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The Future of Public Health Law

Lawrence O. Gostin*

ABSTRACT

Developments in medicine and constitutional law dictate modification of public health legislation in the United States. Traditionally overlooked by legislators, present public health laws provide inadequate decision-making criteria and inappropriate procedures for dealing with issues. Revised legislation should provide health care officials and agencies with the tools to balance individual rights against public health necessities. This Article makes four recommendations for legislative reform: (1) remove artificial legislative distinction between venereal and other communicable diseases; (2) provide criteria defining "public health necessity" to limit discretionary exercise of police power by health officials; (3) provide strong confidentiality protections in the collection and storage of public health information; (4) empower public health officials to select from a graded series of less restrictive alternatives in dealing with public health problems.

INTRODUCTION

The protection and preservation of the public health is among the most important goals of government.[1] The classic problem for public health jurisprudence is to determine the extent to which the state may restrain its citizens in order to interrupt the spread of communicable disease.[2] The tension between protection of the public health and protec-

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[1] *See, e.g.,* Jacobson v. Massachusetts, 197 U.S. 11 (1905).

[2] All of the states have exercised their police power through the enactment of statutes and regulations restricting individual liberty, in order to impede the spread of infectious diseases. W. Curran, L. Gostin & M. Clark, Acquired Immunodeficiency Syndrome: Legal and Regulatory Policy (1986) (Harvard School of Public Health, contract number 282-86-0032).

tion of civil liberties is manifest in each of the traditional modes of government intervention. Public health statutes grant the government several powers: (1) to identify cases of infection through compulsory serologic testing, screening of populations or physical examination;[3] (2) to identify additional cases by investigating sexual or other contacts of known cases or carriers;[4] (3) to require a class of persons to submit to a preventive vaccine or curative treatment;[5] (4) to control personal behavior by isolating cases or carriers of disease or by quarantining exposed individuals;[6] and (5) to control environmental health risks by closing or regulating specified establishments.[7]

In each category of state public health power, there is a cost to the individual. For instance, individuals may be denied the right to decide whether to submit to a medical examination or treatment. The state's collection of sensitive health care information about a person or his or her sexual associates may compromise privacy. Compulsory hospitalization or segregation from one's community may be necessary if the disease is contagious. Finally, in order to maintain the public health, the state may define which places a person may frequent, thereby restricting his or her freedom of association.

The exercise of compulsory public health powers thus poses a classic conflict between the state's power to act for the community's common good and the individual's right to liberty, autonomy and privacy.[8] Public health law requires a most sensitive balancing of collective and individual rights and interests. A formula for accomplishing this balance, however, is conspicuously absent from public health jurisprudence.

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[3] *E.g.*, CAL. HEALTH & SAFETY CODE § 3191 (West 1979) (provides for compulsory examination of individuals infected with venereal disease).

[4] *E.g.*, 10 N.Y. ADMIN. CODE § 2.6 (1985) (requires health officers to discover contacts and unreported cases upon receiving a report of a case of a communicable disease).

[5] *E.g.*, GA. CODE ANN. § 31-17-3 (1985) (provides for isolation or arrest of persons afflicted with a venereal disease).

[6] *E.g.*, N.J. STAT. ANN. § 26:4-2 (West 1987) (authorizes the department and local boards of health to maintain and enforce proper and sufficient quarantine whenever deemed necessary).

[7] *E.g.*, N.Y. CITY HEALTH CODE § 3.01 (1987) (authorizes the commissioner of health to take necessary actions to assure maintenance of public health, the prevention of disease, or the safety of city residents); *see also* City of N.Y. v. New St. Mark's Baths, 130 Misc. 2d 911, 497 N.Y.S.2d 979 (1986).

[8] *See, e.g.*, Moore v. Armstrong, 149 So. 2d 36 (Fla. 1963) (enforcement of quarantine to protect the public health); Dalli v. Board of Educ., 358 Mass. 753, 267 N.E.2d 219 (1971) (vaccination order enforced); Irwin v. Arrendale, 117 Ga. App. 1, 159 S.E.2d 719 (1967) (mandatory X-ray of prisoner not assault and battery, where infection is suspected or X-ray is routine); *cf.* Skinner v. Oklahoma *ex rel.* Williamson, 316 U.S. 535, 536 (1942) (sterilization statute held unconstitutional; court acknowledged that case "touche[d] a sensitive and important area of human rights").

Although the last two decades have witnessed cogent legal analysis of other civil justifications for interference with liberty and self-determination, (consider commitment of the mentally ill), restraint for the good of the health of the people has barely caught the attention of the legal profession. Much of this complacency disappeared, however, with the emergence in 1981 of the lethal, geometrically spreading disease—Acquired Immunodeficiency Syndrome (AIDS).[9]

With the AIDS experience in mind, this Article looks to the future of public health legislation. First, I demonstrate that public health statutes do not reflect modern conceptions of science and law. Second, I discuss the absence of adequate criteria and procedures in current public health legislation. Finally, I propose a number of principles for the development of new statutes and regulations in public health. This Article represents a critical attempt to develop guidelines for a model public health statute for state and local legislatures.

I. AN ANTIQUATED CONCEPTION OF COMMUNICABLE DISEASE CONTROL MEASURES

Appropriately for a commemorative issue, this Article grew out of a national legislative survey for the United States Assistant Secretary for Health conducted by Professor William Curran, Professor Mary Clark and myself at the Harvard School of Public Health.[10] The study contained a thorough analysis of public health statutes passed by Congress, nine state legislatures, and four city governments—New York, Los Angeles, San Francisco, and Houston. We also undertook a full analysis of federal and state court cases in the area of communicable diseases. Finally, the study reported the results of a survey of AIDS-specific legislation and proposed legislation, for which responses were elicited from all fifty states and the District of Columbia. We are currently following this study with a global survey of health legislation on AIDS for the World Health Organization. Our work for the United States Assistant Secretary for Health revealed that public health statutes and case law reflect an approach to communicable disease control fashionable in the earlier part of this century, but no longer appropriate for current concerns.

Most statutes and early court decisions presume the pre-eminence of public health interests over individual rights, utilizing neither cogent scientific examination of a measure's potential benefit nor legal assessment of unnecessary restriction on individual rights. The antiquated nature of

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[9] For a thorough review of law and policy related to AIDS, see generally the special symposium issue in 15 LAW MED. & HEALTH CARE, edited by William J. Curran and Lawrence Gostin.

[10] W. Curran, L. Gostin & M. Clark, *supra* note 2.

public health law is reflected in its failure both to keep up with scientific progress in infectious disease control and to incorporate modern developments in constitutional analysis.

A. Advances in the Science of Public Health

At the time most public health statutes were written and most public health cases decided, the sciences of virology and epidemiology were in their infancy. A crude public health tradition of isolation or quarantine of real or suspected cases of disease was the rule, sometimes involving quarantine of an entire geographic area, without any understanding of the mechanism by which disease spread or how to interrupt it.[11]

Modern public health interventions are founded upon a more sophisticated understanding of disease processes. Science has a more precise understanding of the etiological agents of infectious disease, the most likely harborers of the agent, the most efficient modes of its transmission, and the methods of modifying behaviors or environments in order to interrupt its spread. Accordingly, modern measures for reducing the spread of disease are predominantly based upon research, education, and counselling, specifically targeted to groups at risk of spreading or contracting the disease. Public health statutes and judicial review of public health action should reflect these new scientific understandings by requiring that the goals of public health measures be limited to the interruption of the most efficient modes of disease transmission. The public health benefit is thus maximized, and restrictions on individual liberty limited to those clearly necessary for the community health.

When instituting or reviewing public health measures, legislatures and courts must consider certain scientific realities including method of transmission, period of incubation, and degree of health risk. An effective public health policy must focus specifically upon the *mechanism of transmission* of the infectious agent. The objective is to control the settings or behaviors most efficient in communicating the agent. For example, restriction of associational freedoms may be a valid policy to prevent the spread of an airborne disease, but is not justified for a blood-borne disease such as AIDS. Different methods of transmission suggest different public health responses. Cholera, for example, is spread through food and water, justifying stringent control of specific individual behavior; general associational controls are irrelevant. The quarantine invoked to combat yellow fever proved to be an inappropriate and ineffective response;[12] the agent is transmitted by mosquitoes, not through the air.

[11] *See, e.g.*, Jew Ho v. Williamson, 103 F. 10 (C.C.N.D. Cal. 1900) (court found that quarantine area was too large and was unrelated to effective disease control).

[12] G. Rosen, A History of Public Health 326 (1958); *see also* W. McNeil, Plagues and Peoples 236-37 (1976).

The *period of communicability* limits the time during which a control measure is useful. If the period of communicability is quite short, compulsory measures may be justified, but only while the person poses a health risk. When there is no finite period of communicability, however, in the case of AIDS, it is difficult to justify the potentially significant infringement of individual rights necessitated by compulsory control measures.

