

Florida A&M University College of Law Scholarly Commons @ FAMU Law

Student Works

Students and Alumni

Spring 2016

Preventing Contagion and Protecting Civil Liberties: Problems in Quarantine & Isolation Law in the United States & Suggestions for Reform

Roni Adil Elias

Florida A & M University College of Law

Follow this and additional works at: <http://commons.law.famu.edu/studentworks>



Part of the [Administrative Law Commons](#), and the [Health Law and Policy Commons](#)

Recommended Citation

Roni Adil Elias, Preventing Contagion and Protecting Civil Liberties: Problems in Quarantine & Isolation Law in the United States & Suggestions for Reform, 7 Charlotte L. Rev. 135 (2016).

This Article is brought to you for free and open access by the Students and Alumni at Scholarly Commons @ FAMU Law. It has been accepted for inclusion in Student Works by an authorized administrator of Scholarly Commons @ FAMU Law. For more information, please contact linda.barrette@famu.edu.

PREVENTING CONTAGION AND PROTECTING CIVIL LIBERTIES: PROBLEMS IN QUARANTINE & ISOLATION LAW IN THE UNITED STATES & SUGGESTIONS FOR REFORM

*Mr. Roni Adil Elias**

INTRODUCTION	135
I. THE SCOPE OF GOVERNMENT AUTHORITY TO ORDER QUARANTINES AND ISOLATION	137
II. THE LAW GOVERNING THE AUTHORITY TO ORDER QUARANTINES AND ISOLATION	139
A. <i>Federal Quarantine Law</i>	140
B. <i>State Quarantine Law</i>	144
C. <i>Cases Studies in Quarantine Law</i>	145
1. Andrew Speaker and Drug-Resistant Tuberculosis	145
2. Kaci Hickox and Ebola	147
3. Issues Raised	148
III. PROPOSALS FOR REFORM	149
A. <i>The Model State Emergency Health Powers Act</i> ..	149
B. <i>Criticism of the Model State Emergency Health Powers Act</i>	151
C. <i>An Alternative Proposal for Reform</i>	155

INTRODUCTION

Dealing with catastrophic outbreaks of communicable disease will likely be one of the greatest challenges facing state and federal governments in the United States in the twenty-first century. In the last fifteen years, policymakers have become increasingly sensitive to the prospect of bioterrorism acts involving contagious diseases and the threat of rapid international transmission of diseases rang-

* Roni A. Elias, continues his work *In Re BCCI* in which he has assisted in the return of over \$9 Billion to the depositors J.D. FAMU, College of Law & B.S. NSU. I am so blessed & greatly appreciate the love of my life, M.G.S., for her love and making me smile every minute of every day. To Dr.'s Aida & Adil Elias, my first great teachers in life, I thank you and appreciate more than words can ever say. I am truly grateful to the best brother anyone could be blessed to have, my brother, Pierre A. Elias. To the *Charlotte Law Review*, for their non-stop attention to detail I appreciate and thank. I thank Professor LeRoy Pernel for his countless efforts and all he has done while Dean for the Florida A&M, College of Law and its students.

ing from influenza to Ebola. The danger to public health posed by disease outbreak—and the danger to social order that would follow a disease outbreak—make it clear that any risk of a rapidly spreading, communicable disease would have to be met with swift and decisive measures by officials at every level of government. The use of isolation and quarantine would be among the most powerful instruments government officials would have to control the spread of disease and protect the public.

Although the government's use of quarantine has a long history in the United States, the legal instruments for imposing quarantine are not especially well-developed, and there are serious reasons to question whether governments at the local, state, or federal level in the United States are adequately prepared to effectively use quarantine and isolation to stop the spread of disease. To a significant extent, the problems with the effective use of quarantine stem from the legal structure under which the authority to impose quarantine and isolation is exercised. Officials at all levels of government have extensive power to issue quarantine and isolation orders, but there are two principal problems with how those powers may be used.

First, few formal structures exist to assure coordinated action among officials at different levels of government. Recent events have demonstrated that officials in different places—and therefore subject to different political dynamics—are likely to view possible disease outbreaks in profoundly different ways and therefore undertake profoundly different responses. Without an established framework designed to assure a degree of coordination among officials at various levels of government, there is a risk that the governments' collective response to disease outbreaks will be piecemeal and inconsistent—just the opposite of what is needed to control outbreaks and reassure the public that the risks to its health are being addressed.

Second, regardless of whether public health powers and policy are effectively coordinated on a national level, the law establishing authority for public officials is often ill-defined. In many jurisdictions, public health law gives officials ready opportunities to abuse individual civil rights in the name of the public good. Moreover, the combination of ill-defined official powers and a lack of coordination in policymaking often makes the execution of public health law ineffective.

