The Catholic University of America, Columbus School of Law
CUA Law Scholarship Repository

Scholarly Articles and Other Contributions | Faculty Scholarship

2009

Reshaping the Common Good in Times of Public Health Emergencies: Validating Medical Triage

George P. Smith II
The Catholic University of America, Columbus School of Law

Follow this and additional works at: https://scholarship.law.edu/scholar

Part of the Health Law and Policy Commons, and the Public Law and Legal Theory Commons

Recommended Citation
George P. Smith, II, Reshaping the Common Good in Times of Public Health Emergencies: Validating Medical Triage, 18 ANNALS HEALTH L. 1 (2009).

This Article is brought to you for free and open access by the Faculty Scholarship at CUA Law Scholarship Repository. It has been accepted for inclusion in Scholarly Articles and Other Contributions by an authorized administrator of CUA Law Scholarship Repository. For more information, please contact edinger@law.edu.

Re-shaping the Common Good in Times of Public Health Emergencies:

Validating Medical Triage

*George P. Smith, II**

> It is widely believed that anything done in the public interest is good for society and good for the individual members of society. When the 'anything' involves the health of the people, the belief is rapidly converted to doctrine. Doctrine nowadays means law.[1]

I. INTRODUCTION AND OVERVIEW

There are three major categories of emergencies: (1) those arising from "grave political crises," such as terrorist attacks and armed international conflicts; (2) those resulting from economic events, such as the Great Depression; and (3) those born out of natural disasters, such as Hurricane Katrina, and wider "*force majeure*" events such as strikes.[2] It has been noted, correctly, that modern society faces dangers comparable to those the Nation was forced to deal with at the beginning of World War II.[3] Today,

---

* Professor of Law, The Catholic University of America. In July, 2007, I was a Visiting Fellow at The Center for Law, Ethics, and Health at The University of Michigan's School of Public Health, where this article was researched and written in final form. I thank the Director of the Center, Professor Peter D. Jacobson, for his generous hospitality and support during my stay. I acknowledge, with pleasure, the student research assistance of Diane Paulitz.

1. Theodore Cooper, *Shattuck Lecture – In the Public Interest*, 300 NEW ENG. J. MED. 1185, 1185 (1979).

2. Oren Gross, *Chaos and Rules: Should Responses to Violent Crises Always be Constitutional?*, 112 YALE L.J. 1011, 1025 n.44 (2003).

3. RICHARD A. POSNER, NOT A SUICIDE PACT: THE CONSTITUTION IN A TIME OF NATIONAL EMERGENCY 3 (2006) [hereinafter POSNER, NOT A SUICIDE PACT]. See Bernadette Meyler, *Economic Emergency and The Rule of Law*, 56 DEPAUL L. REV. 539 (2007), for an excellent analysis of economic emergencies and states of political emergency. See generally Eric A. Posner & Adrian Vermeule, *Emergencies and Democratic Failure*, 92 VA. L. REV. 1091 (2006) for an analysis recounting the governmental response to historical public emergencies, and suggesting increased judicial deference as a mechanism to improve response in modern-day emergencies.

therefore, emergencies of one kind or another have almost become the "coin of the realm."[4]

In emergencies of any character, the Nation's survival is imperiled and the Executive Branch must act to preserve the social order.[5] Also, it has been argued that the Executive has a "penumbra of powers" in excess of those enumerated in Article II of the Constitution which allows him to act decisively in times of emergency.[6] Of utmost concern to civil libertarians, with regard to the execution of these powers, is that individual liberties or civil rights—particularly minority interests of an ethnic, ideological or political character—will be subject to abuse, compromise, or even total abrogation.[7]

As early as 1824, the United States Supreme Court recognized the power of the states to compel isolation and quarantine.[8] In 1905, the Court determined in *Jacobson v. Massachusetts* that citizens are subject to certain

---

4. This phrase is adapted from its original Old English usage to illustrate that emergencies are now quite common. *Compare* 1512, 4 HEN. 8, c. 19 § 14 (acknowledging "[s]ilver and prente of the coigne of this realme"), *with* The Cambridge History of English and American Literature (A.W. Ward & A. R. Waller eds., bartleby.com 2000), http://www.bartleby.com/217/1112.html ("Shakespeare, Fletcher, Jonson, Spenser, had imposed themselves on criticism; and criticism grew rich (as it always does) by accepting and passing these great poets as current coin of the realm."). See KENNETH R. WING, ET AL., PUBLIC HEALTH LAW (2007), for reference citations to past emergencies as well as ongoing ones, such as HIV/AIDS and terrorism.

5. Meyler, *supra* note 3, at 541-43. See WING, *supra* note 4, where the authors present and analyze the past epidemics of cholera in 1832, 1849, and 1866, *id.* at 1, wider epidemics, *id.* at 152-53, tuberculosis, *id.* at 153 *passim*, HIV/AIDS, *id.* at 188 *passim*, Severe Acute Respiratory Syndrome (SARS), *id.* at 199 *passim*, influenza in 1918-19, *id.* at 217 *passim*, and bioterrorism, etc., *id.* at 234 *passim*. *See generally* RICHARD A. POSNER, CATASTROPHE: RISK AND RESPONSE 247 (2004) (noting the Black Death as one of the most horrific pandemics in history as it dissipated a significant part of the European population).

6. Meyler, *supra* note 3, at 548-49; *see, e.g.*, Robert T. Stafford Disaster Relief and Emergency Assistance (Stafford) Act, 42 U.S.C. §§ 5121–5206 (2000 & Supp. V 2005) (conferring broad powers upon the President in times of domestic emergencies). *But see* Mark V. Tushnet, *Emergencies and the Idea of Constitutionalism*, *in* AT WAR WITH CIVIL RIGHTS AND LIBERTIES 177-78 (Thomas E. Baker & John F. Stack, Jr., eds., 2006) (presenting three positions on American constitutionalism during wartime, one of which suggests that the Constitution's general standards should be applied).

7. RICHARD A. POSNER, LAW PRAGMATISM, AND DEMOCRACY 296 (2003); POSNER, NOT A SUICIDE PACT, *supra* note 3, at 3. *See generally* Adrian Vermeule, *Posner on Security and Liberty: Alliance to End Repression v. City of Chicago*, 120 HARV. L. REV. 1251 (2007) (analyzing Judge Richard Posner's judicial philosophy in two momentous decisions: Alliance to End Repression v. City of Chicago (Alliance I), 742 F.2d 1007 (7th Cir. 1984) (en banc), Alliance to End Repression v. City of Chicago (Alliance II), 237 F.3d 799 (7th Cir. 2001).

8. Gibbons v. Ogden, 22 U.S. (9 Wheat.) 1, 203 (1824). In assessing the extent of federal power under the Commerce Clause of the Constitution, the Court held (as to the licensing of vessels on waters within the jurisdiction of New York) that "[i]nspection laws, quarantine laws, health laws of every description" are within the Commerce Clause powers of Congress. *Id.*

laws which promote public health and safety for the benefit of the common good.[9]

Since that time, public health ethics (unlike bioethics, which stresses non-malfeasance as one of the cornerstones of individual health care decisions)[10] requires inherently at-risk individuals to suffer elements of harm—through isolation, quarantine, or compulsory vaccination—in order to advance the public good and secure the public-at-large from exposure to the spread of an infectious disease.[11]

Therefore, it is reasoned that individual inconvenience or sacrifice is minimal when compared with the communal benefits of health and safety.[12] Accordingly, under this health care management and decision-making model, the government seeks to balance individual liberty interests and rights against the communal benefits which may result from a limitation or restriction of those liberties. Typically, this balancing of individual rights does not outweigh community health benefits.[13]

When public health strategies are in place to deal with emergencies or pandemics, there is, perhaps, always a fear—if not a risk—that a police state could develop. This fear develops among the public because unnecessarily broad and arbitrary powers are conferred upon health officials with uneven levels of accountability.[14] While the government may limit personal freedoms in times of national emergencies, it must never

---

9. Jacobson v. Massachusetts, 197 U.S. 11, 24-27 (1905).

10. BARRY R. FURROW ET AL., BIOETHICS: HEALTH CARE LAW AND ETHICS 4 (5th ed. 2004).

11. LAWRENCE O. GOSTIN, PUBLIC HEALTH LAW AND ETHICS 13 (2002).

12. *Id.*

13. *Id.* Balancing tests are utilized in other areas of law as well; for example, the cost-benefit test is foundational to nuisance law. *See* George P. Smith, II, *The Morphogenesis of an Historical Revisionist Theory of Contemporary Economic Jurisprudence*, 74 NEB. L. REV. 658, 698 *passim* (1995). In public health governance law, the protection of a population's health is balanced against other policy objectives, normative values, and interests. After establishing that the public health action being advocated has a valid epidemiological and scientific basis, the proposed action should be tested by the principle of non-discrimination and the "least restrictive measure" test. Accordingly, healthcare measures that will interfere in an unreasonable manner with the public's pursuit and exercise of liberties or rights must be executed in reasonable ways which minimize such interferences, and are not seen as acts of invidious discrimination. Finding a point of equilibrium between these two policy objectives which, in turn, do not compromise legitimate efforts to advance and protect population health, is vexatious and, indeed, problematic. David P. Fidler, *Global Health Jurisprudence: A Time of Reckoning*, 96 GEO. L.J. 393, 402-03 (2008).

14. George J. Annas, *Bioterrorism, Public Health and Civil Liberties*, 346 NEW ENG. J. MED. 1337, 1338, 1341 (2002) [hereinafter Annas, NEW ENG. J. MED.]. *But see* POSNER, NOT A SUICIDE PACT, *supra* note 3, at 5 (acknowledging concerns of restrictions on civil liberties and a climate of fear created as a consequence of government actions during emergencies, but dismissing them largely as but inevitable by-products of such emergency powers). *See generally* George J. Annas, *Terrorism and Human Rights*, *in* IN THE WAKE OF TERROR: MEDICINE AND MORALITY IN A TIME OF CRISIS 34 (Jonathan D. Moreno ed., 2003).

disregard—nor abrogate—those freedoms without a set time frame for their reinstatement at the conclusion of the crisis.

Civil libertarians have asserted that in times of emergency, the courts, in exercising their powers of judicial review, should set stricter standards of review for governmental actions that go too far by reducing "the liberties of minorities while providing too much security to the public."[15] They point to the 1938 Supreme Court decision of *United States v. Carolene Products Co.*, which outlines the framework, or mechanism, for protection of these minority and marginal voices.[16] The central issue in *Carolene* was whether the Commerce Clause grants Congress the right to regulate filled milk under the Filled Milk Act of 1923.[17] Elevating the Court's holding—more particularly footnote four within the opinion—to a level of "sanctification" by those intent on curtailing the emergency powers of the state, simply tests the limits of credulity.[18] The argument is thus advanced that where laws target minorities, the courts should declare a clear preference for general laws as opposed to targeted laws—because general laws "require the self-interested majority to internalize costs."[19]

Civil libertarians overlook the notion that, taken in isolation, virtually *all* laws "harm"—to some degree—a minority population.[20] Accordingly, the application of *Carolene* should be limited to situations where a "discrete and insular minorit[y]" has been historically oppressed as a consequence of prejudice.[21] As such, *Carolene* becomes a faulty template for advancing the view that emergency powers exercised by the government must be subject to strict scrutiny because laws promulgated thereunder would have a discriminatory effect upon certain minorities. The discriminatory effect, stemming principally from isolation or quarantine that necessarily occurs when any emergency powers are exercised, is no more disproportionate to the groups historically discriminated against than to other socio-ethnic groupings within contemporary society that also have been victims of

---

15. Posner & Vermeule, *supra* note 3, at 1107.

16. United States v. Carolene Prods. Co., 304 U.S. 144 (1938).

17. *Id.* at 145-46.