The availability of a prevention[13] or treatment[14] for an infectious condition can serve as a weighty justification for the introduction of certain public health measures, including compulsory examination, vaccination, treatment and contact tracing. The use of a simple, safe and efficacious treatment means that the compulsory measure will be of short duration and can be legally justified on grounds of unquestioned benefit to the individual and expected protection of the public. The classic modern example is the use of penicillin to cure the syphilis infection. The availability of a relatively nonintrusive and certain cure helps to justify compulsory case-finding, medical examination, and treatment. No such justification currently exists in the case of AIDS, as medical science has yet to discover an effective curative treatment or vaccine for the disease. Legal intervention is unwarranted where no scientific intervention is capable of breaking the cycle of infection.

Finally, the *seriousness and prevalence* of a disease influences the decision whether or not to adopt a restrictive public health response. A disease that is highly communicable, but usually not fatal, does not warrant significant restrictions on liberty. AIDS, however, is a lethal disease, spreading rapidly in the population. Both of these factors justify control measures, even at some expense to individual liberty. Nonetheless, measures introduced to control AIDS must be clearly effective in interrupting the spread of the disease, and must not be wholly disproportionate to the expected societal benefits.

B. Developments in Constitutional Law

Since the late 18th and early 19th centuries, when much public health law was formulated,[15] the constitutional balance of public health regulation has shifted dramatically. The early courts were highly deferential to state public health regulation under the police powers.[16] Some courts suggested

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[13] *E.g.*, immunization for polio.

[14] *E.g.*, penicillin for gonorrhea.

[15] *See generally* Merritt, *Communicable Disease and Constitutional Law: Controlling AIDS*, 61 N.Y.U. L. Rev. 739 (1986); Parmet, *AIDS and Quarantine: The Revival of an Archaic Doctrine*, 14 Hofstra L. Rev. 53 (1985).

[16] *See, e.g.*, Jacobson v. Massachusetts, 197 U.S. 11, 25-29 (1905) (court held compulsory smallpox vaccination to be a constitutional exercise of the police power; restraint on liberty was essential to secure public health); City of Little Rock v. Smith, 163 S.W.2d 705, 707-08

that police power regulation was immune from constitutional review, expressing the notion that, "where the police power is set in motion in its proper sphere, the courts have no jurisdiction to stay the arm of the legislative branch."[17] In their haste to give effect to any state action designed to promote health and welfare, these courts abdicated their traditional role as guarantor of constitutional rights.

The view that courts lacked the power to intervene in the exercise of public health powers was clearly wrong, even in the context of the early twentieth century. The U.S. Supreme Court, in *Jacobson v. Massachusetts*,[18] explained the proper role of the courts in reviewing public health legislation which prevailed for most of this century. The Court in *Jacobson* mandated that public health regulation be clearly designed to achieve a legitimate public health goal. Even though the goal of the legislature may be valid and beneficent, the methods adopted must have a "real or substantial relation" to protection of the public health, and cannot be "a plain, palpable invasion of rights."[19] The state "must refrain from acting in an arbitrary, unreasonable manner,"[20] or "going so far beyond what [is] reasonably required for the safety of the public."[21]

The "arbitrary, oppressive and unreasonable" standard was highly deferential. The Court would support any reasonable state regulatory measure which was not wholly irrational, indiscriminate or enacted in bad faith. The following cases established the parameters of this standard.

1. True Purpose

The preservation of the public health is a proper concern of state legislatures. Courts have looked beyond the nominal statutory intent to discover the true legislative purpose, however, and have not been bound by "mere forms," nor misled by "mere pretenses" under the guise of police powers.[22] They have required that the legislature's motivation be directed towards health and welfare, thereby disallowing a disguised form of discrimination. If prejudice were shown to have guided the exercise of police powers for the ostensible purpose of controlling AIDS or another infectious disease, the courts would not uphold the statute. Nor could the state,

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(Ark. 1942) ("private rights . . . must yield in the interest of the public security," venereal disease "affects the public health so intimately and so insidiously, that considerations of delicacy and privacy may not be permitted to thwart measures necessary to avert the public peril.").

[17] Arizona v. Southern Pacific Co., 61 Ariz. 66, 145 P.2d 530 (1943) (quoting State *ex rel.* McBride v. Superior Court, 103 Wash. 409, 174 P. 973, 976 (1918)).

[18] 197 U.S. 11 (1905); *see also* Mugler v. Kansas, 123 U.S. 623 (1887).

[19] *Jacobson*, 197 U.S. at 31.

[20] *Id.* at 28.

[21] *Id.*

[22] *See* City of Cleburne, Tex. v. Cleburne Living Center, Inc., 473 U.S. 432 (1985).

purporting to protect the public, arbitrarily interfere with private business, or impose unusual and unnecessary restrictions upon lawful activities; whether they have done so in a particular case is a judicial question.[23] If any doubt existed as to the actual purpose of the exercise of compulsory public health powers, the courts would be expected to delve deeply into the legislative history and full statutory scheme to discover the true legislative intent.

2. The Subject of Compulsory Powers Must Actually be Infectious

A substantial line of cases[24] requires medical proof that the subject of compulsory public health powers was actually infectious when the control measures were imposed.[25] "The mere possibility that persons may have been exposed to such disease [smallpox] is not sufficient .... They must have been exposed to it, and the conditions actually exist for a communication of the contagion."[26] Furthermore, these issues are to be determined by "medical science and skill, and not common knowledge."[27]

3. The Control Measure Itself Should Not Pose a Health Risk to Its Subject

Those who harbor a communicable virus can be required to submit to compulsory measures for the common good. The control measure itself, however, may not pose a health risk to its subject. In *Jew Ho v. Williamson*[28] the court was heavily influenced by evidence that confining large groups of people in an area where bubonic plague was suspected placed those under quarantine at increased risk of contracting the disease.[29]

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[23] *See* Lawton v. Steele, 152 U.S. 133 (1894); Jew Ho v. Williamson, 103 F. 102 (C.C.N.D. Cal. 1900).

[24] The early courts were not entirely consistent in requiring medical proof that the subject of compulsory public health powers was actually infectious. *See, e.g.*, State v. Rackowski, 86 Conn. 677, 681, 86 A. 606, 608 (1913) ("common knowledge tells us that contagious diseases may be communicated by those who have been exposed."). *See generally* Kirk v. Wyman, 83 S.C. 372, 65 S.E. 387 (1909).

[25] Railroad Company v. Husen, 95 U.S. 465, 471-73 (1887) (state prohibition of transporting foreign cattle, whether diseased or not, placed an unconstitutional burden on interstate commerce); *Ex parte* Martin, 83 Cal. App. 2d 164, 188 P.2d 287 (1948) (public health officials must have "probable cause" to quarantine pending an opportunity for further investigation or examination); *Ex parte* Shepard, 51 Cal. App. 49, 195 P. 1077 (1921) (court specifically rejected proposition that mere suspicion is sufficient to uphold a quarantine order); *Ex parte* Arata, 52 Cal. App. 380, 198 P. 814 (1921) (court required that reasonable ground must exist to support the claim that the person is afflicted with venereal disease); *Ex parte* Dillon, 44 Cal. App. 239, 186 P. 170 (1919) (marital status cannot constitute "reasonable cause" for suspicion of venereal disease); People v. Tait, 261 Ill. 197, 103 N.E. 750 (1913) (family member not residing in household affected by scarlet fever should not be quarantined).

[26] Smith v. Emery, 11 A.D. 10, 42 N.Y.S. 258 (1896).

[27] *Id.* at 260.

[28] 103 F. 10 (C.C.N.D. Cal. 1900).

[29] *Id.* at 22.

The court in *Kirk v. Wyman*[30] was quite prepared to uphold a quarantine despite the absence of proof that the form of leprosy from which Mary Kirk was suffering was contagious. Nevertheless, the court would not subject her to an unsafe environment. She was to have been quarantined in a pesthouse—a "structure of four small rooms in a row, with no piazzas, used heretofore for the isolation of negroes with smallpox, situated within a hundred yards of the place where the trash of the city . . . is collected and burned."[31] The court concluded that "even temporary isolation in such a place would be a serious affliction and peril to an elderly lady, enfeebled by disease, and accustomed to the comforts of life."[32] The public health department was compelled to wait until it had finished building Miss Kirk a "comfortable cottage" outside the city limits.[33]

Public health departments have an obligation to avoid unnecessary harm by providing safe environments for quarantine subjects. Indeed, the *quid pro quo* for loss of liberty should be an obligation to provide the finest possible care and conditions to those who must forego their individual rights for the collective good. Subjects of isolation or quarantine have committed no criminal offense, and should be afforded a habitable and healthful place to reside.

