in uncertainty regarding whether he or she has been exposed to or is infected with a contagious or possibly contagious disease or otherwise

113. See, e.g., *Cruzan*, 497 U.S. at 281 (stating that “It cannot be disputed that the Due Process Clause protects an interest in life as well as an interest in refusing life-sustaining medical treatment.”).

114. See, e.g., *Jacobson v. Massachusetts*, 197 U.S. 11, 26 (1904) (stating that the state may require its citizens to submit to medical procedures in order to eliminate a health threat to the community); *Kulak v. City of New York*, 88 F.3d 63, 74 (2d Cir. 1996) (stating that a patient has the right to determine what shall be done with his or her own body and that the patient's right to control the course of their own medical treatment may be set aside only in narrow circumstances, including those where the patient presents a danger to himself or other members of society); GOSTIN, *supra* note 27, at 220.

115. See, e.g., *Riggins v. Nevada*, 504 U.S. 127 (1992) (stating that “forcing antipsychotic drugs on a convicted prisoner is impermissible absent a finding of overriding justification and a determination of medical appropriateness”) (cited in GOSTIN, *supra* note 27, at 220).

116. *Jacobson*, 197 U.S. 11.

117. *Id.* at 37-39.

118. See *supra* text accompanying note 101.

119. GOSTIN, *supra* note 27, at 220.

poses a danger to public health.”¹²⁰ Likewise, the Model Act allows for enforcement of its vaccination and treatment provisions by authorizing use of quarantine or isolation when an individual is “unable or unwilling for reasons of health, religion, or conscience” to undergo vaccination or treatment pursuant to section 603.¹²¹ As the next section will discuss, isolation and quarantine are legitimate tools in the prevention of spreading contagious disease.¹²² However, sections 602 and 603 of the Model Act envision the use of quarantine and isolation as a mechanism for enforcement of the statute’s provisions for forced examination, testing, vaccination and treatment even where a person’s refusal to undergo such measures results in mere “uncertainty regarding whether he or she has been exposed to” a possibly contagious disease. This seems to suggest that the civil commitment method of quarantine and isolation is being used as a penal mechanism in lieu of criminal prosecution, thereby bypassing the extensive criminal procedural protections that imprisonment would necessitate.

The Supreme Court has repeatedly discussed the clear distinction between civil commitment proceedings and criminal prosecutions, and concluded that civil commitment, like criminal imprisonment requires due process protection.¹²³ The key difference is that civil commitment requires a lower standard of proof than the “beyond a reasonable doubt standard” of criminal prosecutions.¹²⁴ In the *Addington v. Texas* case, involving civil commitment for mental illness, the Court declared that it had repeatedly “recognized that civil commitment for any purpose constitutes a significant deprivation of liberty that requires due process protection.”¹²⁵ The Court reasoned “that the individual’s interest in the outcome of a civil commitment proceeding is of such weight and gravity that due process requires the state to justify

120. MSEHPA, *supra* note 11, § 602(c).

121. *Id.* §§ 603(a)(3), 603(b)(3).

122. *See* discussion *infra* Part V-B.

123. *See, e.g.,* *Vitek v. Jones*, 445 U.S. 480 (1980); *Addington v. Texas*, 441 U.S. 418 (1979) (cited in GOSTIN, *supra* note 27, at 213 n.94); *Jackson v. Indiana*, 406 U.S. 715 (1972); *Humphrey v. Cady*, 405 U.S. 504 (1972); *In re Gault*, 387 U.S. 1 (1967); *Specht v. Patterson*, 386 U.S. 605 (1967). *But see* *Morales v. Turman*, 562 F.2d 993, 998 (5th Cir. 1977) (“A state should not be required to provide the procedural safeguards of a criminal trial when imposing a quarantine to protect the public against a highly communicable disease.”) (cited in GOSTIN, *supra* note 27, at 215 n.110).

124. *In re Winship*, 397 U.S. 358, 370 (1970) (Harlan, J., Concurring) (cited in *Addington*, 441 U.S. at 424 (1979)).