18. *Id.* at 152, n.4. In footnote 4, Justice Stone writes, in part:

> It is unnecessary to consider now whether legislation which restricts those political processes which can ordinarily be expected to bring about repeal of undesirable legislation, it is to be subjected to more exacting judicial scrutiny under the general prohibitions of the Fourteenth Amendment than are most other types of legislation. . . . Nor need we consider whether similar considerations enter into the review of statutes directed at particular religious . . . national . . . or racial minorities . . . .

Id. (citations omitted).

19. Posner & Vermeule, *supra* note 3, at 1115. *See generally* GRIFFIN TROTTER, THE ETHICS OF COERCION IN MASS CASUALTY MEDICINE (2007).

20. Posner & Vermeule, *supra* note 3, at 1115-16.

21. Carolene, 304 U.S. at 152 n.4.

discrimination.[22] The unfortunate historical oppression of one group should be neither pivotal nor determinative of the validity of constitutional powers exercised during public health emergencies in order to safeguard the common good.

Today, when the government claims emergency powers in times of disaster, it is most generally justified in doing so under the rubric of the inherent powers of states to advance and maintain the common good through the exercise of their broad police powers.[23] Such broad police powers are, by their nature, "free from principled constraint."[24] In times of national emergencies, the judiciary must make careful efforts to maintain constitutional integrity in the decision-making process—an integrity upheld by a ready willingness to find a "balance between the interest in liberty from government restraint or interference and the interest in public safety."[25] Thus, of necessity, the point of equilibrium must shift as threats to the common good intensify and subsequently abate over the course of time.[26]

Ideally, the point of balance to test the limits of a right, and the point at which it may be re-calibrated, is "the point at which a slight expansion in the scope of the right would subtract more from public safety than it would add to personal liberty and a slight contraction would subtract more from personal liberty than it would add to public safety."[27] Not only do the weights placed upon the various competing values become crucial in reaching the optimal point of balance between liberty and security interests, but the effects of these weights on the actual values of the safety measures being challenged are as significant, if not definitive.[28] The absolute need for a point of balance was articulated in 1949 by Justice Robert H. Jackson

---

22. *Id.* at 144. *See generally* Symposium, *Women and Children Last? Feminist Perspectives on Disaster Relief and Recovery*, 24 WOMEN'S RTS. L. REP. 1 (2007) (providing insight to discrimination during national disaster recovery and the significant issues that women face during relief efforts).

23. Meyler, *supra* note 3, at 549-50.

24. MARKUS DIRK DUBBER, THE POLICE POWER: PATRIARCHY AND THE FOUNDATIONS OF AMERICAN GOVERNMENT 180 (2005).

25. POSNER, NOT A SUICIDE PACT, *supra* note 3, at 31.

26. *See id.*

27. *Id.*; *see also* Sharona Hoffman, *Responders' Responsibility: Liability and Immunity in Public Health Emergencies*, 96 GEO. L.J. 1913, 1919-24 (2008) (analyzing the weaknesses of the present theories of liability and sources of immunity for health emergency responders to public health emergencies, and proposing that a comprehensive immunity provision be incorporated into both federal and state laws which would, in turn, seek to codify a balancing point between the needs of disaster victims with the needs of the emergency responders and the interests that promote and safeguard the common good).

28. POSNER, NOT A SUICIDE PACT, *supra* note 3, at 32-33.

of the U.S. Supreme Court when he cautioned that the Constitution is not a "suicide pact."[29]

Part II of this Article discusses competing conceptions of the common good and posits that a new philosophy is required in public health emergencies. The goal of this new philosophy is to promote unambiguous and balanced normative standards for conduct that are necessary for consensus-based decision-making in times of emergency.

In Part III, this Article tests the extent to which public health emergencies necessitate a reinterpretation or reshaping of the common good[30] and concludes that such emergencies usually do necessitate such a reinterpretation or reshaping.[31] Next, this Article analyzes the extent to which the medical principle of *triage* is a relevant construct for allocating scarce medical resources during contemporary public health emergencies.[32] Part IV tests the efficacy or "codification" of this construct by applying it to The National Strategy of Pandemic Influenza,[33] and more particularly, to the plan for its execution developed by the Department of Health and Human Services.[34] It will be shown that under the rubric of cost-benefit

---

29. Terminiello v. Chicago, 337 U.S. 1, 37 (1949) (Jackson, J., dissenting) ("There is a danger that, if the Court does not temper its doctrinaire logic with a little practical wisdom, it will revert the constitutional Bill of Rights into a suicide pact.").

30. *See generally* RICHARD A. EPSTEIN, PRINCIPLES FOR A FREE SOCIETY: RECONCILING INDIVIDUAL LIBERTY WITH THE COMMON GOOD (2002) (positing that concern with the common good both authorizes state action and hems it in, and it need not abrogate protections of individual liberty and private property); Robert J. Lipken, *The Quest for The Common Good: Neutrality and Deliberative Democracy in Sunstein's Conception of American Constitutionalism*, 26 CONN. L. REV. 1039 (1994) (critiquing Sunstein's conception of deliberative democracy and suggesting that the ideal of governmental neutrality—legislation that does not favor one private actor over another—can be modified if such modifications are made with an eye toward promoting the common good while preserving the principles of capitalism).

31. POSNER, NOT A SUICIDE PACT, *supra* note 3, at 47; Posner & Vermeule, *supra* note 3, at 1094, 1115-21.

32. *Compare* George P. Smith, II, *Triage: Endgame Realities*, 1 J. CONTEMP. HEALTH L. & POL'Y 143, 145-47 (1985) [hereinafter Smith, *Endgame Realities*] (discussing the compromises inherent to the distribution and allocation of scarce medical resources), *with* James G. Hodge, Jr., *Legal Triage During Public Health Emergencies and Disasters*, 58 ADMIN. L. REV. 627, 630-631 (2006) (discussing the myriad legal issues that arise during public health emergencies, and how the prioritization and distribution of legal resources affect the efficacy of public health response efforts). Hodge defines legal *triage*—the counterpoint to medical *triage*—as efforts, during emergencies, to prioritize the vast array of unscripted, developing legal issues, (e.g., isolation, quarantine, and forced immunization) which arise and thereby seek an expeditious and legitimate response to the immediate emergency. *Id.*

33. HOMELAND SECURITY COUNCIL, NATIONAL STRATEGY FOR PANDEMIC INFLUENZA (2005), *available at* http://www.whitehouse.gov/homeland/nspi.pdf [hereinafter NATIONAL STRATEGY].

34. U.S. DEP'T OF HEALTH & HUMAN SERVS., PANDEMIC INFLUENZA PLAN pt. 1,

analysis, *triage* is, indeed, a contemporary tool for distributing scarce medical resources, and therefore embodies a correct use of utilitarian philosophy.[35]

Part V considers two model legislative proposals—the Model State Emergency Health Powers Act (MSEHPA)[36] and The Turning Point Model State Public Health Act (Turning Point Act)[37]—to further test the validity of *triage*.[38] In Part VI, the ultimate conclusion reached is that the ideal of attaining a level of Distributive Justice when allocating scarce medical resources has been achieved in the past,[39] using *triage*, and can continue to be met today in times of public health emergencies by its incorporation into federal policy-making instruments, as well as model state legislative proposals.

II. THE COMMON GOOD

The common good is often seen as a utilitarian ideal of attaining the greatest possible good for the greatest number of individuals,[40] or alternatively, as a complex collective of four notions: aggregative, common-common, supersessive, and integral.[41] Maritain thought of the

---

available at http://www.hhs.gov/pandemicflu/plan/pdf/HHSPandemicInfluenzaPlan.pdf [hereinafter HHS PLAN].

35. *See* discussion *infra* Part IV. *See generally* NANCY L. ROSENBLUM, BENTHAM'S THEORY OF THE MODERN STATE (1978).

36. MODEL STATE EMERGENCY HEALTH POWERS ACT (Ctr. for Law & the Public's Health at Georgetown & Johns Hopkins Univs., Proposed Official Draft 2001), http://www.publichealthlaw.net/MSEHPA/MSEHPA2.pdf.

37. TURNING POINT MODEL STATE PUB. HEALTH ACT (Pub. Health Stat. Modernization Nat'l Excellence Collaborative 2003), http://www.hss.state.ak.us/dph/improving/turningpoint/PDFs/MSPHAweb.pdf.

38. *See generally* 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) (analyzing the MSEHPA as a framework for states to modernize public health laws, but suggesting that significant alterations are necessary before ultimate adoption in order to protect privacy and civil liberty concerns during large scale public health emergencies).

39. *See* George P. Smith, II, *Distributive Justice and Health Care*, 18 J. CONTEMP. HEALTH L. & POL'Y 421, 426-30 (2002) [hereinafter Smith, *Distributive Justice*].

40. *See* Jeremy Bentham, Excerpt on the Phrase "Greatest Happiness of the Greatest Number," *in* THE CLASSICAL UTILITARIANS: BENTHAM AND MILL 92, 92 (John Troyer ed., 2003); GERALD J. POSTEMA, BENTHAM AND THE COMMON LAW TRADITION 372-73 (1986).

41. Daniel P. Sulmasy, *Four Basic Notions of the Common Good*, 75 ST. JOHN'S L. REV. 303, 303-07 (2001). Under the aggregative approach, the common good is seen as the aggregate of all the goods of all individuals in a particular social grouping. *Id.* at 304. Common good are the goods all citizens hold in common. *Id.* The supersessive common good is seen as a good which overrides all the individuals comprising a community (with collective security no doubt being such a good). *Id.* at 305-06. The integral common good derives from mutual human interaction. *Id.* at 306.

common good as "the good life of the multitude."[42] Surely, Rawls would have seen the common good as but a set of conditions allowing man to live under his own autonomous direction and finish his "projects" of choice, since there is no good held in common.[43] Classically, the common good is viewed as embracing the community and its institutions as they serve the good of all citizens, and not the limited or restricted goods of particular rulers or classes.[44] The human good, or the good for human beings, is rooted in the notion that man is both a rational and a political animal.[45]

If, as Hegel posits, the norms and the values of ethical life form the very essence of the common good, that good must therefore be seen as derivative of "conditions of rationality" found within a particular system or set of values of a given society.[46] Accordingly, determining what may be in the common good must be tied to testing the extent to which "currently shared values stipulate" an action to be inclusive.[47] Individual judgments are thus inconsequential. Rooted in the school of conservative relativism, Hegel's position holds that individuals must respect prevailing social values.[48] Indeed, when "questions of right" arise, they must be resolved "by recourse to prevailing values," rather than individual judgment.[49]

Hegel further postures that within each community, there is "a dominant mode of self-reflection" or, "a self-image" which, in turn, "is embodied in a particular structure of norms and values."[50] Competing ideologies within any given society merely result in differing self-images.[51] A new philosophy regarding public health emergencies is needed; society should not continue to accept the common good as but a course of action set by one autonomous social group, since such a course would discount or

42. Glenn N. Schram, *Pluralism and the Common Good*, 36 AM. J. JURIS. 119, 119 (1991) (analyzing, principally, the works of Jacques Maritain).

43. Sulmasy, *supra* note 41, at 307.

44. V. Bradley Lewis, *The Common Good in Classical Political Philosophy*, CURRENT ISSUES IN CATH. HIGHER EDUC., Winter 2006, at 25, 27.