C. The Development of Modern Constitutional Principles

The three standards mentioned above still survive, and should apply in a contemporary judicial analysis, but a more rigorous examination under modern equal protection and due process standards is necessary.

Inherent in the reasoning of modern courts are the different levels of scrutiny undertaken for the various constitutionally protected interests and classes burdened by a particular control measure. Despite the traditional deferential posture of the courts, compulsory measures directed toward persons with infectious diseases are increasingly subject to judicial scrutiny. Almost all of the relevant cases were decided prior to the remarkable

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[30] 83 S.C. 372, 65 S.E. 387 (1909).

[31] *Id.* at 382-83, 65 S.E. at 391.

[32] *Id.*.

[33] *Id.* The court was less rigorous, however, in reviewing the conditions of quarantine in *Ex parte* Martin, 83 Cal. App. 2d 164, 188 P.2d 287 (1948). The court supported giving the health officers discretion as to the place of quarantine. The county jail was designated as a quarantine area for people with venereal disease despite uncontested evidence that it was overcrowded and had been condemned by a legislative investigating committee. The court supported the Attorney General's position that "[W]hile jails, as public institutions, were established for purposes other than confinement of diseased persons, occasions of emergency or lack of other public facilities for quarantine require that jails be used." *Id.* at 170, 188 P.2d at 291.

evolution in constitutional decision-making which has occurred since the civil rights movement.[34]

The Supreme Court, developing a higher level of constitutional review where state action interferes with fundamental liberties, has delineated several constitutionally protected rights, including travel,[35] marriage,[36] and certain privacy interests associated with family life and childbearing.[37] Traditionally, a judicial finding that a state measure impinges upon a fundamental right signals that the statute will be found unconstitutional. In the public health sphere, however, the court could conceivably uphold a statute which impinges upon fundamental rights, if that statute is clearly necessary for the health of the community.

Courts will strictly construe public health measures that burden constitutionally protected liberty, marital or privacy interests.[38] Such measures must be narrowly tailored to serve a compelling state interest. Moreover, the measure must be the least restrictive alternative for achievement of the public health objective.[39]

A number of traditional public health measures that impinge upon fundamental liberties could potentially trigger this higher level of judicial scrutiny. Any form of isolation, quarantine, or civil commitment directly impacts the right to liberty. Certain programs for premarital screening could potentially restrict the right to marry. A recently enacted Utah statute,[40] for example, proscribes marriage for any person with AIDS. As the AIDS infection has no cure, this statutory prohibition is permanent and irreversible. Given that the provision could achieve no compelling public health purpose, and that it would be a direct infringement of a fundamental right, the statute will in all likelihood be found unconstitutional. Total prohibition of marriage can be differentiated from other public health measures such as premarital screening for syphilis. In the latter situation, a person who tests positive can be effectively treated with penicillin and the marriage license can then be issued.

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[34] *See* Note, *The Constitutional Rights of AIDS Carriers*, 99 HARV. L. REV. 1274 (1986); Gostin, *The Future of Communicable Disease Control*, 64 MILBANK MEMORIAL FUND Q. 79 (1986).

[35] Shapiro v. Thompson, 394 U.S. 618, 629-31 (1969).

[36] Loving v. Virginia, 388 U.S. 1, 12 (1966); Zablocki v. Redhail, 434 U.S. 374, 383-84 (1978).

[37] *See* Griswold v. Connecticut, 381 U.S. 479 (1965).

[38] *See, e.g.*, Addington v. Texas, 441 U.S. 418, 425-27 (1979) (evaluating the standard of proof required for civil commitment of the mentally ill); Korematsu v. United States, 323 U.S. 214, 218 (1944) (finding that nothing short of apprehension by proper authorities of the gravest imminent danger to public safety can justify a curfew or forced removal from one's home).

[39] *See* Kramer v. Union Free School Dist., 395 U.S. 621, 627 (1969) (compelling state interest is necessary to justify restrictions on citizens' right to vote); Dunn v. Blumstein, 405 U.S. 330, 337 (1971).

[40] UTAH CODE ANN. § 30-1-2 (Supp. 1987).

The most challenging issue is the extent to which the constitutional right to privacy is applicable to traditional public health policies for casefinding (e.g. testing or contact tracing) and regulation of public facilities such as bathhouses or food establishments. A right to privacy is not enumerated in the Constitution, but the Supreme Court has recognized such a right where there is an expectation of intimacy in relation to contraception,[41] abortion,[42] and childrearing.[43] Any direct state health regulation in these areas could result in application of the highest level of judicial scrutiny. This might occur, for example, if the state required the termination of any pregnancy in which the mother is found to harbor the AIDS virus.

State regulation of sexual intimacy to control sexually transmitted diseases should be subject to right of privacy limitations, without differentiation for gays, prostitutes, or drug abusers. Any careful reading of the current jurisprudence of the Supreme Court, however, would conclude that the right to privacy is not elastic and will be rigidly applied only to those areas where there is direct precedent, such as abortion or contraception.

The most instructive decision on the future of the right to privacy is *Bowers v. Hardwick*,[44] which significantly delimits the privacy rights that the Court is prepared to protect under its higher level of scrutiny. The Court found that the constitutional right to privacy would not "extend to a fundamental right to homosexuals to engage in acts of consensual sodomy."[45] The state interest in interfering with consensual sexual relations among adults is almost entirely a matter of public morality. If the Court is prepared to uphold state action on this basis, it will undoubtedly uphold legitimate public health measures which interfere with intimate sexual activities, such as contact tracing or the closing of bathhouses.[46]

The two-tiered constitutional analysis developed by the courts is subject to criticism because it is highly mechanistic. If specific "fundamental" rights are affected, a court will analyze the statute critically; if no "fundamental" rights are affected, the constitutional restraints on state action are negligible. This form of constitutional analysis is not useful in the area of public health, which requires a sensitive balancing of the efficacy of a public

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[41] Carey v. Population Servs. Int'l, 431 U.S. 678 (1976).

[42] Roe v. Wade, 410 U.S. 113 (1973); Doe v. Bolton, 410 U.S. 179 (1973).

[43] *See* Pierce v. Society of Sisters, 268 U.S. 510, 535 (1925); Meyer v. Nebraska, 262 U.S. 390 (1923).

[44] 106 S. Ct. 2841 (1986). *See generally* Stoddard, *Bowers v. Hardwick: Precedent by Personal Predilection*, 54 U. CHI. L. REV. 648 (1987).

[45] *Bowers*, 106 S. Ct. at 2844.

[46] The Supreme Court has yet to decide whether infringements on the right to heterosexual privacy, such as fornication statutes, are constitutional. It is arguable, however, that the Court would more closely scrutinize public health measures which restrict heterosexual activities than it would those proscribing homosexual relations.

health measure with the infringement upon individual rights. Consider, for example, a statute banning certain meeting places where sexual activity takes place, such as bathhouses, brothels, or even hotel rooms used by unmarried couples. Such a statute would interfere with sexual intimacy, but the circumstances probably do not come within the Supreme Court's narrow view of constitutionally protected privacy interests.

Recent decisions, notably *City of Cleburne, Texas v. Cleburne Living Center*,[47] have begun to erode the Supreme Court's artificial tiers of scrutiny. The *Cleburne* Court struck down a zoning ordinance excluding group homes for mentally handicapped people. Although the Court found no reason to raise its standard of review, it nevertheless searched deep into the record to conclude that no rational basis existed for believing that mentally handicapped people would pose a special threat to the city's legitimate interests.[48]

The critical teaching of *Cleburne* is that public policy makers can be virtually assured of judicial and political support for compulsory public health measures to control the spread of infectious disease, provided they are based upon the current state of scientific understanding. Such measures would not be required "to resort to close distinctions or to maintain a precise, scientific uniformity,"[49] no matter how desirable this may be. What policy makers may *not* do—even under the judiciary's "minimum rationality" review—is base their measures on "vague, undifferentiated fears . . . of some portion of the community" or on "irrational prejudice."[50] Nor may public health regulators succumb to "a bare . . . desire to harm a politically unpopular group."[51] Thus a measure adversely affecting any individual must not only be justified by a good faith intention to promote the health of the community and shown not to discriminate against particular groups such as gays, prostitutes, or IV-drug abusers; it must also be supported by evidence of the potential efficacy of the measure.

II. CRITERIA AND PROCEDURES FOR PUBLIC HEALTH STATUTES

Most public health statutes and court decisions have expressed little regard for the burden imposed upon individual rights by the exercise of compulsory powers; therefore, no clearly stated criteria or procedures exist to guide public health officials in the exercise of their powers. Society,

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[47] City of Cleburne, Tex. v. Cleburne Living Center, Inc., 473 U.S. 432 (1985).

[48] *Id.* at 447-50.

[49] *Id.* at 459 (opinion of Marshall, J., concurring in part) (quoting Allied Stores of Ohio, Inc. v. Bowers, 358 U.S. 522, 527 (1959)).