125. *Addington*, 441 U.S. at 428.

confinement by proof more substantial than a mere preponderance of the evidence” but that the “beyond a reasonable doubt standard” historically reserved for criminal law was inappropriate for civil confinement cases that involved “medical ‘impressions’ drawn from subjective analysis and filtered through the experience of the diagnostician.”¹²⁶ Thus, the *Addington* Court concluded that due process in a civil commitment case requires a middle level standard of proof (e.g. “clear, unequivocal and convincing”).¹²⁷

The *Addington* Court also explained that one of the “significant reasons why different standards of proof are called for in civil commitment proceedings as opposed to criminal prosecutions” is that “[i]n a civil commitment state power is not exercised in a punitive sense.”¹²⁸ Thus, one of the defining features of civil confinement is that it is not used as a punitive measure. Where confinement is used as a form of punishment, the required standard of proof should be “beyond a reasonable doubt.”

In a situation involving a public health emergency, it is certainly possible that a person might fail to comply with a compulsory public health scheme and that this failure to comply may be reason for the state to isolate or quarantine such person under the criteria provided in sections 104(h) (isolation) and 104(o) (quarantine).¹²⁹ However, quarantine and isolation should not be used as a punitive measure. Section 604(a) contains a problematic presumption that “individuals or groups who have not been vaccinated, treated, tested, or examined pursuant to Sections 602 and 603” would be subject to isolation or quarantine under sections 104(h) or 104(o).¹³⁰ The resulting quarantine or isolation would be effectively the same as for a person deemed to fall under sections 104(h) and 104(o). However, the process would involve a blurring of civil confinement and punitive criminal prosecution. Quarantine and isolation under sections 104(h) and 104(o) is preferable because the former delinks the quarantine and

126. *Id.* at 430.

127. *Id.* at 431-32.

128. *Id.* at 428

129. For exact text of sections 104(h) and 104(o), see discussion accompanying *infra* notes 140-142.

130. MSEHPA, *supra* note 11, § 604(a) (“During the public health emergency, the public health authority may isolate (consistent with the definition of ‘isolation’ in Section 103(h) [sic]) or quarantine (consistent with the definition of quarantine in section 103(o) [sic]) an individual or group of individuals. This includes individuals or groups who have not been vaccinated, treated, tested, or examined pursuant to Sections 602 and 603.”).

isolation analysis from the compulsory treatment analysis. Using sections 104(h) and 104(o) as a basis for quarantine and isolation, rather than presuming that those failing to comply with compulsory public health measures would fall under 104(h) or 104(o), means that the law would force the public health authority to engage in a separate determination of whether quarantine or isolation is appropriate. This, in turn, reduces the likelihood that a public health official will be able to invoke quarantine and isolation as a punishment for failure to comply with a compulsory scheme. This proposed modification to the model law would help ensure that quarantine and isolation measures will not involve exercise of state power in a punitive sense and that these civil confinement measures will not be used as a way to bypass the higher standard of proof required for enforcement of punitive criminal laws.

The Model Act's provisions authorizing the state to forcibly subject individuals to examination, testing, vaccination and treatment are necessary in order to provide the state with the range of tools it may need in responding to a public health emergency. While the balance between individual interests, and communal interests is a tricky one, it is clearly possible for the state to exercise its compulsory powers in a constitutional manner. However, the presumption that individuals or groups refusing vaccination, treatment, testing or examination should be subject to quarantine and isolation leads to the problematic potential abuse of quarantine and isolation as a mechanism for enforcing compulsory public health measures. Legislators looking to the Model Act for guidance should consider alternative methods to enforcing the statute's emergency powers, including the possibility of arresting and trying these individuals in accordance with standard criminal procedures.

B. Isolation and quarantine

Sections 604 and 605 of the MSEHPA lay out provisions for implementation of isolation and quarantine in the case of a public health emergency.¹³¹ Quarantine and isolation are words often used interchangeably, but they are in fact distinct terms with clear technical meanings.¹³² "Quarantine" is generally defined as "detention, under enforced isolation, of persons suspected of carrying a contagious disease."¹³³ "Isolation" is the separation of people known to be infected

131. MSEHPA, *supra* note 11, §§ 604-605.

132. GOSTIN, *supra* note 27, at 209.

133. *Id.*

from the general population in such a manner so as “prevent or limit the transmission of the infectious agent.”¹³⁴ So quarantine applies to persons suspected of carrying a disease while isolation applies to persons known to be infected. In analyzing the scope and procedure of measures in the Model Act that require restriction of personal liberty, it is important to keep in mind this distinction between quarantine and isolation.