45. *Id.* at 25-26. Common sense helps define the applicable borders of the common good. *See generally* Gary Lawson, *Ordinary Powers in Extraordinary Times: Common Sense in Times of Crisis*, 87 B.U. L. REV. 289, 307 (2007).

46. A. S. Walton, *Hegel, Utilitarianism, and the Common Good*, 93 ETHICS 753, 766 (1983).

47. *Id.*

48. *Id.*

49. *Id.* Conservative relativism determines what is in the common good by ascertaining "that which currently shared values stipulate as being so." Accordingly, this view supports the proposition that individual judgment has no relevance in the shared values of the common good. *Id.* at 766. *See also* 2 THE NEW SHORTER OXFORD ENGLISH DICTIONARY 2535 (Lesley Brown ed., 1993) (defining "relativism" as "a doctrine or theory which holds knowledge, truth, and morality are relative and not absolute").

50. Walton, *supra* note 46, at 767.

51. *Id.*

completely disregard ideological conflicts.[52] This new philosophy must recognize that competing disagreements of the common good can only be resolved satisfactorily "through a reconsideration of the language of which they are expressions."[53] Ideally, this philosophy will spawn a new and informed level of debate, which will ultimately spur the emergence of legislative frameworks for consensus-based decision-making that sets unambiguous and balanced normative standards for conduct.

III. *TRIAGE*: VALIDATING THE BALANCING TEST AS A TOOL FOR ALLOCATING SCARCE HEALTHCARE RESOURCES

A. Origins of the Modern Triage System

Because of the limited resources and the limited surge capacity of the health care system, a pandemic raises an unavoidable reference to—and dependence upon—the principle of *triage*.[54] *Triage* is a French word which means "sorting, picking, grading or selecting according to quality."[55] As early as 1717, *triage* was applied in the English language to denote the separation of wool and coffee beans according to quality.[56] Coffee beans were separated into three classes: best quality, middling and *triage*—the lowest grade.[57] Today, *triage* is defined as:

> The medical screening of patients to determine their priority for treatment; the separation of a large number of casualties, in military or civilian disaster medical care, into three groups: those who cannot be expected to survive even with treatment, those who will recover without treatment, and the priority group of those who need treatment in order to survive.[58]

Modern medical *triage* developed from the military system.[59] Napoleon's chief surgeon, Baron Dominique Jean Larrey, was the first to

---

52. *See id.* at 768.

53. *Id.* at 771.

54. James F. Childress, *Triage in Response to a Bioterrorist Attack*, *in* IN THE WAKE OF TERROR: MEDICINE AND MORALITY IN A TIME OF CRISIS 77 (Jonathan D. Moreno, ed., 2003).

55. *Id.* at 78; *see also* Smith, *Endgame Realities*, *supra* note 32, at 144.

56. Childress, *supra* note 54, at 78; *see also* Smith, *Endgame Realities*, *supra* note 32, at 144.

57. Childress, *supra* note 54, at 78; *see also* Smith, *Endgame Realities*, *supra* note 32, at 144.

58. Smith, *Endgame Realities*, *supra* note 32, at 144 (quoting STEDMAN'S MEDICAL DICTIONARY 1476 (W. Corsette ed., 4th unabridged law's. ed. 1976)).

59. Mary Faith Marshall & Martin Perlmutter, *The Construction of Ethics and Its Reconstruction in Critical Care: Ethical Theory and Practice*, *in* ETHICS IN CRITICAL CARE MEDICINE 34 (James P. Orlowski ed., 1999).

introduce *triage* as a concept for medical treatment.[60] Barron Larrey developed a system for removing soldiers from the battlefield which used then-novel selection criteria—not the soldier's rank (which was formerly the practice)—but rather the severity of the soldier's injury.[61] His goal was to provide efficient medical services.[62] As a result, he sorted casualties based on medical need: those most severely wounded received the highest priority, while those least severely injured waited to receive medical attention.[63] At that time, the concern was to conserve the scarce medical resources; specifically, the time and energy of medical personnel.[64] Concurrently, the ultimate objective was a speedy restoration of the fighting function.[65] The most "salvageable" were deemed those who could be rehabilitated in order to return to fight another day and thereby preserve the common good.[66] Before French *triage*, the wounded remained on the battlefield where they fell and would only be gathered and evaluated at the conclusion of battle—if even alive—and only then would they be sent to hospitals.[67]

During the United States Civil War, wounded soldiers were treated without regard to the type and severity of their condition.[68] In World War I, the United States took an example from the French and British armies by creating a sorting station for wounded soldiers and adopting the term *triage*.[69] World War I ambulance drivers devised a system of prioritizing in which wounded soldiers would be treated first, with the determinative selection factor being whether the soldier could easily be returned to battle.[70] Those who could not be returned to the battlefield were treated last, and some were even left to die.[71] The problem was that insufficient numbers of health care workers and medical facilities prevented simultaneous treatment of the wounded; consequently, difficult choices were made and some soldiers had to wait—or even pay the ultimate price.[72]

---

60. *Id.*
61. *Id.*
62. Smith *Endgame Realities*, *supra* note 32, at 144.
63. *Id.*
64. *Id.*
65. ALBERT R. JONSEN, THE NEW MEDICINE AND THE OLD ETHICS 45 (1990).
66. *See id.*
67. David E. Hogan & Julio Raphael Lairet, *Triage*, *in* DISASTER MEDICINE 12, 12 (David E. Hogan & Jonathan L. Burstein eds., 2007).
68. Childress, *supra* note 54, at 78; *see also* Smith, *Endgame Realities*, *supra* note 32, at 144.
69. Childress, *supra* note 54, at 78.
70. MILTON D. HEIFETZ, ETHICS IN MEDICINE 197 (1996).
71. *Id.*
72. *Id.*

In essence, the soldiers were treated under the "doctrine of common good," where winning the war was the top priority.[73] Accordingly, those who could not return to the battlefield were lower on the priority list.[74] Therefore, the military *triage* systems developed a utilitarian approach in which soldiers who needed limited treatment, and readily could be returned to battle, were given a higher priority while those with life-threatening wounds were given a lower priority.[75] According to the U.S. military policy, the purpose of *triage*-sorting is to evaluate and classify casualties for treatment and evacuation to accomplish "the greatest good for the greatest number of wounded and injured men."[76]

The military *triage* system, which began during World War I, has continued to develop and now governs the treatment of many patients in U.S. hospitals. Thus, patients presenting in a hospital emergency room are evaluated according to their medical condition and needs; in other words, the extent to which their injuries are life-threatening, urgent, semi-urgent or in need of no care,[77] and the likely outcome resulting from medical intervention.[78] Since healthcare workers are unable to treat everyone simultaneously, and medical resources are limited, *triage* allows (as discussed) for the actual rationing of these medical resources to "produce the greatest good for the greatest number by meeting human needs most effectively and efficiently under conditions of scarcity."[79] *Triage* relies on the utilitarian rationale and goal of achieving the maximum amount of good.[80] In a purely utilitarian approach, actions are judged based on their benefits and whether they provide maximum utility to the general welfare, with little or no regard for moral rights.[81] Moral questions may, indeed, be seen as inappropriate because in contemporary society, immorality governs interpersonal actions and is seen as a quality of personhood.[82]

---

73. *Id.*

74. *Id.*

75. Marshall & Perlmutter, *supra* note 59, at 34.

76. Childress, *supra* note 54, at 79 (quoting DOUGLAS A. RUND & TONDRA S. RAUSCH, TRIAGE 9 (1980)).

77. *Id.*

78. Childress, *supra* note 54, at 79; *see also* Marshall & Perlmutter, *supra* note 59, at 35 ("The severity of an individual's illness, or need, is generally tempered by survivability or chance of a successful outcome.").

79. Childress, *supra* note 54, at 79.

80. Smith, *Endgame Realities*, *supra* note 32, at 146-47.

81. *Id.* at 147.

82. DUBBER, *supra* note 24, at 180.

B. Contemporary Applications

Disaster *triage* is "a dynamic process of rapid evaluation and frequent reassessment of casualties presenting for evaluation."[83] The practice of disaster *triage*—especially at the pre-hospital or field stage—is admittedly, on consensus opinion, an inexact science,[84] or stated simply, a determination of what best preserves the "common good."[85] Although inextricably linked to utilitarianism, the philosophy of disaster *triage*—it is asserted—must be grounded in measurable or objective criteria by which a correct assessment is made of a victim's medical condition, instead of evaluating *triage*'s use or non-use based on the achievement of the "greatest good."[86] Efforts to standardize this level of *triage* in the field have proven difficult.[87]

One significant attempt at standardization was developed in California in 1983 and designated as *Simple Triage and Rapid Treatment* (START).[88] START, updated in 1994, is the most commonly used *triage* methodology in the United States.[89] It identifies, within one hour of a victim's trauma, three conditions which—if not treated—may lead to death: impaired breathing, head injury, and severe hemorrhage.[90] START is not designed for scenarios involving biological, chemical, or nuclear emergencies, and is faulted for its lack of differentiation regarding trauma types and estimations of prognosis or probability.[91] Another *triage* system has been developed in recent years to allow for rapid treatment during disasters: Move, Assess, Sort and Send (MASS).[92] Critical care decisions have yet to be tested fully under this operational system;[93] but it nonetheless is a positive indication of re-assessment and openness to change.

83. Hogan & Lairet, *supra* note 67, at 27.

84. *Id.* at 26-27.

85. JONSEN, *supra* note 65, at 45.

86. Hogan & Lairet, *supra* note 67, at 17, 19.

87. *Id.* at 24.

88. *Id.* at 25.

89. *Id.*

90. *Id.*

91. *Id.*

92. Hogan & Lairet, *supra* note 67, at 25-26. Another set of recommendations for patient treatment during a flu pandemic or other incidents involving mass casualties was issued in January, 2007. The Task Force for Mass Critical Care—a multidisciplinary and governmental group working under the Critical Care Collaborative Initiative—has offered proposals which resemble a battlefield triage approach in which, essentially, scarce health care resources are reserved for those most likely to survive. Triage teams in hospitals would determine those at high risk of death and very diminished chances of long term survival (including people 85 years of age or older). *See* Asha Devereaux et al., *Summary of Suggestions from the Task Force for Mass Critical Care Summit, January 26-27, 2007*, 133 CHEST (May Supp.) 1S (2008).

93. Hogan & Lairet, *supra* note 67, at 26.

C. Criticism and Disappointments

One critic of the *triage* system has opined that, today, the whole process for its use has been reversed—those with the most serious conditions are seen, evaluated and attended to first while the "merely mutilated," or salvageable, are forced to wait.[94] That certainly appeared to be the situation, in very large part, in the aftermath of Hurricane Katrina. At one staging center, those found to be in "[direct] need of medical attention" were rushed by ambulance to medical facilities in Baton Rouge, while those "in the best shape" were sent to Thibodaux some sixty minutes outside of New Orleans and sheltered in a gymnasium.[95] In retrospect, this was the most humane and reasonable policy to follow. But, in one particular case, tragic consequences flowed from its adoption. Because of this *triage* practice in New Orleans, a physician and two nurses at one particular hospital—Memorial Medical Center—were charged with "mercy killing" for injecting four patients with lethal doses of a combination of morphine and midazolam.[96] The injections were apparently ordered as a result of a *triage* ranking that found these patients—not considered in imminent danger of dying—nonetheless incapable of sustaining themselves without considerable pain or anxiety for a protracted period in the hospital before being evacuated.[97] Inside the hospital itself, some 250 patients were trapped and unable to be transferred; thus, they were subjected to a facility where temperatures were extreme and neither electricity nor waste disposal was available.[98] None of the four patients had, incidentally, asked for assistance in euthanizing themselves.[99] Subsequently, the prosecutor dropped the charges against the nurses,[100] and a Grand Jury refused to indict the physician; yet three of the four patients' families filed civil actions against her.[101]

---

94. JONSEN, *supra* note 65, at 46.

95. Tamer El-Ghobashy, *Homeless and Haunted: Triage Center Full of Misery*, DAILY NEWS (New York), Aug. 31, 2005, at 7; *see also* Felicity Barringer & Donald G. McNeil Jr., *Grim Triage for Ailing and Dying at a Makeshift Airport Hospital*, N.Y. TIMES, Sept. 3, 2005, at A13 (describing the dire situation at the Louis Armstrong International Airport which served as a triage center and hospital in the aftermath of Hurricane Katrina).