[50] *Id.* at 445, 450.

[51] *Id.* at 447 (quoting United States Dep't of Agric. v. Moreno, 413 U.S. 528, 535 (1973)).

through the legislature, has not yet established the proper criteria for making important public health decisions. The delicate balance between public protection and individual rights is thus left to the unfettered, largely unreviewable discretion of public health officials. Moreover, public health statutes often fail to provide the rigorous and impartial decision-making standards required by fourteenth amendment due process considerations. Considering that public health law is one of the very few areas in which individual liberty can be restricted without the commission of a criminal offense, the criteria and procedures for decision-making must be clearly understood and fairly applied.

A. Criteria for Accountable and Consistent Decision-Making

Clearly stated criteria for the regulation of public health and civil liberties are essential. Society, through its legislature and judiciary, must determine the circumstances under which exercise of compulsory public health powers is justified. Both legislatures and courts have, however, been silent with respect to the legitimate boundaries of public health power. The absence of clear legislative criteria and judicial oversight has resulted in unjustifiably restrictive measures due to health officials' response to the pressure of public fear. Even worse, public health measures have sometimes been mere pretenses for restricting the rights of politically insular or unpopular minority groups.[52]

Current public health statutes provide only the most general criteria under which compulsory powers can be exercised, leaving the public health officer with wide discretion. The California Health and Safety Code, for example, allows the state to imprison or confine an individual "for the protection of the public peace or health . . . ."[53] The New York Public Health Law similarly empowers the health officer to isolate persons when necessary for the protection of the public health.[54]

If challenged in court today, the criteria in many current public health statutes for depriving an individual of liberty would likely be held unconstitutionally vague.[55] Civil commitment of the mentally ill or drug dependent is the only other legal context in which liberty may be deprived without proof of the commission of a criminal offense; confinement for both public health and mental health reasons is based upon the principle

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[52] *See, e.g.*, Jew Ho v. Williamson, 103 F. 10 (C.C.N.D. Cal. 1900), discussed *infra* at text accompanying notes 89-91.

[53] Cal. Gov't Code § 202 (West 1980) (authority to confine for protection of public peace or health).

[54] N.Y. Pub. Health Law § 2100 (McKinney 1985) (communicable disease provisions and powers, duties of local boards of health and health officers).

[55] *E.g.*, Hancock v. Cox, 212 Va. 215, 183 S.E.2d 149 (1971) (statute requiring civil commitment of alcoholics struck down as unconstitutionally vague).

that restriction of individual rights is justified by the avoidance of future harm to the community. Mental health statutes prior to the 1970's had language similar to that still used in public health statutes. They authorized civil commitment if the patient was mentally ill and "in need of treatment or care" or if commitment was necessary to protect the welfare of the individual or the welfare of others.[56] Many statutes were struck down as unconstitutionally vague and insufficiently related to the state's valid interests in protecting the public from harm.[57]

Broad discretionary language has remained in public health statutes only because it has not been challenged in the courts since the developments in constitutional law described above. The incorporation of clear statutory criteria into public health statutes could help prevent inappropriate use of public health powers. Objective criteria are important because they place boundaries upon the discretion of public health officials, and put individuals on notice as to the circumstances which may give rise to loss of liberty. Ultimately, such standards allow society, through its legislative process, to achieve the delicate balance between individual autonomy and the public health. Clear statutory criteria would produce more consistent decision-making and avoid measures based upon unsubstantiated fears or prejudice.

B. Procedures for Fair and Impartial Decision-Making

In addition to specifying standards for restraining individuals, a scheme for the control of communicable disease must identify the decision-makers and describe a process for gathering information and making fair and correct decisions. Most state statutes delegate wide discretion to public health officials and have not carefully considered procedural safeguards designed to achieve both a more accurate fact-finding process and greater equity and fairness to the individual whose liberty is to be restrained.

Many public health statutes are either silent or wholly inconsistent in their provision of procedural due process protections to subjects of compulsory powers. Commonly, compulsory powers are delegated to administrative public health officers without any explicit procedural requirements. California law, for example, authorizes the California Department of Health Services to identify and then quarantine or isolate individuals with a

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[56] *See generally* Developments in the Law, *Civil Commitment of the Mentally Ill*, 87 HARV. L. REV. 1190 (1974).

[57] *E.g.*, Lessard v. Schmidt, 349 F. Supp. 1078 (E.D. Wis. 1972) (statute permitting civil commitment without adequate notice or opportunity for hearing violates due process); Johnson v. Soloman, 484 F. Supp. 278 (D. Md. 1979)(civil commitment based on assessment of juvenile's "best interests" is unconstitutionally vague).

communicable disease whenever, *in its judgment*, such action is necessary to protect or preserve the public health.[58] Similar language is found in many public health statutes across the country.[59]

A few statutes do mandate application to a judge or magistrate for an order of isolation or quarantine, but specify no other procedural requirements.[60] Even statutes recognizing the importance of an impartial fact-finder for an order of isolation or quarantine fail to provide procedural safeguards prior to the exercise of other compulsory powers, such as mandatory physical examination, treatment, or contact tracing. For example, several statutes originating in the 1940's identify specific categories of individuals who may be required to undergo venereal disease examination by a public health officer.[61] The applicable New Jersey statute, for example, creates a presumption that a prostitute "or other lewd person" may reasonably be suspected of having a venereal disease and may therefore be subjected to examination at any time without a hearing.[62]

These statutory provisions survive only because they have yet to be challenged in the courts. Mental health statutes before the 1970's which failed to require rigorous due process procedures were found violative of the due process clause of the fourteenth amendment.[63] The mental health cases have required notice and a hearing before a judge, and established a right to counsel.[64] The standard of proof constitutionally required at civil commitment hearings is more than a preponderance of evidence; typically, commitment demands "clear and convincing evidence."[65]

Courts in the current process-oriented era of constitutional review would most likely require procedural safeguards prior to or—in an emergency—immediately after the exercise of personal control measures to protect the public health. In determining the kinds of procedures re-

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[58] CAL. HEALTH & SAFETY CODE § 3050 (West 1979).

[59] *E.g.*, FLA. STAT. ANN. § 384.28(1) (West Supp. 1987); N.J. STAT. ANN. § 26:4-2 (West 1987). *But see* CONN. GEN. STAT. ANN. § 19a-5 (West 1986) (duties of Public Health Commissioner more detailed).

[60] *See, e.g.*, N.Y. PUB. HEALTH LAW § 2301 (McKinney 1985). For example, the court in *State v. Snow*, 230 Ark. 746, 324 S.W.2d 532 (1959) was able to thwart a state effort to quarantine an individual for tuberculosis only because initial judicial approval was required by the authorizing statute before enforcement could take place.

[61] *E.g.*, N.J. STAT. ANN. §§ 26:4-32 (applicable to prostitutes), § 26:4-49.6 (West 1987) (applicable to migrant workers).

[62] N.J. STAT. ANN. § 26:4-32 (West 1987).

[63] *See, e.g.*, Lessard v. Schmidt, 349 F. Supp. 1078 (E.D. Wis. 1972); *In re* Seefield, 2 MENTAL DISABILITY L. REP. 363 (Wis. Cir. Ct. 1977) (sequel to *Lessard*; the Wisconsin statute enacted in response to *Lessard* was held unconstitutional); Colyar v. Third Judicial Dist. Court, 469 F. Supp. 424 (D. Utah 1979); Suzuki v. Yuen, 617 F.2d 173 (9th Cir. 1980).

[64] Vitek v. Jones, 445 U.S. 480 (1980) (inmate has liberty interest in preventing transfer from prison to mental institution).

[65] Addington v. Texas, 441 U.S. 418 (1979)("clear and convincing proof" is required for indefinite involuntary commitment).

quired under the fourteenth amendment, the courts balance the interests of the state with those of the individual.[66] The state's interest in protecting the public from serious harm is compelling. The interest of the individual grows with the level of coerciveness of the public health measure to be applied. When a control measure, such as isolation, infringes upon liberty, the courts will likely require strict procedural due process safeguards in light of the deep invasion of personal rights, the risk of erroneous fact-finding, and the importance of avoiding confinement of nondangerous persons.

The West Virginia Supreme Court reasoned in *Greene v. Edwards*[67] that there is little difference between loss of liberty under mental health and public health rationales. Each case bases the exercise of the police power upon protection of the public. The individual's loss of freedom is calculated primarily for the common good. Prospective subjects of quarantine are therefore entitled to the same procedural safeguards as a person facing civil commitment: written notice, counsel, presentation of evidence, cross examination, a "clear and convincing" standard of proof, and a verbatim transcript for appeal. The state need not, however, go so far as to provide the procedural safeguards of a criminal trial.[68] The foregoing procedural requirements should be built into public health statutes. Prior to—or in cases of urgent necessity—immediately after the imposition of personal control measures, an impartial decision-maker should hear the case. This function should properly come within the jurisdiction of the courts. The states should bear the burden of providing a hearing; the individual should not be left to discover after-the-fact remedies such as habeas corpus. The potential subject of control measures should have the right to be represented by counsel, to promote critical examination of the grounds and evidence upon which decisions are to be made.