Any kind of restriction of personal liberty such as quarantine or isolation raises serious civil liberties questions.¹³⁵ The problem is that most of the cases reviewing quarantine measures predate the developments in fourteenth amendment jurisprudence of the later half of the twentieth century, and it is unclear how modern constitutional jurisprudence would impact judicial review of quarantine regulations. Thus far, quarantine measures have been assumed to be a legitimate exercise of the police power. In *Hennington v. Georgia*,¹³⁶ for example, the Supreme Court held that:

[Q]uarantine laws of every description, if they have real relation to the objects named in them, are to be referred to the power which the states have to make provision for the health and safety of their people. But neither inspection, quarantine nor health laws enacted by a State have been adjudged void, by force alone of the Constitution and in the absence of Congressional legislation, simply because they remotely, or even directly, affected or temporarily suspended commerce among the State and with foreign nations. Of course, if the inspection, quarantine or health laws of a State, passed under its reserved power to provide for the health, comfort, and safety of its people, come into conflict with an act of Congress, passed under its power to

134. *Id.* at 210.

135. For excellent surveys of the civil liberties issues relating to quarantine, see GOSTIN, *supra* note 27, at 203-216; Lawrence Gostin, *Tuberculosis and the Power of the State: Toward the Development of Rational Standards for the Review of Compulsory Public Health Powers*, 2 U. CHI. L. SCH. ROUNDTABLE 219 (1995); and Ronald Bayer & Amy Fairchild-Carrino, *AIDS and the Limits of Control: Public Health Orders, Quarantine, and Recalcitrant Behavior*, 83 AM. J. PUB. HEALTH 1471 (1993). *Cf.* Joseph Barber et al., *Large-Scale Quarantine Following Biological Terrorism in the United States: Scientific Examination, Logistics and Legal Limits, and Possible Consequences*, 286 JAMA 2711 (2001) (arguing that quarantine of entire populations in the event of a bioterrorism attack may not be the most effective method for containing the spread of infectious disease and that there may be better methods for limiting the spread of disease that are less likely to infringe upon civil liberties).

136. 163 U.S. 299 (1896) (*cited in* GOSTIN, *supra* note 27, at 206 n.19).

regulate inter-state and foreign commerce, such local regulations, to the extent of the conflict, must give way in order that the supreme law of the land—an act of Congress passed in pursuance of the Constitution—may have unobstructed operation.¹³⁷

Thus, we see that quarantine laws have historically been allowed as legitimate exercises of a State's police powers, and that the power to quarantine falls to the states unless such power is superceded by Congressional action taken in the interests of inter-state commerce. Indeed, there are federal quarantine laws in place, which give the federal government the power to use quarantine as a method of preventing the spread of disease.¹³⁸ While a federal quarantine is the likely mechanism to be used should quarantine be necessary to respond to a public health emergency that is national in scope, it is important that each state have its own quarantine laws to respond to local public health emergencies or to implement a federal response at the local level.¹³⁹

The MSEHPA is a great step forward in laying the groundwork for debate on reconsideration and improvement of state quarantine laws. However, the MSEHPA quarantine and isolation provisions do have some problematic elements. As a general rule, the Model Act empowers the state public health authority to "isolate . . . or

137. *Hennington*, 163 U.S. at 309; *see also* *Compagnie Francaise de Navigation a Vapeur v. La. State Bd. of Health*, 186 U.S. 380 (1902) (reasoning that "whenever Congress shall undertake to provide . . . a general system of quarantine, or shall confide the execution of the details of such a system to a National Board of Health, or to local boards, as may be found expedient, all state laws on the subject will be abrogated, at least so far as the two are inconsistent. But, until this is done, the laws of the State on the subject are valid.") (cited in GOSTIN, *supra* note 27, at 206 n.20).

138. 42 U.S.C. §§ 243, 264, 266-272 (2002). The federal quarantine laws were recently invoked by President Bush when he added SARS (Severe Acute Respiratory Syndrome) to the list of quarantinable diseases as a "pragmatic step of readying all options" in tackling SARS. E.O. 13295, April 4, 2003, 68 Fed. Reg. 17,255; Press Release, U.S. Department of Health and Human Services, Statement by HHS Secretary Tommy G. Thompson Regarding Executive Order on Quarantinable Diseases (Apr. 4, 2003), *available at* <http://www.hhs.gov/news/press/2003pres/20030404a.html>.