96. *Cf.* Tyler J. Curiel, *Murder or Mercy? Hurricane Katrina and the Need for Disaster Training*, 355 NEW ENG. J. MED. 2067 (2006) (suggesting that healthcare providers need better training to make competent provision of care decisions during disasters).

97. *Id.* at 2067.

98. *Id.* at 2067-68.

99. *Id.* at 2068.

100. Mary Foster, *Prosecutor Drops Case Against 2 Nurses in Four Post-Katrina Deaths*, WASH. POST, July 4, 2007, at A7.

101. Adam Nossiter, *Grand Jury Won't Indict Doctor in Hurricane Deaths*, N.Y. TIMES, July 25, 2007, at A10.

D. A Modified Utilitarian Approach Through the Principle of Distributive Justice

Because of the synergy of public health with human rights and the defense of individual rights and dignity, together with the recognition of the health of the greater community, a purely utilitarian approach to *triage* will not be adequate.[102] The utilitarian ethical theory as developed by Jeremy Bentham and John Stuart Mill is, as seen, the principle of the greatest happiness and actions that promote the greatest happiness are of most utility and are considered right.[103] However, a major objection to utilitarianism is that, as a society, certain acts are valued because they are fair and just and not because they maximize happiness.[104] A concern is that the utilitarian principle of the "greatest happiness for the greatest number of people" sacrifices some members of society to serve the happiness of the majority.[105]

An alternative decision model has been suggested which would be applicable to the response strategies to pandemics. Under this model, decisions would be made "in a rational manner and guided by a spirit of humanism which minimizes human suffering and maximizes the social good of each situation, a humane standard of justice will be achieved and *triage* will operate as a complement to its attainment."[106]

The principle of distributive justice requires that benefits and burdens ought to be distributed equitably, that resources ought to be allocated fairly, and that one ought to act in such a manner that no one person or group bears a disproportionate share of benefits or burdens.[107] A stockpile of countermeasures raises, in particular, two questions: in what order will citizens or patients receive these medical resources, and who will make the decision of how to allocate them?[108] This is a matter of distributive justice and would require the government to make very difficult decisions and to list, in order of priority, who is to receive these resources first and who must wait.

This prioritization of citizens for the distribution of medical resources seems harsh, and some may argue that patients should be provided treatment on a first-come-first-served basis or on a random selection

102. GOSTIN, *supra* note 11, at 97.

103. FURROW ET AL., *supra* note 10, at 8.

104. *Id.* at 11.

105. *Id.*

106. Smith, *Endgame Realities*, *supra* note 32, at 149; *see also* Smith, *Distributive Justice*, *supra* note 39, at 428-30 (suggesting that fair procedures for health care rationing must be shaped by the goal of humane care which reduces suffering, enhances the common good, and safeguards the dignity of the human spirit).

107. Smith, *Distributive Justice*, *supra* note 39, at 421 *passim*.

108. GEORGE P. SMITH, II, BIOETHICS AND THE LAW 47 (1993).

principle—based on chance—or based on the idea that no one should be given priority, since if all cannot be saved, then no one should be saved.[109] These are the three core principles of an egalitarian approach that attempts to promote equality among persons who require a scarce resource.[110] Because of the chaos a pandemic is likely to bring, a strategy that focuses on benefiting society at large is a useful one, however, it must also be "guided by a spirit of humanism" and not eliminate autonomy altogether in the process.[111]

In a pandemic, the influx of diseased or at-risk individuals will cause a surge on the health care system, inevitably raising the question of whether *triage* and rationing of scarce medical resources is unethical, unfair, and unjust.[112] The health care system will "face opposing moral obligations: to provide [good] health care and at the same time to protect the fabric of society."[113] During a dire situation like a pandemic, with thousands of citizens becoming stricken with a deadly influenza virus, rationing health care and medical resources will not only be necessary, but it will be just if applied correctly.[114] Because a large scale pandemic requires the distribution of health care and medical resources for the greater society, difficult choices will have to be made to determine who will receive certain kinds of care and treatment.[115] Health care practitioners will be forced to make difficult decisions in the way of "patient selection" for treatment and care, while refusing treatment to others.[116] *Triage* will be the tool used for patient selection,[117] which also will provide a method for just distribution of scarce medical resources.

---

109. Smith, *Endgame Realities*, *supra* note 32, at 147.

110. *Id.*

111. *Id.*

112. Childress, *supra* note 54, at 77.

113. Edmund D. Pellegrino, *Rationing Health Care: The Ethics of Medical Gatekeeping*, 2 J. CONTEMP. HEALTH L. & POL'Y 23, 38 (1986).

114. *Id.* at 38-39 ("[M]orally valid criteria can be established for both allocation and rationing of national resources dedicated to health and medical care."). *See generally* Kenneth Kipnis, *Overwhelming Casualties: Medical Ethics in a Time of Terror*, *in* IN THE WAKE OF TERROR: MEDICINE AND MORALITY IN A TIME OF CRISIS 95 (Jonathan D. Moreno ed., 2003).

115. Childress, *supra* note 54, at 78.

116. JOHN F. KILNER, WHO LIVES? WHO DIES? ETHICAL CRITERIA IN PATIENT SELECTION, at xi (1990).

117. Marshall & Perlmutter, *supra* note 59, at 34.

IV. PREPARING FOR THE ASIAN BIRD FLU PANDEMIC

A. Limited Resources

It is feared that within a relatively short period of time, the avian flu H5N1 virus will mutate into a form which will pass easily among persons throughout the world, thereby triggering a pandemic.[118] This, in turn, will create a public health crisis which will be focused, in very large measure, on the distribution of scarce medical resources.

An integral part of any strategy designed to combat this crisis will be the manufacture of an effective anti-viral vaccine. But, this vaccine cannot be produced until the pandemic influenza strain emerges and is identified.[119] In the meantime, prior to the production of the vaccine, the World Health Organization recommends that the anti-viral medication, Tamiflu, be prescribed.[120] The United States stockpiles Tamiflu treatment courses for eighty-one million people.[121] Rather than treat only those clinically affected with the virus, present plans call for the delivery of anti-viral drugs to those within an identified or specific area of infection.[122] As of July 2008, the estimated population of the United States was 303,824,640.[123]

Estimates have been made that if an influenza pandemic were to occur, much as one did throughout the globe in 1918-1920, some sixty-two million people, today, would succumb and die[124]—with ninety-six percent of these deaths occurring among developing countries.[125] Thirty-eight to eighty-nine million people in the United States would become clinically ill; eighteen to forty-two million would require outpatient care; 314,000 to

---

118. Michelle A. Daubert, Comment, *Pandemic Fears and Contemporary Quarantine: Protecting Liberty Through a Continuum of Due Process Rights*, 54 BUFF. L. REV. 1299, 1300 n.2 (2007).

119. Andrew C. Singer et al., *Potential Risks Associated with the Proposed Widespread Use of Tamiflu*, 115 ENVT'L HEALTH PERSP. 102, 102 (2007).

120. *Id.*; *cf.* N. Pieter O' Leary, *Combating Nature's Insurgency: Tamiflu and Vaccination in the Fight Against Avian Influenza*, 10 J. MED. & L. 469 (2006) (reporting on the fact that there is a very limited number of vaccine manufacturers today and only one in the United States).

121. Singer et al., *supra* note 119, at 102.

122. *Id.* The United States and WHO have an additional five to six million courses of Tamiflu for blanketing in specific regions once a confirmed outbreak occurs. *Id.*

123. THE CIA WORLD FACTBOOK (2008), *available at* https://www.cia.gov/library/publications/the-world-factbook/geos/us.html.

124. Christopher J. L. Murray et al., *Estimation of Potential Global Pandemic Influenza Mortality on the Basis of Vital Registry Data from the 1918-20 Pandemic: A Quantitative Analysis*, 368 THE LANCET 2211, 2211 (2006).

125. *Id.*

734,000 people would be hospitalized and 89,000 to 207,000 people of the U.S. population would die.[126]

B. A Pandemic Strategy for the United States

On November 1, 2005, President Bush released *The National Strategy for Pandemic Influenza*, the purpose of which is to guide the preparedness and response of the Nation to an influenza pandemic.[127] President Bush's pandemic strategy recognizes that vaccines and antiviral medications are available in limited supply.[128] The strategy sets out distribution protocols for these countermeasures.[129] The Administration plans to develop distribution mechanisms for antivirals and vaccines prior to and during a pandemic.[130] Another goal is to prioritize the allocation of vaccines and antivirals before an outbreak and update the prioritization when the pandemic arrives based on the knowledge of at-risk populations, supplies, and viral characteristics at the time of the outbreak.[131]

The following day, November 2, 2005, the U.S. Department of Health and Human Services (HHS) released *The Pandemic Influenza Plan* (*HHS Plan*).[132] HHS is the "United States Government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves."[133] The

---

126. Senator William Frist, Speech at the National Press Club, Pandemic: The Economy's Silent Killer (Dec. 8, 2005), *available at* http://www.volpac.org/index.cfm?FuseAction=News.Speeches&ID=21 (quoting statistics from the Centers for Disease Control & Prevention); *see also* HHS PLAN, *supra* note 34; Singer et al., *supra* note 119; Murray et al., *supra* note 124, at 2214; *cf.* Serafini *infra* note 137, at 3258 and accompanying text (reporting that the economic impact of a pandemic to the Nation would be range from $87 billion to $203 billion).

127. NATIONAL STRATEGY, *supra* note 33. *See generally* Alfred J. Sciarrino, *The Grapes of Wrath and the Speckled Monster, Part III: Epidemics, Natural Disasters and Biological Terrorism—the Federal Response*, 10 J. MED. & L. 429 (2006) (discussing historical governmental responses to epidemics with the use of compulsory vaccination and quarantine).

128. NATIONAL STRATEGY, *supra* note 33, at 5.

129. *Id.*

130. *Id.*

131. *Id.* at 6; *see also* Christopher Lee, *U.S. Flu Outbreak Plan Criticized*, WASH. POST, Feb. 2, 2008, at A3 (reporting on how anticipated consequences of a mild or serious flu outbreak would overwhelm medical centers, cause delays in emergency and routine care, and also impede the distribution of antiviral vaccines; thereby concluding that an infusion of billing must be made by Congress if a disease containment strategy is to be viable); Hoffman, *supra* note 27, at 1925 (recognizing the liability risk to vaccine producers and other medical suppliers during an emergency which would require them to produce the vaccine at accelerated rates).

132. Press Release, U.S. Dep't of Health & Hum. Servs., HHS Releases Pandemic Influenza Plan: Plan Provides Guidance to Prepare Nation's Health Care System for a Pandemic (Nov. 2, 2005), http://www.hhs.gov/news/press/2005pres/20051102.html.