State legislatures should give careful thought to these procedural safeguards designed to achieve both a more accurate fact-finding process and greater equity and fairness to the individual whose liberty is to be restrained. Procedural due process is not merely protective of the individual; it is also a means of ensuring high quality decision-making where a structured opportunity for full information is presented to a dispassionate decision-maker. Such hearings provide an opportunity for public health officials to review their general strategy for controlling disease epidemics, together with the application of that strategy in the particular case.

Society has not used its legislature to delimit the circumstances under which important public health decisions should be made. As public health

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[66] Mathews v. Eldridge, 424 U.S. 319 (1976).
[67] 263 S.E.2d 661 (W. Va. 1980).
[68] *Id.* at 662.

is one of the very few reasons for which individual liberty can be restricted absent the commission of a criminal offense, it is essential that legislatures guide officials to clearly understand and fairly apply decision-making criteria and procedures.

III. PRINCIPLES FOR THE FUTURE OF PUBLIC HEALTH LEGISLATION

As guidelines for state and local legislatures in reforming their public health statutes, I propose the following bases for public health statutes:

(1) public health statutes should be uniformly structured; the current artificial boundaries extended between venereal and communicable diseases should be removed;
(2) the exercise of compulsory powers should be based upon a demonstrated "public health necessity," which includes a serious danger to others;
(3) strong confidentiality protections should be in place; and
(4) a graded series of less restrictive powers should be available to the public health department.

A. Structural Defects in Public Health Statutes: Disease Classification

Most public health statutes cannot deal sensitively and flexibly with the wide range of diseases facing modern public health departments. Many are severely outdated, having been fashioned on an ad hoc basis, with new statutory or administrative layers added as new health crises arose. In essence, the laws have developed by putting out fires, without comprehensive planning for modern public health problems. This "firefighting" approach to public health laws left health officials with few tools to combat the sudden introduction of a highly lethal blood borne disease such as AIDS, a disease with a long incubation period and chronic infectiousness. AIDS has drawn attention to the deficiencies in public health legislation.

Most current statutory schemes erect an artificial boundary between venereal (sexually transmitted) diseases and other communicable diseases.[69] Each disease must fit within the straitjacket of these two rigid classifications. The rationale behind classifying diseases is to distinguish between their modes of transmission. Most state statutes deal with sexually transmitted diseases, such as syphilis, gonorrhea, and herpes, separately from all other communicable diseases.

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[69] *E.g.*, Cal. Health & Safety Code § 3194 (West 1979); Fla. Stat. Ann. § 384.01 (West 1986). Sometimes diseases are classified as neither communicable nor venereal, but simply as "reportable" or "notifiable." This indicates that the disease is not subject to control measures, but that it must be reported to the public health department. The public health department collects this data for epidemiologic purposes, to determine the spread pattern of the disease within the population.

The classification of a particular disease is of particular significance in most statutory schemes. Current venereal or sexually transmitted disease classifications almost universally authorize stricter personal control measures.[70] Individuals with a venereal disease are potentially subject to compulsory reporting requirements, surveillance, sexual contact tracing, physical examination, treatment and isolation. Approximately one-half of the public health statutes also specifically make the intentional or reckless spread of venereal diseases a criminal offense.[71]

By contrast, diseases classified as communicable generally do not automatically authorize isolation, contact tracing, physical examination, or treatment. Most statutes require the promulgation of a specific regulation in order to exercise compulsory public health powers to combat communicable diseases.

Another consequence of classification is a greater degree of confidentiality for individuals with venereal diseases. If a disease is classified as sexually transmitted, there is usually a specific statutory provision proscribing the release of personal information, sometimes even in response to a judicial subpoena.[72] If a disease is classified as communicable, there is frequently only weak statutory protection of confidentiality. The justification most often offered is that sexually transmitted diseases are believed to involve social or moral opprobrium and reputational damage.

The artificial boundary between communicable and venereal disease is attributable to the dead weight of tradition; no substantial justification exists for its continuance in public health statutes. There are four major reasons for this conclusion. First, many diseases do not come tidily packaged according to their mode of transmission, but have overlapping mechanisms of communication. Blood-borne diseases, such as hepatitis B or AIDS, are transmitted through bodily fluids including blood and semen. There is no logical reason for designating such diseases exclusively as either communicable or venereal, as they have characteristics of both categories. When a new infectious disease is spreading rapidly through the population, it must be classified within the rigid statutory scheme. Placing a disease in a particular classification often requires a public health (sometimes a quasi-political) decision involving a time consuming amendment to the regulations. State by state classification decisions for AIDS have resulted in confusion, delay, and illogical conclusions.

Second, the overriding purpose of public health statutes is to determine the circumstances under which public health officials should be au-

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[70] *E.g.*, CAL. HEALTH & SAFETY CODE § 3191 (West 1979); ILL. ADMIN. CODE tit. 77, § 690 (1985 & Supp. 1986).

[71] *See generally* Field & Sullivan, *AIDS and the Criminal Law*, 15 LAW MED. & HEALTH CARE 46 (1987).

[72] *E.g.*, CAL. HEALTH & SAFETY CODE § 199.20-21 (West Supp. 1987); WISC. STAT. ANN. § 146.025(5) (West Supp. 1987).

thorized or mandated to exercise their powers. The major concerns of public health officials are the degree of danger to the community, the existence of effective public health interventions to impede the spread of disease, and the liberty and privacy infringement entailed in exercising public health powers. These considerations cut across the statutory classifications and are equally applicable to venereal and communicable diseases. Although the mode of transmission is of critical importance in formulating infection control strategies, there is no neat package of measures appropriate to one disease grouping as opposed to another. Confidentiality is desirable for all diseases.

The third reason for opposing the traditional classification of diseases is that venereal disease controls are based upon antiquated and decidedly discriminatory public health and social perspectives. Reminiscent of an earlier era, venereal disease classifications connote punishment for wrong-doers. The concomitant problems inherent in surveillance, intimate physical examination, and personal controls have little to do with valid public health concerns such as the degree of risk to the population. These provisions have persistently been targeted at prostitutes, and, in the early to middle part of this century, resulted in isolation of thousands of people.[73] This use of public health isolation became entwined with social stigma, social control, and the criminal law. The interconnection of public health and punitive criminal law was manifested in several ways: states allowed prostitutes to be held in custody longer than the criminal law would itself allow,[74] created specific criminal penalties for intended or reckless transmissions of disease,[75] allowed the indiscriminate use of public health powers without proof that the "prostitute" was even infectious,[76] and permitted the use of overcrowded prisons for incarceration pursuant to public health powers.[77]

The fourth reason for opposing existing disease classifications is that they are unnecessarily complicated and confusing. Public health statutes across the nation are often indigestible amalgams, comprised of several layers of statutory provisions and administrative rulemaking. They are often beyond the comprehension of informed members of the public, and difficult to construe even for experienced public health officials and lawyers. Simply gaining access to a complete package of regulatory measures and relevant notices is a difficult undertaking. Lack of clarity in law is

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[73] *See* A. BRANDT, NO MAGIC BULLET: A SOCIAL HISTORY OF VENEREAL DISEASE IN THE UNITED STATES SINCE 1880 84-92 (1985); *see also* Parmet, *supra* note 15, at 66-67.

[74] Parmet, *supra* note 15, at 66.

[75] Field & Sullivan, *supra* note 71.

[76] *Ex parte* Company, 106 Ohio St. 50, 53, 139 N.E. 204, 205 (1922).

[77] *Ex parte* Martin, 83 Cal. App. 2d 164, 170, 188 P.2d 287, 291 (1948).

unsatisfactory, particularly where the decisions to be made affect the public health and individual rights.

The only arguably valid reason for creating separate disease categories is that the substantive provisions in the different categories may be better suited to helping public health officials impede the spread of disease. This advantage does not accrue, however, from existing disease classifications. No clear public health rationale exists for providing statutory authority to control the spread of only venereal diseases, and not certain communicable diseases. It is odd, for example, to suppose that an airborne disease is not necessarily isolable without a specific regulatory amendment, while a sexually transmitted disease is always isolable.