139. *See* State Emergency Health Powers and the Bioterrorism Threat, *supra* note 7, at 5, 8-13.

quarantine . . . an individual or group of individuals.”¹⁴⁰ For purposes of this provision, the Model Act defines “quarantine” as:

the physical separation and confinement of an individual or groups of individuals, who are or may have been exposed to a contagious or possibly contagious disease and who do not show signs or symptoms of a contagious disease, from non-quarantined individuals, to prevent or limit the transmission of the disease to non-quarantined individuals.¹⁴¹

Clearly distinguishing quarantine from isolation, the MSEHPA defines “isolation” as “the physical separation and confinement of an individual or groups of individuals who are infected or reasonably believed to be infected with a contagious or possibly contagious disease from non-isolated individuals, to prevent or limit the transmission of the disease to non-isolated individuals.”¹⁴²

The definitions of both “quarantine” and “isolation” in the Model Act are not sufficiently narrow. First of all, the inclusion of individuals who “may have been exposed” to a contagious disease is too broad.¹⁴³ Use of measures as restrictive as a quarantine should only be limited to people who have in fact been exposed to the disease. Second, the applicability of this provision to “possible contagious disease” is also far too open-ended. Once again, when implementing measures as coercive as quarantine, it is important that the criteria for determining to whom it applies must be based on scientific facts. This method should only be used when a disease is known to be contagious, through extensive scientific study. Furthermore, the quarantine and isolation power extends so far as to allow the public health authority to isolate and quarantine “individuals or groups who have not been vaccinated, treated, tested, or examined.”¹⁴⁴ This provision essentially allows the public health authority to quarantine anyone it suspects of being infected or having come in contact with someone who is infected, without requiring that there be any scientific basis for this determination such as a medical test. Legislators looking to this Model Act for guidance would be well advised to adopt a much more

140. MSEHPA, *supra* note 11, § 604(a).

141. *Id.* § 104(o).

142. *Id.* § 104(h).

143. *Id.* § 104(o).

144. *Id.* § 604(a). The “least restrictive alternative” language seems to be borrowed from case law holding that the state can resort to quarantine via confinement only when it could not achieve its objectives through less drastic means. *City of New York v. Doe*, 614 N.Y.S.2d 8 (App. Div. 1994) (cited in GOSTIN, *supra* note 27, at 215 n.104). *See also* text accompanying *infra* note 165.

restrictive approach to the application of quarantine and isolation measures.

The Model Act does lay down conditions and principles to which the public health authority is expected to adhere when isolating or quarantining individuals. First, the public health authority must use the “least restrictive means necessary” to prevent the spread of the disease.¹⁴⁵ Furthermore, isolated individuals must be physically separated from quarantined individuals,¹⁴⁶ lest those who are actually infected spread the disease to those in quarantine who are not infected.¹⁴⁷ The state must further monitor the status of infection of isolated and quarantined individuals to determine that the kind of confinement to which they are subjected is still necessary, and it must transfer infected individuals to isolation or release those individuals who pose “no substantial risk of transmitting” the disease.¹⁴⁸ The statute also establishes a minimum standard of care for persons in isolation or quarantine.¹⁴⁹ While these measures are not adequate as checks on the overbreadth of the definitions of quarantine and isolation discussed above, they are important steps in ensuring that any quarantine and isolation scheme will be implemented with adequate regard to the safety and well being of the affected individuals.

In addition to the aforementioned substantive protections, the Model Act lays out a detailed procedural scheme in an attempt to protect the due process rights of isolated and quarantined individuals.¹⁵⁰ Recognizing that the kinds of procedure that can be implemented may depend on the urgency of the emergency, the model formulates two kinds of procedures: one for “*temporary* isolation and quarantine *without* notice”¹⁵¹ and one for “isolation or quarantine *with* notice.”¹⁵² Temporary quarantine and isolation may be implemented via a written directive in circumstances where “a delay in imposing the isolation or quarantine would significantly jeopardize the public health authority’s ability to prevent or limit the transmission of a contagious

145. *Id.* § 604(b)(1).

146. *Id.* § 604(b)(2).

147. *See Jew Ho v. Williamson*, 103 F. 10 (C.C.N.D. Cal. 1900) (example of a quarantine that was implemented without separating the infected individuals from the non-infected ones).

148. MSEHPA, *supra* note 11, § 604(b)(5).

149. *Id.* § 604(b)(6).