133. HHS.gov, HHS: What We Do, http://www.hhs.gov/about/whatwedo.html (last

two main goals of the *HHS Plan* are to decrease the health impacts of the pandemic such as morbidity and mortality and to minimize the societal and economic impacts, thus providing a plan for guidance for state and local preparedness and response.[134]

In order to achieve these goals while working with limited resources, HHS has incorporated the concept of *triage* in its framework by suggesting priority groups of those who should receive the vaccines and antiviral medications.[135] Minimizing morbidity and mortality rates requires a conservation of those medical resources so they may be used to their full potential and are not wasted. An important theme that has been running through the decision-making process is that in order to limit the effects of a pandemic on society, the essential functions must be preserved.[136] Beyond health care costs, there will be significant social and economic impacts on the nation. People will probably avoid areas where they are likely to be in contact with many people, such as schools, malls, theaters, bars, and stadiums; thereby imposing large costs on vendors, workers, suppliers, and merchants.[137] When parents do not send their children to school, they will likely stay home with the children resulting in absenteeism from their jobs, thus decreasing productivity and affecting our economy.[138] Trade and transport of goods, foods, and services, both internationally and domestically, are likely to be halted.[139] Additionally, the tourism industry will fall victim to public fear during an outbreak.[140] With the loss of jobs, productivity, and fear pervading the lives of citizens, the social and economic impact will be significant.[141]

---

visited Nov. 12, 2008).

134. *See* NATIONAL STRATEGY, *supra* note 33, at 3. The entire 396-page Pandemic Influenza Plan is available online. HHS PLAN, *supra* note 34. Additionally, access is available to U.S. Government information on the avian and pandemic flu, Homeland Security Council issues, WHO releases, and ongoing updates to the National Strategy for the Pandemic Influenza Implementation Plan One Year Summary, via PandemicFlu.gov. The World Health Organization also provides a listing of its guidelines online. World Health Organization, WHO Guidelines on the Use of Vaccines and Antivirals During Influenza Pandemics 4 (2004), http://www.who.int/csr/resources/publications/influenza/11_29_01_A.pdf. The American Public Health Association has, as well, a comprehensive listing and discussion of health work force issues available at http://www.apha.org/advocacy/policy/APHA+Prescription+for+Pandemic+flu.htm.

135. NATIONAL STRATEGY, *supra* note 33, at 5-6.

136. HHS PLAN, *supra* note 34, pt. 1, app. D, at D-10.

137. Marilyn Werber Serafini, *The Big One?*, 37 NAT'L J. 3258, 3260 (2005).

138. *Id.*

139. *Id.*

140. *Id.*

141. *Id.* Marilyn Werber Serafini, *Short on Supplies—and Nurses*, 37 NAT'L J. 3264, 3264 (2005). A recent study confirmed that nonpharmaceutical interventions used by forty-three cities during the 1918 Spanish flu pandemic had a salutary effect on the management of the emergency. Howard Markel et al., *Nonpharmaceutical Interventions Implemented by*

The *HHS Plan* provides guidance to state, local, and tribal groups for implementing plans that: define priority groups by their functions to maintain social continuity; develop a plans to identify individuals within these groups, and; establish effective and equitable distributive methods of vaccines and antivirals to these populations.[142] States and localities are in a better position than the federal government to identify the critical functions that must be maintained to preserve the services and infrastructure, and those individuals essential to achieve that goal.[143] Though it cannot provide much tactical aid to each community, the federal government, through HHS, is striving to "mitigate the severity of a pandemic by setting standards for pandemic care, and by helping local officials understand the circumstances under which they should take dramatic action."[144]

US Cities During the 1918-1919 Influenza Pandemic, 298 JAMA 644, 644 (2007). The cities that followed these interventions by closing schools, banning public gatherings, isolating flu patients and placing in quarantine people exposed to them, suffered less than the cities that chose not to enforce these measures. *Id.* at 654.

142. HHS PLAN, *supra* note 34, pt. 1, app. D, at D-11; *see also* Lee, *supra* note 131. *See generally* David Brown, *If Bioterrorists Strike, Letter Carriers Might Deliver Antibiotics*, WASH. POST, Oct. 2, 2008, at A2 (detailing a plan being developed by the HHS which would build upon the federally-funded Cities Readiness Initiative designed to assist some seventy-two major urban areas in developing strategies to distribute drugs to these target populations within forty-eight hours of bioterrorist attacks, by providing for the delivery of antibiotics necessary to combat an exposure to anthrax by volunteer letter carriers who might be accompanied by city police officers and who, themselves, would be screened medically, fitted with N95 face masks as well as being issued an appropriate antibiotic for their own family households).

143. *See* U.S. DEP'T OF HEALTH & HUMAN SERVS. & THE CTRS. FOR DISEASE CONTROL & PREVENTION, INTERIM PRE-PANDEMIC PLANNING GUIDANCE: COMMUNITY STRATEGY FOR PANDEMIC INFLUENZA MITIGATION IN THE UNITED STATES—EARLY, TARGETED, LAYERED USE OF NONPHARMACEUTICAL INTERVENTIONS (2007), http://www.pandemicflu.gov/plan/community/community_mitigation.pdf. In February 2007, HHS and the Centers for Disease Control and Prevention (CDC) released new guidance on community planning strategies which focus on self-quarantine of ill persons at their homes and away from work environments for seven to ten days; home confinement for household members of ill patients for seven days; a cessation of schools and child care programs for upwards of three months and social distancing of adults in the community and at work. *Id.* at 37-40. Interestingly, these guidelines complement many of the same practices which were followed during the 1918 flu epidemic. *See* David Brown, *1918 Flu Epidemic Teaching Valuable Lessons; Actions Taken Apparently Were Effective*, WASH. POST, Dec. 13, 2006, at A4.

144. Shane Harris, *Every Community for Itself*, 37 NAT'L J. 3265 (2005). *See also* HHS PLAN, *supra* note 34, at pt. 1; Mary Beth Sheridan, *Area Told It Needs to 'Do More' to Prepare for Flu Epidemic*, WASH. POST, Oct. 3, 2007, at B3. The story described testimony at a congressional hearing by public officials from Virginia and the District of Columbia who urged greater federal cooperation in planning for a pandemic flu outbreak, and especially the delivery of critical medications to key employees in order to assure the continued operation of government. The District of Columbia has stockpiled only some 45,000 courses of antiviral medication to combat the anticipated pandemic. *Id.*

A Report by The Commission on The National Guard and Reserves on the readiness of these two branches of service to respond to assaults on the homeland from domestic attacks, incidents by bioterrorism and catastrophes, was issued February 1, 2008. Ann Scott Tyson,

Because much is unknown about when the pandemic will occur, what form the influenza virus causing the pandemic will take, and the uncertainty of the impact of a pandemic, assumptions must be made to create a workable plan for distributing vaccines and antiviral medications based on *triage* principles and humanism. HHS has outlined its decisional framework in determining priority groups for resource allocation following consideration of five major factors.[145] First, those most likely to become infected and die from the influenza virus must be considered.[146] Second, the health care system will experience a "surge" of patients requiring hospitalization and care into their facilities, possibly overwhelming the system.[147] Third, the workforce will suffer from the increased absenteeism due to illness, fear of becoming infected, and caring for ill family members.[148] Fourth, there will be potential impacts on critical infrastructure such as transportation, since people will not want to travel with others out of fear of infection, as well as utility services to maintain continuity and safe, sanitary, and healthy conditions.[149] Finally, a realistic level of understanding needs to be shown regarding the inherent market limitations imposed upon the production capacity for vaccines.[150]

'Appalling Gap' Found in Homeland Defense Readiness, WASH. POST, Feb. 1, 2008, at A4. In March, 2007, the Commission found eighty-eight percent of the Army and National Guard was neither ready nor fully operational for national emergencies. *Id.* Greater funding to train and equip the military's 836,000 selected reserves in order to assure that they can operate interchangeably with active duty personnel is, the Commission concluded, needed immediately. *Id.* The Commission also recommended that the Pentagon be charged with providing the bulk of support to civilian authorities in the likely that event local responders will be overwhelmed by a major catastrophe. *Id.* Furthermore, it was suggested that state governors be allowed to command federal troops during times of national emergencies. *Id.*

145. HHS PLAN, *supra* note 34, pt. 1, app. D, at D-13.

146. *See* JOHN M. BARRY, THE GREAT INFLUENZA: THE EPIC STORY OF THE DEADLIEST PLAGUE IN HISTORY 4 (2004); *see also* HHS PLAN, *supra* note 34, pt. 1, app. D, at D-12. In the 1918 pandemic, most deaths, surprisingly, occurred in young adults. *Id.* In the 1957 and 1968 pandemics, as well as the annual flu, infants, the elderly and the unhealthy are the most at risk. *Id.* Because of the uncertainty of the form of the virus, a distributive plan must be flexible enough to adjust as the epidemiology of the pandemic virus is discovered. *Id.* at D-19. The problem is that the human-to-human infectious version of the virus does not yet exist, and it is therefore uncertain as to which age groups will be most victimized by this influenza virus. *See id.*

147. HHS PLAN, *supra* note 34, pt. 1, app. D, at D-12. The CDC estimates that the demand for hospitalization will increase twenty-five percent even in a moderate pandemic. *Id. See also* Serafini, *supra* note 141, at 3259, 3264; Lee, *supra* note 131, at A3.

148. HHS PLAN, *supra* note 34, pt. 1, app. D, at D-12. The CDC estimates that ten percent of the work force will be absent during a pandemic. *Id. See also* Serafini, *supra* note 137, at 3260.

149. HHS PLAN, *supra* note 34, pt. 1, app. D, at D-12. *See also* Serafini, *supra* note 137, at 3260.

150. HHS PLAN, *supra* note 34, pt. 1, app. D, at D-12. The HHS has assumed that the U.S. can produce three to five million doses per week of the vaccine; however, it will take three to six months before the first dose can be produced once the virus is detected. *Id.*

C. Triage of Vaccine Distribution

The priority group recommendations of HHS appear to seek to do the greatest good for the most people while attempting to minimize the burden on the health care resources.[151] At the outbreak of a pandemic, those of top priority (Tier 1) under the *HHS Plan* to receive vaccinations are the vaccine and antiviral manufacturers and those essential to their production.[152] Production of vaccines and antiviral drugs will provide for the common good in a pandemic. Next on the priority list are the medical and public health workers in direct patient contact, others responsible for direct patient care, and vaccinators.[153] This will be necessary to help hospitals deal with the "surge" of ill people as well as limit the potential that healthcare personnel will not come to work out of fear of getting infected.[154] The health care facilities will need "all hands on deck" to deal with the hospitalizations potentially resulting from a pandemic. The selection of these groups as top priority to receive vaccinations is based on one of the utilitarian principles of *triage*—general social value.[155] The principle as applied to this situation shows that these manufacturers and medical and public health workers are "believed to have the greatest actual or potential general social worth."[156] Because the scarcest resources in a pandemic will be vaccinations, antiviral medications, and health care workers, it is imperative that the production of these countermeasures continue, and that heath care workers are available and healthy to treat ill patients.

The *HHS Plan* seeks to save the most lives, as well as protect the health care resources during a surge into the hospitals. After the vaccine and antiviral manufacturers, and the public health workers, HHS seeks to protect those persons from six months of age with influenza, those with high-risk conditions, and those with a history of pneumonia and influenza hospitalizations.[157] The goal here is to identify and protect those most susceptible and most likely to be hospitalized or die from influenza, thereby

---

Also, two doses per person are required to protect against the H5N1 virus. *Id. See also* Neil Munro, *Don't Count on a Vaccine*, 37 NAT'L J. 3261, 3261 (Oct. 22, 2005).