The modes of transmission of the human immunodeficiency virus (HIV) cut across both statutory classifications; it is not logical, therefore, to classify AIDS under a single heading. Yet, the fact that AIDS is a rapidly spreading disease and that sexual contact is by far the major means of transmission suggest a designation as venereal. The Texas Public Health Department proposed to categorize HIV as a sexually transmitted disease in 1985 and 1986, but was forced to withdraw the proposal. (In 1987, Texas finally changed the classification of HIV infection to communicable).[78]

Public health departments generally have avoided classifying AIDS as a venereal disease or have simply failed to amend their regulations at all, because any AIDS activity is subject to intense public scrutiny, and may be construed as an intention to secure those compulsory powers against vulnerable groups. Yet, there is no clear public health rationale for providing statutory authority to control the spread of venereal communicable diseases, while providing no statutory authority to control the spread of AIDS. Nor is there a clear rationale for affording greater confidentiality protection for venereal diseases than for AIDS and diseases like it. The political entanglement caused by the classification of AIDS is exemplified by Proposition 64 in California, in which voters were asked whether AIDS should be added to the list of "infectious, contagious, and communicable diseases" for which reporting, employment restriction, and isolation of individuals were specifically authorized. The voters overwhelmingly rejected the proposal. The California experience demonstrates that public health regulation has become a charged political act, rather than a rational public health determination.

B. PUBLIC HEALTH NECESSITY

The constitutional foundation for the exercise of compulsory powers is a public health necessity.[79] This section proposes that "public health neces-

[78] TEX. REV. CIV. STAT. ANN. art. 4419b-1 (Vernon Supp. 1988).

[79] *See, e.g.*, Jacobson v. Massachusetts, 197 U.S. 11, 25 (1905); State v. Rackowski, 86 Conn.

sity" should be made a specific component of modern public health statutes. Although the principle of public health necessity may appear basic, a brief review of the exercise of public health powers during this century will demonstrate that repeated and serious abuses of public health powers are traceable to statutory lack of clarity and the failure to require scientific evidence of necessity.

1. The Historical Use of Public Health Powers in the Absence of Necessity

The absence of a clear statutory or judicial requirement of necessity as the foundation for public health action has resulted in largely ineffective and highly invidious infection control strategies. Some of the worst abuses against vulnerable groups have occurred in the name of public health.

Some early public health cases illustrate the harm that can result from imposing control measures that are not clearly supported by scientific evidence. In *Kirk v. Wyman*,[80] an elderly woman with anaesthetic leprosy was isolated even though there was "hardly any danger of contagion."[81] She had lived in the community for many years, attended church services, taught in school, and mingled in social life without ever communicating the disease. The court thought it "manifest that the board were well within their duty in requiring the victim of it to be isolated" when the "distressing nature of the malady is regarded."[82] The court's preparedness to support the public health department was not diminished by the fact that Mrs. Kirk's disease was incurable and that the isolation would be indefinite. In *State v. Rackowski*,[83] the court did not require any more than "common knowledge" in deciding whether or not a person had scarlet fever.[84]

The worst cases of misuse of public health power occur when public health measures appear to be associated with discrimination against vulnerable groups. In the early to middle part of this century, tens of thousands of prostitutes were "quarantined" as real or suspected carriers of venereal disease.[85] In *Ex parte Company*,[86] the court upheld a quarantine regulation which included a provision that "[a]ll known prostitutes and persons associated with them shall be considered as reasonably suspected of

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677, 680, 86 A. 606, 608 (1913); Chy Lung v. Freeman, 92 U.S. 275, 280 (1875) (the right of a state to protect the public health can only arise from a vital necessity for its exercise, and cannot be carried beyond the scope of that necessity); Rock v. Carney, 216 Mich. 280, 297, 185 N.W. 798, 799 (1921); Wilson v. Alabama G.S.R. Co., 77 Miss. 714, 719, 28 So. 567, 569 (1900). *But see* Kaul v. City of Chehalis, 45 Wash. 2d 616, 623, 27 P.2d 352, 356 (1954).

[80] 83 S.C. 372, 65 S.E. 387 (1909); *see* text accompanying notes 22-33 *supra*.

[81] *Kirk*, 83 S.C. at 377, 65 S.E. at 390.

[82] *Id.*

[83] 86 Conn. 677, 86 A. 606 (1913).

[84] *Id.* at 681, 86 A. at 608.

[85] A. BRANDT, *supra* note 73.

[86] 106 Ohio St. 50, 139 N.E. 204.

having a venereal disease."[87] The court did not appear unduly concerned with whether or not Martha Company actually had venereal disease. Even as late as 1944, a court accepted the logic that "suspected" prostitutes were "natural subjects and carriers of venereal disease," making it "logical and natural that suspicion be cast upon them."[88]

One of the most invidious public health measures was struck down in *Jew Ho v. Williamson.*[89] Public health officials had quarantined an entire district of San Francisco containing a population of more than 15,000 persons, ostensibly to contain an epidemic of bubonic plague, which is most easily communicated in conditions of overcrowding and unsanitary conditions. The court said that the public health measure actually posed a danger to the health of the community: "[i]t must necessarily follow that, if a large territory is quarantined, intercommunications of the people within that territory will rather tend to spread the disease than to restrict it."[90] More importantly, the quarantine was made to operate exclusively against the Chinese community, demonstrating an "evil eye and an unequal hand."[91]

Modern courts have consistently required a clear public health justification for any personal control measure. In *New York State Association for Retarded Children v. Carey,*[92] the Court of Appeals for the Second Circuit determined that mentally retarded children who were carriers of serum hepatitis could not be excluded from regular public school classes. Hepatitis B is transmitted by blood. Although the virus is found in saliva, it is an inefficient mode of transmission. The court found that "the Board was unable to demonstrate the health hazard . . . was anything more than a remote possibility."[93] This remote possibility did not justify the action taken, considering "the detrimental effects of isolating the carrier children."[94] The Court was sensitive to the fact that segregation of mentally retarded children would "reinforce the stigma to which these children have already been subjected."[95]

The trial court in *District 27 Community v. The Board of Education*[96] proscribed discrimination against a school child with AIDS:

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[87] *Id.* at 53, 139 N.E. at 205.

[88] People *ex rel.* Baker v. Strautz, 386 Ill. 360, 367, 54 N.E.2d 441, 444 (1944).

[89] 103 F. 10 (C.C.N.D. Cal. 1900).

[90] *Id.* at 22.

[91] *Id.* at 24.

[92] New York State Assoc. for Retarded Children, Inc. v. Carey, 612 F.2d 644 (2d Cir. 1979).

[93] *Id.* at 645.

[94] *Id.* at 650.

[95] *Id.*

[96] District 27 Comm. School Bd. v. Board of Educ., 130 Misc. 2d 398, 502 N.Y.S.2d 325 (Sup. Ct. 1986).

> [Since] the apparent nonexistent risk of transmission of HTLV-III/LAV in the school setting finds strong support in the epidemiologic data ... and because the automatic exclusion of children with AIDS ... would effect a purpose having no adequate connection with public health, it would usurp the function of the commissioner of health if this court adjudged ... that the non-exclusion policy was arbitrary and capricious.[97]

Other contemporary public health cases have taken the same view of the requirement of a public health necessity. Discrimination against a teacher with tuberculosis was proscribed in *Arline v. School Board of Nassau County*.[98] The Supreme Court insisted upon some plausible medical justification for the discriminatory action.[99] The danger of proceeding with compulsory public health action in the absence of a solid scientific foundation has been frequently demonstrated in the course of contemporary public health history.[100] It is important that state statutes clearly specify "public health necessity as the foundation for the exercise of compulsory powers."

2. The Avoidance of Serious Harm

To establish a public health necessity, the state should demonstrate, by clear and convincing scientific, epidemiologic, and/or medical evidence, that:

> (1) there is urgent need to interrupt the spread of an epidemic;
> (2) in a particular case, the person is shown to be infectious by a thorough medical examination and any necessary serologic or other tests;
> (3) there is a reasonably high probability that the infection will be communicated; and
> (4) the control measure is likely to be effective in eliminating or reducing the risk of contagion.

Public health statutes should be designed to prevent a significant deprivation of individual rights based upon purely speculative assumptions. The justification for a public health action that fundamentally interferes with individual rights must be a currently established scientific assessment of reasonably high probability of serious harm. Public health powers are exercised under the theory that they are necessary to prevent an avoidable harm. An important public health question is how serious and

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[97] 502 N.Y.S.2d at 335.
[98] *School Bd. v. Arline*, 107 S. Ct. 1123 (1987).
[99] *Id.* at 1129.
[100] *See generally* A. BRANDT, *supra* note 73.

probable that harm must be in order to justify deprivation of individual rights.

In exercising a compulsory power, the state is not purporting to act in the interest of the individual and does not require a showing that the intervention is justified by personal incompetency, self-protection, or the need for care or treatment. As the predominant rationale for public health intervention is prevention of harm to the public, the seriousness and probability of that harm should be the primary parameter for decision-making. The absence of any intention to serve the interests of the individual suggests that the threshold for public health action should be a reasonably high probability of serious harm to the public.