150. *Id.* § 605.

151. *Id.* § 605(a)(1)(emphasis added).

152. *Id.* § 605(b)(1) (emphasis added).

or possible contagious disease to others.”¹⁵³ The model establishes specific content requirements for the directive and requires that the public health authority file a petition for a court order authorizing the isolation or quarantine measures taken within ten days after issuance of the written directive.¹⁵⁴ Ten days is a considerable amount of time to spend in isolation without a proper court order, so legislators may want to consider shortening this period of time. Otherwise, these procedural safeguards seem quite fair in circumstances in which the need for an urgent response does not allow for judicial review prior to subjecting an individual to quarantine or isolation.

A preferable alternative to that laid out above is the “isolation or quarantine with notice” provision, which involves the public health authority filing a written petition with the local trial court for an order authorizing the isolation or quarantine of an individual or group.¹⁵⁵ One of the requirements of this petition is that it include a “statement of compliance with the conditions and principles for isolation and quarantine of Section 604(b)” discussed above.¹⁵⁶ This provision further requires that the petition include a statement explaining the basis for isolation or quarantine and that it be accompanied by a sworn affidavit of the public health authority attesting to the facts asserted in the petition.¹⁵⁷ Section 605(b) further provides that a court hearing must be held within five days of the petition being filed.¹⁵⁸ Upon reviewing the petition, the court will determine whether “by a preponderance of the evidence, isolation or quarantine is shown to be reasonably necessary to prevent or limit the transmission of a contagious or possibly contagious disease to others.”¹⁵⁹ Should the court grant the order, it may only authorize isolation or quarantine for up to thirty days, though the public health authority may move to

153. *Id.* § 605(a).

154. *Id.*

155. *Id.* § 605(b).

156. *Id.* § 605(b)(2); *see supra* text accompanying notes 145-149.

157. MSEHPA, *supra* note 11, § 605(b)(2).

158. *Id.* § 605(b)(4). The provision does allow the public health authority to apply to continue the hearing date for up to ten days “in extraordinary circumstances and for good cause shown.” *Id.* In deciding whether to allow the continuance, the reviewing court is expected to “giv[e] due regard to the rights of the affected individuals, the protection of the public’s health, the severity of the emergency and the availability of necessary witnesses and evidence.” *Id.*

159. *Id.* § 605(b)(5).

continue isolation or quarantine for additional periods of up to thirty days each.¹⁶⁰

In addition to the above protections, the Model Act provides that those subject to isolation or quarantine under this law may apply to the trial court for habeas-like review, requiring that the public health authority show cause why the person(s) in question should not be released.¹⁶¹ This provision establishes a clear set of deadlines, limiting to three days the period from submission of the application to show cause to the actual court hearing.¹⁶² Quarantined or isolated individuals are also given the right to request a court hearing for remedies regarding breaches of the statute's conditions for quarantine or isolation.¹⁶³ Finally, the Model Act requires that the court appoint counsel to represent any individual(s) in hearings related to isolation or quarantine if they do not retain their own counsel.¹⁶⁴ These procedures do seem to be an effective way to ensure that the relevant authorities actually comply with the conditions and principles laid out in the law and, if implemented, would significantly reduce the risk that the due process rights of those quarantined or isolated will be violated. It is essential that any quarantine or isolation mechanism established by the state include provisions for this kind of judicial review.

It is also important to bear in mind that in addition to any statutory limitations on the quarantine and isolation powers, any quarantine or isolation program implemented by the state health authority must conform to constitutional standards requiring the state to demonstrate that there is a compelling public health interest, that the intervention is "well-targeted" and that there is no "less restrictive alternative" for preventing spread of the disease.¹⁶⁵ The Constitution also requires that the state provide individuals subject to detention

160. *Id.* §§ 605(b)(5)-(6).

161. *Id.* § 605(c).

162. *Id.*

163. *Id.*

164. *Id.* § 605(e).