151. *See* HHS PLAN, *supra* note 34, pt. 1, app. D, at D-13.

152. *Id. See generally* Gary R. Noble, *The Promise of Vaccines and the Influenza Vaccine Shortage of 2004: Public and Private Partnerships*, *in* ETHICS AND THE PHARMACEUTICAL INDUSTRY 352 (Michael A. Santoro & Thomas Gorrie eds., 2005) (explaining the demands on the pharmaceutical industry).

153. HHS PLAN, *supra* note 34, at D-13. *See generally* Adrian A. Maung & Susan M. Briggs, *Disaster Planning*, *in* THE TRAUMA HANDBOOK OF THE MASSACHUSETTS GENERAL HOSPITAL 58, 58-60 (Robert L. Sheridan ed., 2004) (emphasizing the important role of medical personnel in the functioning of triage during a crisis).

154. *See* HHS PLAN, *supra* note 34, pt. 1, app. D, at D-12-13.

155. Smith, *Endgame Realities*, *supra* note 32, at 146.

156. *Id.*

157. HHS PLAN, *supra* note 34, pt. 1, app. D, at D-13.

making hospital resources available to those who are most likely to recover with treatment.[158] By vaccinating those identified to be most susceptible to influenza, the government is using *triage* principles because it is immediately useful to those patients, and it seeks to conserve antivirals and other health care resources for those less likely to be infected by influenza.[159] In a further effort to conserve vaccine resources, the elderly in nursing homes and those with compromised immune systems are excluded from vaccination because it is unlikely that the vaccine would have a protective effect on such individuals.[160] Also, under another *triage* principle, vaccinating these individuals will have the lowest possibility of medical success and, therefore, it would be futile and a potential waste of limited resources that could be used for a patient that will benefit from the vaccination.[161] The goal of vaccination is to help those who will most benefit from a vaccine and not those who are unlikely to benefit.

The *HHS Plan* does provide for the vaccination of those who are in regular contact with individuals with compromised immune systems.[162] Pregnant women are in a high priority group of those vaccinated because it was observed from past pandemics that pregnant women were at high risk, and that vaccinations will also protect infants who cannot be vaccinated.[163] Since children less than six months of age cannot be vaccinated, those in household contact with children of that age are to be vaccinated.[164] In prioritizing these groups of individuals, the *triage* system is fulfilling the parent role principle because both the caretakers and pregnant women have others who are dependent upon them for survival.[165] It would therefore be in the best interests of the community to allow for those individuals to continue caring for their dependents so as to conserve the resource of the health care system. Finally, public health officials are playing a critical role in the pandemic response; thus key government leaders making decisions and implementing the response are to be vaccinated to maintain its continuity.[166]

Tier 2 protects healthy individuals aged sixty-five and older, healthy infants aged six to twenty-three months and those six months old to sixty-

---

158. *Id*; *see also* Smith, *Endgame Realities*, *supra* note 32, at 146.

159. Smith, *Endgame Realities*, *supra* note 32, at 146.

160. HHS PLAN, *supra* note 34, pt. 1, app. D, at D-13.

161. Smith, *Endgame Realities*, *supra* note 32, at 146.

162. HHS PLAN, *supra* note 34, pt. 1, app. D, at D-13.

163. *Id. See generally*, Symposium, *supra* note 22.

164. HHS PLAN, *supra* note 34, pt. 1, app. D, at D-13.

165. Smith, *Endgame Realities*, *supra* note 32, at 146.

166. HHS PLAN, *supra* note 34, pt. 1, app. D, at D-13. The social worth of these leaders' works to society and in promotion of the common good, during a pandemic is potentially great—thus they have been listed on the priority list. *Id.*

four years old with high-risk conditions of influenza.[167] These groups are at less of an increased risk than those in Tier 1; nevertheless, they are still at a high risk for influenza.[168] Here, the *HHS Plan* continues to try to solve the problem of the scarcity of health care resources by providing these high-risk groups with preventative vaccination.[169] Hopefully, it will eliminate the need for future treatment in hospitals by conserving the resources for others.[170] Included in this Tier are other public health emergency responders, public safety workers (police, fire, 911 dispatchers and correctional facility staff), utility workers (power, water, and sewage), transportation workers (fuel, water, food, and medical supplies), and telecommunications workers.[171] These workers are important for maintaining the continuity of societal functions and critical infrastructure, and thus are valued contributors to society.[172] Here, the *HHS Plan* is providing a federal guideline for the states, which the states must modify to suit the needs of their communities and citizens.[173] In order for a state to determine effectively which social functions are essential, the affected populations in the community must be encouraged to cooperate, so that state officials may understand the values and priorities of the affected communities.[174] However, when a state or locality develops a plan to maintain the social order in a time of crisis, it is important that the public is encouraged to cooperate and participate in its development so the public perceives the *triage* standards as fair.[175] When the public is regarded as a partner and an ally in the planning effort, public confidence and trust in the process is established.[176] When the public understands the rationale and has participated in the process by contributing their values and priorities, social disruption will be minimized during the pandemic.[177] Prior to a health emergency, the government must maintain the public's trust, and achieving this trust will be more likely if the public "participate[s] in setting [the] procedures and material criteria and . . . in determining what to emphasize

167. *Id.* at D-14.

168. *Id.*

169. *Id.* at D-12.

170. KILNER, *supra* note 116, at 11.

171. HHS PLAN, *supra* note 34, pt. 1, app. D, at D-14.

172. *Id.*

173. *Id.* at D-11.

174. Childress, *supra* note 54, at 89.

175. *Id.* at 88-89.

176. Thomas A. Glass & Monica Schoch-Spana, *Bioterrorism and the People: How to Vaccinate a City Against Panic*, 34 CLINICAL INFECTIOUS DISEASES 217 (2002) ("Failure to involve the public as a key partner in the medical and public-health response could hamper effective management of an epidemic and increase the likelihood of social disruption.").

177. Childress, *supra* note 54, at 89.

in medical utility, which functions and roles are essential in judgments of narrow social utility."[178]

Tier 3 includes other government decision makers, funeral directors and embalmers.[179] However, the priority given to funeral directors and embalmers is a value judgment that members of the public must consider in their communities.[180] In the federal strategy, funeral directors and embalmers are seen as lower-priority individuals, however, with the anticipated mortality rate of the H5N1 virus being so significant, mortuaries are likely to also experience "surge" of the dead if the virus remains this virulent.[181] The jobs of the embalmers and funeral directors who will be in close contact with increasing numbers of dead bodies will become all the more important for society. Families would like to provide their loved ones with a proper funeral. The position of the embalmers and funeral director on the priority list of vaccinations should be reconsidered when implemented by the states.

In 1918, "the most terrifying aspects of the epidemic was the piling up of bodies."[182] The undertakers, responsible for the bodies, were sick and overwhelmed.[183] There was nowhere to put the bodies.[184] Gravediggers were also sick or refused to bury influenza victims out of fear of getting sick.[185] The bodies could not be buried because there were no gravediggers.[186] Bodies piled up because they could not be buried.[187] Coffins ran out.[188] The morgues could not accommodate all the bodies that were brought in, so bodies remained in the homes where they died, and some even put their loved ones on ice—creating unsanitary conditions to say the least.[189] People were dying so quickly that there was no way to accommodate the bodies.[190] Learning from the past, it would be helpful to make those that deal with the dead a higher vaccination priority than under the current plan.

Finally, Tier 4 requires the vaccination of healthy persons between the ages of two and sixty-four years who are not included in the other

---

178. *Id.* at 91.

179. HHS PLAN, *supra* note 34, pt. 1, app. D, at D-14.

180. *See id.* at D-11 (acknowledging that communities have specific needs and that specific composition of priority groups thus necessarily differs).

181. HHS PLAN, *supra* note 34, pt. 1, app. D, at D-14. *See also* Singer, *supra* note 119.

182. BARRY, *supra* note 146, at 223.

183. *Id.*

184. *Id.*

185. *Id.*

186. *Id.*

187. *Id.*

188. BARRY, *supra* note 146, at 223.

189. *Id.* at 223-24.

190. *See id.*

categories.[191] Those who request a vaccination would be provided with one.[192] This plan assumes that H5N1 will not affect the young, twenty-to forty-year-olds, as occurred with the 1918 virus.[193] There, the death curves were not like those of usual influenza; instead, they were "W-shaped" with deaths occurring in children under age five, elderly between the ages of seventy and seventy-four, and those between the ages of twenty and forty.[194] Therefore, a supplemental plan must be developed if the virus shows to be one of the epidemiology of the 1918 pandemic. Vaccinations of those aged twenty to forty must be of a much higher priority, as the supplemental plan affects more people than those at the other peaks of the younger and the older.

D. Triage of Antiviral Medications

The priority groups for those being treated with antiviral medications are typically those most at risk of becoming infected with influenza and would create the greatest burden on the health care system and its critical infrastructure.[195] A system of *triage* in the hospital when patients come in for treatment is designed to make the most efficient use of the antiviral medications and health care system resources.[196] According to the *HHS Plan*, those groups of first priority are the patients admitted to hospitals with serious illness and high risk of death.[197] This brings in an egalitarian alternative to the *triage* principle by giving priority on the basis of general neediness—those at the top of the list are the most helpless and the most ill.

Second in priority are the health care workers and emergency medical service providers who are in direct contact with patients.[198] Health care workers are a limited resource, and during a pandemic, health care personnel will be in great demand to treat those affected by the influenza virus. These health care providers, because of their limited availability, have great social worth during a successful pandemic response.

Antiviral medications are then distributed to those outpatient groups at highest risk of hospitalization and death, as well as those for whom vaccines are ineffective because their immune systems are significantly compromised.[199] Next, antiviral medications will be administered to health

---

191. HHS PLAN, *supra* note 34, pt. 1, app. D, at D-14.

192. *Id.*

193. GINA KOLATA, FLU: THE STORY OF THE GREAT INFLUENZA PANDEMIC OF 1918 AND THE SEARCH FOR THE VIRUS THAT CAUSED IT 5 (1999).

194. *Id.* at 4-5.

195. HHS PLAN, *supra* note 34, pt. 1, app. D, at D-21.

196. Marshall & Perlmutter, *supra* note 59, at 159.

197. HHS PLAN, *supra* note 34, pt. 1, app. D, at D-21.

198. *Id.*

199. *Id.*

responders, public safety officials, and government decision-makers to ensure that the pandemic health response continues effectively.[200] The fifth priority group includes those outpatients at increased risk: young children, those over sixty-five years of age, and people with medical conditions.[201]

The final five priorities include those who are not going to be vaccinated, such as those in nursing homes with compromised immune systems, other health care workers necessary to the health care response, those necessary to prevent absenteeism, and societal responders to implement the pandemic response are to be provided with antiviral medications.[202] The last three on the priority list are those outpatients and health care workers not included on the list above.[203] Again, however, those aged twenty to forty are excluded from the top priority groups because of their strong immune systems.[204] However, during the 1918 virus, the strength of the immune response itself was the killer, and not the virus, in those aged twenty to forty.[205] Those aged twenty to forty with healthy immune systems were the most severely attacked during the 1918 pandemic,[206] but they are last on the priority distribution list of countermeasures to the virus in the current plan.[207] Those within that age group seeking to protect themselves from the virus in the prime of their lives will have to sacrifice their personal autonomy to medical treatment for others in the community.