A decision to take compulsory public health action in any individual case should be based upon a careful balance between the degree of intrusion upon individual rights and the probability and gravity of the harm to be avoided. As the public health measure becomes more intrusive in its restriction of rights and longer in duration, the gravity and probability of harm must be greater in order to justify the action. Ultimately, the right of the state to take measures which avoid a probable and grave harm must be respected, even at the cost of individual civil liberties. It does no service to groups at risk for disease to fail to implement effective public health measures in the name of protection of their liberty. The health of the community is perhaps the most important human and societal value.

C. Confidentiality

A person's health status is a private matter, and contraction of a communicable disease can be stigmatizing. Many personal reasons exist for keeping health care information confidential. The methods usually associated with contracting the disease can be deeply intertwined with morals and the criminal law. Sexual transmission of syphilis or gonorrhea is an intimate matter. Certain forms of transmission of a sexually transmitted disease, such as through anal intercourse, associates a person with homosexuals, a group long scorned and victimized. Sodomy, moreover, is a crime in approximately half the states,[101] and the Supreme Court has held these criminal statutes constitutional.[102] Other diseases such as AIDS and hepatitis can be contracted through intravenous needle use, associated with drug abusers.

In addition to the method of *contracting* the disease, an important

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[101] *See* Note, *The Constitutional Status of Sexual Orientation: Homosexuality as a Suspect Classification*, 98 HARV. L. REV. 1285, n.4 (1985) (twenty-three states and the District of Columbia still have criminal statutes proscribing private, consensual sodomy).

[102] Bowers v. Hardwick, 106 S. Ct. 2841 (1986) (state criminal sanctions for consensual homosexual sodomy upheld as applied).

reason for confidentiality is the perceived chance of *transmitting* the disease. AIDS, leprosy, and tuberculosis are feared because they are sometimes perceived as being transmittable through casual contact. People with these and other diseases are shunned, because the community fears that their children will be exposed to the disease in public places such as schools.

For certain noninfectious diseases such as mental illness, drug dependency, or alcoholism, there is often an attribution of blame, and a perceived association with dangerous behavior and/or idleness. Many in the community morally disapprove of the disease status itself. Social stigmatization is a strong reason for holding health information confidential. Even more important is the discrimination which can result from a breach of confidence. America has read almost daily about the discrimination against persons with the AIDS virus: seclusion of children from school, and loss of employment, housing, or insurance.[103]

Confidentiality also has an important public health purpose. The objective of public health officials is to encourage individuals to come forward for testing, education, counselling, medical examination, vaccination and treatment. The basis for cooperation with public health objectives depends upon both the trust a person has in the confidentiality of information, and the strength of legal protection.

Confidentiality of health care information at present can be compromised in many ways. The diagnosis that a person has an infectious disease, or carries an infectious agent, may trigger a statutory or regulatory obligation upon the physician or laboratory to report the patient's name to the public health department. The public health department will usually keep the person's name or other identifying characteristics on a register, and may use the information for tracing sexual contacts.

A diagnosis of an infectious disease will also be written into the patient's medical record. That record is made available to staff throughout the hospital, and is frequently given to third party payors outside the hospital. This wide accessibility to the medical record increases the likelihood of negligent or intentional disclosure. A number of common law, constitutional, and statutory confidentiality protections exist, but are sometimes insufficient.

The unauthorized disclosure of confidential information during the course of a physician-patient relationship is a common law tort. Most courts have imposed a legally enforceable duty of confidentiality and have grounded their decisions upon the importance to public policy of a sphere of privacy between doctor and patient.[104] The Massachusetts Supreme

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[103] *See generally* D. ALTMAN, AIDS IN THE MIND OF AMERICA: THE SOCIAL, POLITICAL, AND PSYCHOLOGICAL IMPACT A NEW EPIDEMIC (1986).

[104] *See* Hammonds v. Aetna Casualty & Sur. Co., 243 F. Supp. 793, 801-02 (N.D. Ohio 1965); Humphers v. First Interstate Bank, 298 Or. 706, 696 P.2d 527 (1985); *cf.* Hague v. Williams, 37 N.J. 328, 181 A.2d 345 (1962).

Judicial Court held that a "duty of confidentiality arises from the physician-patient relationship and that a violation of that duty, resulting in damages, gives rise to a cause of action sounding in tort against the physician."[105]

Constitutions also protect the right to privacy.[106] The Supreme Court has limited the right to privacy under the U.S. Constitution to certain narrow areas surrounding procreation, family life and child rearing.[107] Yet, the Court has indicated that the state must maintain strong protections of confidentiality of information collected by the public health department. In *Whalen v. Roe*,[108] although the Court upheld reporting requirements reasonably related to a valid public health purpose, it required both the containment of the information within the public health department, and the existence of adequate statutory protection of confidentiality.

In addition to information reported to the public health department, federal courts have required confidentiality of research data. In *Farnsworth v. Procter & Gamble Co.*,[109] the United States Court of Appeals for the Eleventh Circuit upheld the right of the Centers for Disease Control ("CDC") to protect information furnished by women research subjects in the CDC's Toxic Shock Syndrome Studies, noting:

> [T]he Center's purpose is the protection of the public's health. Central to this purpose is the ability to conduct probing scientific and social research supported by a population willing to submit to in-depth questioning. Undisputed testimony in the record indicates that disclosure of the names and addresses of these research participants could seriously damage this voluntary reporting. Even without an express guarantee of confidentiality there is still an expectation, not unjustified, that when highly personal and potentially embarassing information is given for the sake of medical research, it will remain private.[110]

Finally, protections of confidentiality are founded in most state public health statutes.[111] The strongest confidentiality protections apply to sexually transmitted diseases, "STDs," because of the deeply rooted personal values and moral overtones associated with venereal diseases.[112] One of the

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[105] Alberts v. Devine, 395 Mass. 59, 69, 479 N.E.2d 113, 120 (1985).

[106] The right to privacy has been expressly protected in several state constitutions. *See, e.g.*, CAL. CONST. art. 1, § 1.

[107] *See supra* notes 37, 41, 44 and accompanying text.

[108] 429 U.S. 589 (1977).

[109] 758 F.2d 1545 (11th Cir. 1985).

[110] *Id.* at 1547.

[111] *E.g.*, FLA. STAT. ANN. § 381.231 (West 1986); ILL. REV. STAT. ch. 126, ¶ 21 (West Supp. 1987).

[112] *See* notes 70-72 *supra* and accompanying text.

major elements of a sound confidentiality statute is its ability to protect records against subpoena or judicial order. A few statutes such as those in Illinois[113] and New York City[114] have been judicially construed to ensure that the privilege or exemption under the statute overrides the subpoena or judicial order.

Certain diseases, such as chemical dependency and AIDS, have been considered sufficiently stigmatizing to warrant special confidentiality protection. The federal Confidentiality of Alcohol and Drug Abuse Records Regulations[115] cover any program which holds itself out as providing diagnoses, treatment, or treatment referrals for alcohol or drug abuse, and which is federally assisted, directly or indirectly.

An increasing number of state statutes also protect HIV-related information.[116] The level of protection of confidentiality varies under each statute. Early statutes, such as those of California and Massachusetts, explicitly prohibited disclosure without consent. Recent confidentiality statutes have begun to require notification of medical personnel in an emergency (California, Hawaii, Kentucky, Maine).

Yet, existing common law, and constitutional and statutory protections of confidentiality of public health information remain inadequate. The duty of confidentiality under the common law is based upon the intimacy of the doctor-patient relationship. Accordingly, disclosures of information by the public health department may not be actionable at common law. The constitutional right to privacy is not limited by the nature of the therapeutic relationship, but by the Supreme Court's narrow conception of what spheres of privacy are protected. It is unclear whether the Court would find a constitutionally protected privacy interest in all health care information.

The major source of protection of confidentiality, therefore, is statutory. Yet existing statutory protection is idiosyncratic and depends upon the jurisdiction and/or the classification of the patients' infectious condition. A modern public health confidentiality statute should apply uniformly to all disease classifications. Any public health information may become an intensely private matter for the individual. The degree of confidentiality protection should not depend upon a preconceived view of the stigma

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[113] People *ex rel.* Director of Public Health v. Calvo, 89 Ill. 2d 130, 137, 432 N.E.2d 223, 226 (1982).

[114] *In re* Baker's Mut. Ins. Co. of New York, 301 N.Y. 21, 25-26, 92 N.E.2d 49, 51 (1950); McGowan v. Metropolitan Life Ins. Co., 141 Misc. Rep. 834, 182 N.E. 81 (1932).

[115] 52 Fed. Reg. 21, 797 (1987) (to be codified at 42 C.F.R. Part 2).