165. GOSTIN, *supra* note 27, at 214. *See generally id.* at 213-215 (describing in detail the state's obligation to demonstrate that there is a compelling state interest, that the intervention is well-targeted, and that the state is adopting the least restrictive alternative) (citing *City of Cleburne v. Cleburne Living Ctr., Inc.*, 473 U.S. 432, 440 (1985); *Covington v. Harris*, 419 F.2d 617, 623 (D.C. Cir. 1969); *Lessard v. Schmidt*, 349 F. Supp. 1078, 1096 (E.D. Wis. 1972); *City of New York v. Doe*, 614 N.Y.S.2d 8 (App. Div. 1994)).

with procedural due process.¹⁶⁶ Given the procedural protections of section 605, it is likely that the Model Act's quarantine measures will satisfy procedural due process requirements should they be challenged in any court. However, the overbroad definitions of quarantine and isolation in section 104 of the Model Act¹⁶⁷ may not satisfy the requirement that such measures be "well targeted" and the "less restrictive alternative" available, and thus may not pass constitutional muster. Consequently, it is important that these definitions be narrowed in the manner discussed earlier in this section.¹⁶⁸

VI. CONCLUSION

The MSEHPA is an important piece of model legislation that has been and will continue to be used by many state legislators as they update their public health laws in response to public demands for improved preparedness on the part of the public health infrastructure. September 11 and the anthrax scare have brought a new sense of urgency to the project of public health law revision and galvanized state legislatures to begin updating often outdated legislation. The aim of these projects is to provide government authorities with necessary tools for quick and effective response to future public health threats resulting from bioterrorist attack or naturally occurring infectious or contagious disease. In order to evaluate the MSEHPA as a model for legislative reform, this Article analyzes three elements of the Model Act—measures to detect and track public health emergencies, the trigger for declaration of a public health emergency and the compulsory powers of the state over the person in a time of public health emergency—and concludes that while the Act lays down a generally sound framework for government response in a public health emergency, it does not strike the appropriate balance between granting authority to the state and protecting individual liberty.

First, the provisions for mandatory reporting of diseases and other health conditions overstep the bounds of privacy. Further, the Model Act should set stricter limits on the types of data that can be reported and the range of people to whom they may be reported. The Model Act also should provide a mechanism for patient consent for release of information and for judicial review in cases where patients do not give

166. *Id.* at 215 (citing *O'Connor v. Donaldson*, 422 U.S. 563, 580 (1975) (Berger, C.J., concurring); *Addington v. Texas*, 441 U.S. 418, 425-27 (1979); *Vitek v. Jones*, 445 U.S. 480, 491-92 (1980); *Project Release v. Prevost*, 722 F.2d 960, 971 (2d Cir. 1983)).

167. *See supra* text accompanying notes 140-149.

168. *Id.*

consent. Second, the section of the Model Act setting the conditions for declaration of a public health emergency, while justifiably broad in order to encompass the broad range of unforeseen possibilities, must incorporate greater safeguards on the executive in the form of relatively prompt review of the governor's declaration of a state of emergency by the legislature. Third, the compulsory powers granted to the state under the Model Act—examination, testing, vaccination and treatment—are justifiable as long as they are implemented in a manner consistent with the Constitution. However, the Model Act's use of quarantine or isolation as a mechanism for enforcement of the state's compulsory powers must be reconsidered. Finally, the definition of quarantine and isolation in the MSEHPA must be more narrowly tailored to satisfy the constitutional requirements that such measures be well targeted and adopt the least restrictive alternative available. While these definitions must be refined, it is worth noting that the Model Act's procedural mechanisms for implementation and review of quarantine and isolation present a procedural framework for the most extreme form of compulsory government power over the person that strikes the right balance between individual liberties and community interests.

The MSEHPA does not reflect the most desirable response to public health emergencies. There is no question that effective government leadership and voluntary cooperation between citizens and local authorities are the cornerstones of effective public health response. However, it is important that the legal authority be in place for the government to utilize compulsory measures in the face of adverse citizen response. As the anthrax scare suggests, it is possible that even when the community comes together in response to tragic events that threaten the well being of a nation, individual citizens may take advantage of the situation to exacerbate rather than help it. The general model of cooperation seen in the fall of 2001 presents the ideal framework for effective response to a public health emergency; the MSEHPA presents the necessary tools for dealing with situations in which the ideal response does not take effect. The U.S. Constitution and laws are robust and resilient, and it is therefore crucial that Americans seek to build a degree of flexibility into them by allowing for the government to evoke emergency powers in the face of emergency. If citizens design appropriate responses to public health emergencies within this framework of laws rather than resigning themselves to extralegal responses in the face of necessity, Americans will ultimately be doing a great service to both their interests as individuals and their interests as members of a community.