The *HHS Plan* recommendations take into great consideration the limited supply of medications that would be available in a pandemic, as well as the strain on healthcare systems when patients flood the hospitals. One goal of the plan is to target vaccination toward groups that are most susceptible to illness to keep those individuals out of hospitals.[208] In the event that those who are less susceptible to the virus fall ill and come to the hospital, there will be beds, nurses, antiviral medications, and other medical necessities available to them. Also, those individuals with compromised immune systems not likely to be protected by a vaccine will not be provided one, because vaccinating those individuals would be futile and others who may benefit from the vaccination would not receive one.[209]

---

200. *Id.*
201. *Id.*
202. *Id.*
203. HHS PLAN, *supra* note 34, pt. 1, app. D, at D-21.
204. *See id*; *cf.* BARRY, *supra* note 146, at 247.
205. BARRY, *supra* note 146, at 247.
206. *Id.*
207. *See* HHS PLAN, *supra* note 34, pt. 1, app. D, at D-14, D-21.
208. *Id.* at pt. 1, app. D, at D-12 to -15, pt. 2, supp. 7, at S7-11.
209. *See generally* George P. Smith, II, *Utility and the Principle of Medical Futility: Safeguarding Autonomy and the Prohibition Against Cruel and Unusual Punishment*, 12 J. CONTEMP. HEALTH L. & POL'Y 1, 7, 15 (1995) (explaining the principle of futility in a medical context with associated moral implications).

E. Implementation Plan Update

On July 17, 2007, the government issued an update[210] on the *Pandemic Influenza Implementation Plan* originally released on November 1, 2005.[211] This new assessment of progress shows—rather strikingly—the weakness in the federal government's ability to both detect an outbreak of the flu or to even track the progress of it as it moves throughout the country.[212] The federal government is developing, as well, a nationwide surveillance system able to track the directions of the pandemic as it moves throughout the world, but it is not yet operational.[213] Having concluded that sealing the Nation's borders in the event of an influenza pandemic will be impractical, since it will enter the country regardless of physical restrictions at border crossings, the government has nevertheless underscored its intent to limit the entry of individuals who might be infected or who would be considered suspects of carrying the virus.[214]

Over time, the government will refine the priority list for individuals who will receive the flu vaccine first when an outbreak occurs and—as well—will develop more fully and then release plans for coordinated school

---

210. *See* HOMELAND SECURITY COUNCIL, NATIONAL STRATEGY FOR PANDEMIC INFLUENZA: IMPLEMENTATION PLAN ONE YEAR SUMMARY 1 (2007), *available at* http://www.whitehouse.gov/homeland/nspi_oneyear.pdf [hereinafter ONE YEAR SUMMARY]; *see also* Gardiner Harris, *Limited Capacity is Seen in Flu Defenses*, N.Y. TIMES, July 18, 2007, at A14 (assessing the still limited capacity of the federal government to combat a pandemic influenza outbreak).

On September 10, 2007, the federal government released a draft National Response Framework (NRF) designed to establish a national approach to catastrophic incidents and, as such, serve as a blueprint for dealing with terrorist attacks and other disasters. Press Release, Office of the Press Sec'y, U.S. Dep't of Homeland Sec., Draft National Response Framework Released for Public Comment (Sept. 10, 2007), http://www.dhs.gov/xnews/releases/pr_1189450382144.shtm; U.S. DEP'T OF HOMELAND SEC., NATIONAL RESPONSE FRAMEWORK (Draft) (Sept. 10, 2007), *available at* http://www.regulations.gov/fdmspublic/ContentViewer?objectId=09000064802841 2b&disposition=attachment&contentType=pdf [hereinafter FRAMEWORK (Draft)]. Initial criticism of the draft has been that it provides insufficient detail for guidance by local officials charged with managing specific incidents, and—furthermore—is unclear as to levels of accountability and supervision in the chain of command. Spencer S. Hsu, *Proposed Disaster-Relief Plan Faulted*, WASH. POST, Sept. 12, 2007, at A4. For the present, the NRF will seek—through fifteen federally designated disaster scenarios—to develop separate strategic plans for disaster relief. FRAMEWORK (Draft), *supra* at 2-3; *see also* Hsu, *supra; cf.* Bill Walsh, *FEMA Gets Mixed Grades: Homeland Security Assesses Preparedness*, TIMES-PICAYUNE (NEW ORLEANS), Apr. 4, 2008, National at 6 (reviewing FEMA's uneven performance record in preparing for another post-Katrina type disaster, concluding the Agency is simply not prepared to deal with a catastrophe of the magnitude of Hurricane Katrina, and further concluding that the Agency is especially vulnerable in its ability to track whether its orders, once given, are implemented); *infra* note 215 (commenting on the finalization of the draft framework).

211. NATIONAL STRATEGY, *supra* note 33.

212. ONE YEAR SUMMARY, *supra* note 210.

213. *Id.*

214. Harris, *supra* note 210, at A16; *see also id.*

closings between state and local governments.[215] Additional concern has been raised regarding the present capacity for all healthcare facilities to manage effectively the additional patient burdens arising from the influenza disease.[216]

While the federal government has dedicated capital investments of $1 billion to develop new ways to manufacture flu vaccines, HHS has released additional sums to include $897 million to state governments for emergency preparedness, of which $175 million is set aside specifically for the pandemic.[217]

The obvious conclusion to be drawn from this update is that while the federal government is making progress in preparing the Nation for an influenza pandemic, considerable work must be undertaken before all levels of government—national, state, and municipal—will be able to make a coordinated response to the pandemic. In developing effective emergency planning and preparedness an all hazards approach must be developed—one which, of necessity, includes not only pandemic influenza strategies, but also those for the emergence of new diseases, terrorist attacks, and natural disasters. Accordingly, preparing for a pandemic must not be taken

---

215. *See* ONE YEAR SUMMARY, *supra* note 210, at 3; Harris, *supra* note 210; *see also* Spencer S. Hsu, *States Feel Left Out of Disaster Planning*, WASH. POST, Aug. 8, 2007, at A1 (reporting as to the Nation's overall response to disaster planning that state and local officials charged with emergency management are concerned that the federal government is acting unilaterally and emphasizing responses to terrorism at the cost of neglecting safeguards against natural disasters); Eileen Sullivan, *Disaster Response Coordination Positions Bypass FEMA*, CQ HOMELAND SEC., July 23, 2007, http://public.cq.com/docs/hs/hsnews110-000002556714.html (commenting on how the National Protection and Programs Directorate, within the Department of Homeland Security, is now the states' contact for disaster preparedness—not FEMA).

On January 22, 2008, the Department of Homeland Security announced a new, final framework for managing domestic incidents which exceed or are anticipated to exceed state resources or when an incident is managed by federal departments directly and declared to be Incidents of National Significance. *See generally* Spencer S. Hsu, *DHS to Unveil New Disaster Response Plan; FEMA Will Regain Power; State, Local Input Included*, WASH. POST, Jan. 19, 2008, at A3. This National Response Framework is seen as a direct response to the previous concerns of state and local units of government regarding their level of participation in disasters which require a unified "all-hazards response." *Id.* Consequently, FEMA's power is restored, and it therefore has the delegated responsibility to clarify and coordinate heretofore diffuse any confusing levels of responsibility among the states and their municipalities. *Id.* This Framework document is required by, and integrates under, the larger National Strategy for Homeland Security. U.S. DEP'T OF HOMELAND SEC., NATIONAL RESPONSE FRAMEWORK 12 (2008), *available at* http://www.fema.gov/pdf/emergency/nrf/nrf-core.pdf. It supersedes the corresponding sections of the National Response Plan (2004, with 2006 revisions). *Id.* at i. Updates and amendments to the Framework and its various specific indexes are to be posted at http://www.fema.gov/emergency/NRF as made available. *Id.* at 1.

216. ONE YEAR SUMMARY, *supra* note 210, at 4; *see also* Harris, *supra* note 210.

217. Harris, *supra* note 210; *see also* ONE YEAR SUMMARY, *supra* note 210, at 16.

as a threat to or competition with other efforts directed at disaster preparedness.

V. LAW REFORM THROUGH MODEL LEGISLATION

A majority of state statutes dealing with public care and, specifically, isolation and quarantine, were enacted a number of years, if not decades ago.[218] In order to allow the states to come into the new age of bioterrorism and public health emergencies, in 2003, the National Association of Attorneys General (NAAG) urged them to amend or enact new legislation appropriate to effectuating this goal.[219] In order to "jump start" this updating process, the NAAG brought forward two model proposals—the Model State Emergency Health Powers Act[220] and the Turning Point Model State Public Health Act.[221] Particular care was placed on redefining due process rights in relation to cases where isolation and/or quarantine are ordered.[222]

The work product of the Center for Law and the Public's Health at Georgetown and Johns Hopkins Universities in collaboration with the Centers for Disease Control, the MSEHPA arose as a consequence of the attacks by bioterrorists on New York City on September 11, 2001, and the subsequent realization that "a coordinated, appropriate response in the event of a public health emergency" was lacking.[223] In granting to both state governors and public health officers a wide array of specific emergency powers, the MSEHPA also seeks to strike a balance between their powers and the personal liberties and civil rights of the medical detainees.[224] Testifying to the "catalystic" effect of this model legislation, by August, 2003, some thirty-four states and the District of Columbia had introduced legislation which either included provisions of the MSEHPA or adoptions from it.[225] By July, 2006, the number of states subscribing to the model act had risen to thirty-eight.[226]

---

218. Daubert, *supra* note 118, at 1336.

219. *Id.*; *see also* Nat'l Ass'n of Attorneys Gen., Resolution: Urging States to Review Their Public Health Laws (Dec. 2003), *available at* http://www.publichealthlaw.net/Resources/ResourcesPDFs/PHL%20NAAG.pdf.

220. MODEL STATE EMERGENCY HEALTH POWERS ACT pmbl. at 6 (Ctr. for Law & the Public's Health at Georgetown & Johns Hopkins Univs., Proposed Official Draft 2001), http://www.publichealthlaw.net/MSEHPA/MSEHPA2.pdf.

221. TURNING POINT MODEL STATE PUB. HEALTH ACT intro. 1-2, prefatory nn. 3 (Pub. Health Stat. Modernization Nat'l Excellence Collaborative 2003), http://www.hss.state.ak.us/dph/improving/turningpoint/PDFs/MSPHAweb.pdf.

222. Daubert, *supra* note 118, at 1336-37.

223. *Id.* at 1337.

224. *Id.* at 1337-41.

225. Lawrence O. Gostin et al., *The Model State Emergency Health Powers Act: Planning for and Response to Bioterrorism and Naturally Occurring Infectious Diseases*,

Public health law reform opportunities were enhanced, as well, by the completion of a collaborative work product undertaken by nine national organizations and government agencies, representatives from five states, and the Public Health Statute Modernization collaborative.[227]Termed the Turning Point Act, this legislative model structures a framework by which states can measure their preparedness for public health emergencies.[228] By March, 2007, some thirty-three states had—to one degree or another—adopted features of this proposed model legislation.[229]

While the two Acts overlap, there are two central and important differences to be found regarding due process rights during an isolation or quarantine.[230] When either isolation or quarantine is ordered (with notice) under the MSEHPA, a hearing must be held within a five-day period—with a ten-day maximum time being allowed for extraordinary and good cause.[231] Under the Turning Point Act, however, detainment hearings must be conducted upon the filing of the petition, within a forty-eight hour period, or within five days under extraordinary circumstances, and for good cause as determined by the discretion of the court.[232]

Regarding the evidentiary burden to be met under confinement by isolation or quarantine, MSEHPA directs the judiciary to grant any petition made when by "a preponderance of the evidence" it is determined that either of these two acts of confinement is reasonably necessary to limit or prevent "transmission of a contagious or possibly contagious disease."[233] Under the Turning Point Act, the court shall grant a petition if "clear and convincing evidence" is presented.[234] Overall, greater protection of

---

288 JAMA 622, (2002); *see also* Lawrence O. Gostin, *The Model State Emergency Health Powers Act: Public Health and Civil Liberties in Time of Terrorism*, 13 HEALTH MATRIX 3, 5 (2003).