[116] Gostin & Ziegler, *A Review of AIDS-Related Legislative and Regulatory Policy in the United States*, 15 LAW MED. & HEALTH CARE 5, 13 (1987) (reviewing, among others, statutes in California, Florida, Hawaii, Kentucky, Maine, Massachusetts and Wisconsin). *See generally* Nanula, *Protecting Confidentiality in the Effort to Control AIDS*, 24 HARV. J. ON LEGIS. 315 (1987).

attached to a disease. Further, dissemination of information should be a personal matter within the patient's control.

The components of a strong confidentiality statute are:

(1) a specific subpoena exemption protecting all information and records held by the health department relating to known or suspected cases of disease;
(2) a disclosure allowance enumerating the conditions under which a release is permissible and specifying that patient consent is required for the release of any details; and
(3) a testimonial exemption protecting all state and local health department officers and employees from courtroom examination, and covering records of cases examined and/or treated by private sector medical facilities.

Statutes also do not currently explain clearly the doctors' or public health officials' duty to protect or warn third parties. The common law has developed a doctrine which, in certain circumstances, requires the physician to breach confidentiality in order to protect third parties in immediate danger of contracting a disease. The tort is based upon the special relationship between doctor and patient, and the theory that the law should prevent an imminent and avoidable harm.[117]

In the absence of legislative guidance, the physician is confronted with a conflict of duties. Does the law require him or her to maintain confidentiality or to warn? Consider the case of a physician, who reports a case of HIV infection or AIDS to the public health department, knowing the patient is married. Are the physician and public health official authorized or obliged to inform the spouse? The legal consequences can be significant, for some statutes provide for treble damages and/or criminal penalties for breach of HIV related information. Failure to warn, however, can result in significant liability if the warning would have avoided transmission to the spouse or offspring. A statute rigorously protecting confidentiality and clearly specifying those circumstances in which the public interest overrides the patient's confidentiality interest would benefit all parties.

In light of the weaknesses, lack of clarity, and variability between state confidentiality requirements, it is important to fashion a federal statute[118]

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[117] This tort theory is examined in Gostin, Curran & Clark, *The Case Against Compulsory Casefinding in Controlling AIDS: Testing, Screening and Reporting*, 12 AM. J.L. & MED. 7 (1986).

[118] One suggested way of balancing confidentiality and the duty to warn is to *authorize*, but not *compel*, a physician to warn only in cases where the physician has a reasonable belief that there is an immediate and serious danger to an identifiable third party. The statute would eliminate the absurd situation where good faith disclosure to prevent an avoidable harm can result in civil or criminal penalties. It also eliminates the equally absurd scenario of a physician being compelled by law to betray a confidence which he or she feels ethically bound to keep. This is the balance adopted in the AIDS Federal Policy Bill of 1987, introduced by Senator Edward Kennedy.

or a model state statute.[119] Such a statute would strongly protect the confidentiality of all public health information, and clarify those circumstances in which there is a need to know the information for the purposes of effective treatment and in which disclosure is strictly necessary to protect a third party in imminent danger.[120]

D. The Absence of Graded Series of Less Restrictive Measures

Most current public health laws provide a set of personal control measures limited to compulsory examination, vaccination, treatment, isolation, or quarantine. They seldom have a graded series of more flexible, less restrictive, measures. The effective options for public health officials are to introduce either voluntary programs or severe restrictions upon personal liberty. The temptation is either to exercise no statutory power or to reach for provisions which are too restrictive of individual liberty to be acceptable in a modern democratic society. In effect, public health laws provide a stick too big to wield.

The analogy to civil commitment is useful in this context, as well. Compulsory mental health strategies have long been limited to involuntary hospital admission. Increasingly, care and supervision in the community are seen as viable, less restrictive alternatives to civil commitment. Community-based mental health programs can often accomplish the goals of treatment and public protection as well as, or more effectively than, institutional confinement.

When mental health joined the judicial revolution of the civil rights movement, many courts adopted the doctrine of the least restrictive alternative.[121] Since that time, there has been increasing support for voluntary measures or legal controls within a community setting. Guardianship and conservatorship are two current legal mechanisms that require the mentally ill person to receive care, treatment, and some degree of control in the community, without the necessity of full deprivation of liberty.

The principle of the least restrictive alternative can also be of great use in the exercise of public health powers. A major goal of public health legislation is to foster voluntary cooperation through testing, notification of contacts, and alteration of high risk behavior. The use of a drastic involuntary measure may deter vulnerable individuals from cooperating with public health officials or taking advantage of public health programs, such

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[119] *See generally* National Conference of Commissioners on Uniform State Laws, UNIFORM HEALTH CARE INFORMATION ACT § 2-101, 9 U.L.A. 502 (Supp. 1985).

[120] *See* Centers for Disease Control, Recommended Additional Guidelines for HIV Antibody Counseling and Testing in the Prevention of HIV Infection and AIDS (Apr. 30, 1987).

[121] Lake v. Cameron, 267 F. Supp. 155 (D.C. Cir. 1967); Lessard v. Schmidt, 349 F. Supp. 1078 (E.D. Wis. 1972); *see* text accompanying notes 39-40 *supra*.

as clinics for the treatment of sexually transmitted diseases or drug or alcohol abuse.

Public health officials can easily misunderstand the principle of the least restrictive alternative. Public health is based upon the assumption that it is preferable to provide the maximum protection against the spread of infectious disease. It is best that any risk of error be on the side of a more restrictive, and thus more cautious, approach. As a matter of risk management, it is understandable that if the almost certain result of contracting a disease like AIDS is death, aggressive use of public health powers at an early stage may be justified. The principle of the least restrictive alternative is not necessarily inconsistent with this view. It does not require a less effective measure merely because that measure is less intrusive; it requires a less intrusive measure only if it is equally or more effective than a more restrictive procedure. The legal principle thus represents good public policy. Vulnerable groups will appreciate the adoption of equally effective, less restrictive alternatives and will be encouraged to comply voluntarily with public health advice.

The doctrine of the least restrictive alternative, however, cannot resolve all dilemmas in public health policy. The nature of public health policy is such that decisions are made under some conditions of uncertainty, and it is usually impossible to measure accurately the efficacy of two competing public health approaches. It is, therefore, seldom a question of choosing the least restrictive of two equally effective measures.

Nevertheless, the principle requires the decision-maker to achieve his or her public health goals, wherever possible, with the least drastic means. Public health statutes should make this an explicit requirement and provide a set of less restrictive options from which the official can choose.

A comprehensive public health program should utilize a variety of less restrictive powers, broader in scope than those currently contained in most public health statutes. The use of less restrictive community-based powers could allow for continued association with family, community, and work environments; public health officials would accomplish their goals without significant disruption of community life. By allowing infected persons to participate in social activities, the law would encourage voluntary cooperation, while drawing clear limits by proscribing particular unsafe behaviors or exposures.

The public health department should be empowered to issue a community health order; this would increase flexibility in fashioning a remedy to a public health risk. This community health order might require the person: to report all changes of address to the public health department; to be present at appropriate places and times for the purposes of education, counseling, testing, medical examination, or treatment; or to be admitted on an out-patient or day-patient basis to a hospital, detoxification center, or

clinic for treatment of drug dependency or sexually transmitted disease. A community health order would enable public health officials to supervise and control the infected person who poses a danger to the public, without full deprivation of liberty.

The intention behind a community health order is not to widen the net of persons potentially subject to control measures, but only to provide public health officials with less intrusive, more flexible powers with which to accomplish their objectives. Governmental powers entail restriction of freedoms and autonomy, and can adversely affect a person's reputation. They should be used only after complying with the same strict procedural and substantive safeguards as previously discussed. Thus, the individual should be entitled to a full and fair hearing by a court or tribunal. The court or tribunal must find, by clear and convincing evidence, that the person is infectious and likely to endanger seriously the public health. The order should be effective for a specified duration based upon a careful assessment of the length of time that the health risk is likely to continue. The order should specify a maximum duration, with periods of renewal permitted only after further review by the court or tribunal.

IV. CONCLUSION

Public health statutes for the control of communicable disease have received less than serious examination in this century. They have developed, layer by layer, in response to new epidemics of disease. Numerous ineffective, highly invidious measures have been attempted under the auspices of these statutes.

Professor Curran's survey for the U.S. Secretary for Health points to the need for major review of the objectives, criteria, powers, and procedures of public health statutes. This essay can only serve as a starting point, mapping out the major deficiencies in current legislation. The next phase in the process of reform should be the creation of a task force of national caliber comprised of persons experienced in public health law, virology, epidemiology, and other relevant disciplines to formulate guidelines and a model statute for consideration and adoption at the state and local level.

Legal reforms in mental health during the 1970's resulted in sweeping changes in state statutes. Reform of that magnitude is long overdue in the public health field, and will require thoughtful and systematic consideration in the coming years. This challenge requires the leadership of Bill Curran, to whom this symposium is dedicated.