226. Daubert, *supra* note 118, at 1337; THE CTR. FOR LAW & THE PUB.'S HEALTH AT GEORGETOWN & JOHNS HOPKINS UNIVS., *The Model State Emergency Health Powers Act (MSEHPA) State Legislative Activity*, 1 (2006), http://www.publichealthlaw.net/MSEHPA/MSEHPA%20Leg%20Activity.pdf (listing updates and comparisons of the state enactments of MSEHPA).

227. Daubert, *supra* note 118, at 1337.

228. *See* M. Jane Brady et al., *How States Are Using the Turning Point Model State Public Health Act*, 33 J.L. MED. & ETHICS (SPECIAL SUPP.) 97, 98-99 (2004).

229. The Ctr. for Law & the Pub.'s Health at Georgetown & Johns Hopkins Univs., *The Turning Point Model State Public Health Act State Legislative Update Table* 1, 1 (2007), http://www.publichealthlaw.net/Resources/ResourcesPDFs/MSPHA%20LegisTrack.pdf.

230. Daubert, *supra* note 118, at 1341.

231. *Id.*

232. *Id.*

233. *Id.*, *quoting* MODEL STATE EMERGENCY HEALTH POWERS ACT § 605(b)(5) (Ctr. for Law & the Public's Health at Georgetown & Johns Hopkins Univs., Proposed Official Draft 2001).

234. Daubert, *supra* note 118, at 1341 *quoting* TURNING POINT MODEL STATE PUB.

individual liberties and rights is achieved under the Turning Point Act—owing to the stricter due process requirements within its provisions.[235]

Although "tools of last resort," isolation and quarantine are effective public health measures.[236] When isolation is ordered, those individuals diagnosed with a specific infectious illness are separated from association with healthy individuals in an attempt to block the spread of the illness.[237] Quarantine may be defined as "the separation and restriction of movement of persons who, while not yet ill, have been exposed to an infectious agent and therefore may become infectious."[238] Absent punishment for a crime, involuntary detention must always be about establishing a justifiable balancing point that, while acknowledging the state's duty in protecting and safeguarding the health and safety of the public, also is both sensitive and reasonable as to the liberty interests and due process rights of the individual detained.[239]

Other concerns and criticisms of MSEHPA are tied to a number of issues: the extraordinarily broad discretionary powers of a governor to declare, unilaterally, without consultation with public health officials, a state of public health emergency.[240] The conditions under which the declaration is made are not spelled out by usage of words such as "significant" and "substantial."[241] As well, the expanded police powers granted to state and local governments are worrisome to those who fear misuse.[242] Additionally, some critics express concerns over provisions in MSEHPA which force vaccination, treatment or quarantine upon individuals; allow the state to track and share the personal health information of citizens without their consent; and mobilize state militias to enforce and penalize those who disobey state orders.[243]

HEALTH ACT § 5-108(e)(4) (Pub. Health Stat. Modernization Nat'l Excellence Collaborative 2003).

235. Daubert, *supra* note 118, at 1342.

236. *Id.* at 1299. *See generally* Lawrence O. Gostin & Benjamin E. Berkman, *Pandemic Influenza: Ethics, Law, and the Public's Health*, 59 ADMIN. L. REV. 121, 171-74 (2007).

237. Daubert, *supra* note 118, at 1301.

238. *Id.* at 1301-02.

239. *Id.* at 1328-29. For a recent application of isolation and quarantine, see David Brown, *Man with Rare TB Detained, Isolated: He Ignored Orders, Traveled Extensively*, WASH. POST, May 30, 2007, at A3; *Man Quarantined After Flying Across Atlantic with TB*, WASH. TIMES, May 30, 2007, at A3.

240. *See* Annas, NEW ENG. J. MED., *supra* note 14, at 1338-39.

241. Lorena Matei, Case Note, *Quarantine Revision and The Model State Emergency Health Powers Act: "Laws for the Common Good,"* 18 SANTA CLARA COMPUTER & HIGH TECH. L.J. 433, 438 (2002); *see also* Annas, NEW ENG. J. MED., *supra* note 14, at 1340 (expressing concerns over the misuse of public health emergency measures).

242. *See* Matei, *supra* note 241 at 439-44; Annas, NEW ENG. J. MED., *supra* note 14, at 1340.

243. *See* Sue Blevins, President, Inst. for Health Freedom, Remarks at the 25th Annual

For civil libertarians, a provision within MSEHPA that the government will—in exercising its emergency powers—protect the civil rights and liberties to the "fullest extent possible consistent with the primary goal of controlling serious health threats" goes too far in its stated endeavors to strike an appropriate "balance" between those actions taken, during emergencies, to safeguard the common good and those actions which respect the rights and liberties of citizenship.[244] The drafters of this Act contend that a right and proper balance between the execution of compulsory powers during emergencies and the rights of personal dignity has been maintained.[245] And, furthermore, they remind the naysayers that there is no "right to be free of any restraint, but the right to be free of a particular restraint that is not justified under the circumstances."[246]

Both of these legislative modes—MSEHPA and the Turning Point Act—rather successfully, on balance, seek to facilitate the implementation of five foundational functions of public health: preparedness (through public health emergency planning); surveillance (by establishing measures to not only detect, but track emergencies); management of property (by securing the availability of vaccines, pharmaceuticals and hospitals); protection of persons (by compelling, when clearly necessary, vaccinations, testing, treatment, isolation and quarantine);[247] and communication (by ensuring unambiguous and authoritative information reaches the public at large in a timely manner).[248] As such, both models provide that forum for debate called for previously to re-evaluate, re-educate, and inform public opinion to the evolving nature of the common good during these perilous times.[249]

VI. CONCLUSION

For every fundamental right or civil liberty asserted, there is a coordinate responsibility or even a correlative duty to realize, when directed by the needs of the common good, that that right must be executed *reasonably*. A synonym for reasonableness is cost-effectiveness attained, as such, by and through a cost-benefit analysis. For purposes of this present analysis, the

---

Resource Bank Meeting: The Model State Emergency Health Powers Act: An Assault on Civil Liberties in the Name of Homeland Security (Jun. 10, 2002) (Heritage Lecture #748), *available at* http://www.heritage.org/Research/HomelandSecurity/HL748.cfm; THE INST. FOR HEALTH FREEDOM, REVISED MODEL STATE EMERGENCY HEALTH POWERS ACT (Mar. 1, 2002), http://www.forhealthfreedom.org/Publications/Informed/RevisedModelState.html.

244. Matei, *supra* note 241, at 439; *see* Fidler, *supra* note 13 (discussing the balance of components necessary to validate health law governance measures).

245. Gostin et al., JAMA, *supra* note 225, at 627.

246. *Id.*

247. *See id.* at 622, 626-28 (discussing civil liberty protections).

248. *Id.* at 622, 626.

249. *See, e.g.*, *supra* notes 10-14, 23-29, 103-105 and accompanying text.

standard of reasonableness is found, historically, within the tenets of the principle of medical *triage*. It is then adopted properly by the Executive and codified in the *Pandemic Influenza Plan* authored by the U.S. Department of Health and Human Services.[250] As well, the standard is set once again within the provisions of MSEPHA[251] and the Turning Point Act.[252] Either of these model statutes can serve as catalysts for law reform, and therefore become templates for a new level of public health awareness and repressiveness.

When executive actions or legislative schemes put forward to safeguard the public in times of emergency and to preserve the common good are tested in the courts for their legitimacy and constitutional efficacy, the wisest course of action should be that of "judicial modesty."[253] Indeed, it may be properly regarded as the "cornerstone of judicial interpretation of the Constitution in emergency situations."[254] Instead of holding for constitutional invalidity, the courts should decide the test case challenges on narrow statutory grounds[255] and eschew consideration of the "probabilistic" effects of restrictions on various civil liberties within the "social landscape."[256]

Endeavoring to find an accurate and fair point of equilibrium in balancing competing values should dictate that the judiciary gives serious attention to risks rather than being tied to certainties and rules.[257] This is the case simply because the aim of most emergency measures is to reduce risks and not to eliminate certainties.[258] Therefore, standards, not rules, must—perforce—shape the breadth of judicial review of the constitutionality of security measures.[259] Standards are more flexible and situational and allow for accommodation by balancing the costs versus the benefits of each case in reaching a disposition.

Sadly, all too often civil *liberties* are seen as synonymous with constitutional *rights*.[260] These rights may be modified—indeed, should be—when they, as rights, "no longer strike[] a sensible balance between competing constitutional values, such as personal liberty and public

250. *See* HHS PLAN, *supra* note 34.

251. *See* MODEL STATE EMERGENCY HEALTH POWERS ACT (Ctr. for Law & the Public's Health at Georgetown & Johns Hopkins Univs., Proposed Official Draft 2001).

252. *See* TURNING POINT MODEL STATE PUB. HEALTH ACT (Pub. Health Stat. Modernization Nat'l Excellence Collaborative 2003).

253. POSNER, NOT A SUICIDE PACT, *supra* note 3, at 149.

254. *Id.*

255. *Id.* at 34.

256. *See id.* at 35.

257. *Id.* at 34.

258. *Id.*

259. POSNER, NOT A SUICIDE PACT, *supra* note 3, at 33-34.

260. *Id.* at 149.

safety."[261] National emergencies force disequilibrium in the system of liberties and constitutional rights which have the effect of placing public safety concerns above what, heretofore, were seen as unassailable fundamental values.[262] Pragmatic courts and pragmatic social orders, then, must respond accordingly to these changed circumstances by recalibrating what has been a point of balance or equilibrium by restricting previously validated civil liberties in favor of safety[263] and maintenance of the common good.[264]

As seen, the frameworks or mechanisms to ensure the recalibration of the balancing test have been discussed and analyzed, namely the scope of the common good; the principle of *triage*—grounded in the philosophy of utilitarianism and cost-benefit analysis; and the *Pandemic Influenza Plan* of the federal government together with the MSEHPA and the Turning Point Act. What remains is for the *vox populi* to be educated as to their responsibilities of citizenship which demand—in times of national and public health emergencies—that the common good be protected and secured, and further, that this responsibility justifies the curtailment of basic liberties and rights during the time of the emergency. The failure to recognize or accept this responsibility courts the collapse of society itself.

The supersessive common good, or—in other words—the good seen as overriding all members of a community or, here, the Nation—is surely security.[265] Put simply, without security, there can be no community. To state it otherwise, security is the greatest good for the greatest number within a given community.[266] The attainment and guarantee of this good, grounded in common sense, must always be preferred over an abridgement or temporary suspension of civil liberties.[267] Otherwise, the Constitution will, indeed, become little more than "a suicide pact."[268]

---

261. *Id.* at 147. *See generally* TROTTER, *supra* note 19.

262. POSNER, NOT A SUICIDE PACT, *supra* note 3, at 147.

263. *Id.*

264. *See* Hoffman, *supra* note 27, at 1920. *See generally* MARK A. LUTZ, ECONOMICS FOR THE COMMON GOOD: TWO CENTURIES OF SOCIAL ECONOMIC THOUGHT IN THE HUMANISTIC TRADITION (1999) (applying the "common good" to economic policy).

265. *See* Sulmasy, *supra* note 41, at 305.

266. *See generally* Lawson, *supra* note 45.

267. *See id.*

268. Terminiello, 337 U.S. at 37 (Jackson, J., dissenting).