This Article examines the existing local, state, and federal law that authorizes quarantines and isolations and considers these laws in the context of public health policy and recent events. This Arti-

cle also focuses on two recent cases involving the exercise of quarantine authority to illustrate the problems with existing law. Finally, this Article considers proposals for quarantine and isolation law reform at the state level and evaluates the ability of these proposals to solve the problems with existing law. This Article concludes that the most effective reform measure is to give federal public health agencies primary jurisdiction over the control of the diseases within their authority, with the power to delegate disease control tasks to state agencies. Such an allocation of jurisdiction assures greater coordination in the making and execution of public health policy regarding disease outbreaks, and it is the best way to cure the primary existing problems in the law governing quarantine and isolation.

I. THE SCOPE OF GOVERNMENT AUTHORITY TO ORDER QUARANTINES AND ISOLATION

Federal, state, and local governments all have the authority to order quarantines and isolation as an aspect of their general police power.¹ If and when a government agency issues a quarantine order, it implicates the liberty interests protected by the Due Process Clauses of the Fifth and Fourteenth Amendments.² Any judicial review of an individual's challenge to the legality of a quarantine order will necessarily involve assessing the balance of the government's legitimate interests in protecting the health and safety of the public with the individual's constitutionally protected interest in avoiding arbitrary and capricious exercises of government police power.³

In general, especially in matters relating to public health and the control of disease, courts are inclined to defer to the government's definition of the public's interest and its assertion of the means necessary to protect that interest. For example, in *Jacobson v. Massachusetts*, the United States Supreme Court upheld the authority of state and local government agencies to impose a mandatory vaccination program in response to the threat of a disease outbreak.⁴ As an initial matter, the Court asserted a general principle: "[T]he lib-

1. *See Jacobson v. Massachusetts*, 197 U.S. 11 (1905) (discussing the scope of the government's police power in public health matters and the constitutional limits on that power).

2. *See id.*

3. *See id.* However, in 1902 the Court considered a challenge to the legality of a quarantine order issued by a state agency, and this challenge turned on the Commerce Clause, not the principles of due process. *Compaigne Française de Navigation à Vapeur v. State Board of Health*, 186 U.S. 380, 387 (1902).

4. *Jacobson*, 197 U.S. at 39.

erty secured by the Constitution of the United States to every person within its jurisdiction does not import an absolute right in each person to be, at all times and in all circumstances, wholly freed from restraint.”⁵ On the basis of this principle, the Court concluded the vaccination program represented a reasonable incursion on individual liberty by a duly authorized government agency.

The authority to determine for all what ought to be done in such an emergency must have been lodged somewhere or in some body; and surely it was appropriate for the legislature to refer that question, in the first instance, to a board of health composed of persons residing in the locality affected, and appointed, presumably, because of their fitness to determine such questions. To invest such a body with authority over such matters was not an unusual, nor an unreasonable or arbitrary, requirement.⁶

In this analysis, the Court demonstrates it is willing to defer to state and local authority in two important respects: (1) the identification of the agency empowered to make decisions about what is necessary to protect public health; and (2) the substance of the decisions made by that agency. In other words, the Court did not, to use a contemporary phrase, “micromanage” the agency’s decision-making. Instead, its inquiry essentially began and ended with the question of whether the agency’s action could be deemed reasonable. If so, the Court was content to leave it alone.

In the century since *Jacobson*, courts have followed its deferential example. In *Miller v. Campbell County*, the Tenth Circuit considered whether a local agency exceeded the constitutional limits on its authority by ordering the evacuation of a residential area in response to a gas leak.⁷ By affirming the legality of the evacuation order and the arrest of the person who violated that order, the Tenth Circuit concluded there was no violation of due process principles, as long as the officials acted in good faith.⁸

Similarly, in *United States v. Shinnick*, a district court upheld the Public Health Service’s (“PHS”) decision to keep an individual in medical isolation based on the showing that the PHS acted in good faith.⁹ The district court did not undertake any specific inquiry about whether the agency’s decision was well-grounded in fact; it

5. *Id.* at 26.

6. *Id.* at 27.

7. *Miller v. Campbell Cty.*, 945 F.2d 348, 351 (10th Cir. 1991).

8. *Id.* at 354.

9. *United States v. Shinnick*, 219 F. Supp. 789, 791 (E.D.N.Y. 1963).

was enough for the court that the decision had a facially reasonable foundation in fact.¹⁰ Other cases involving similar constitutional challenges to quarantine orders have demonstrated a similar degree of judicial deference.¹¹

There is some precedent under which a court could justify undertaking more than a facial inquiry into the reasonableness of a public health order seeking to control the spread of disease, but this authority is not especially powerful nor is it likely to be particularly relevant in contemporary challenges to quarantine orders. In 1900, city officials in San Francisco concluded nine persons in a primarily Chinese neighborhood were infected with bubonic plague.¹² In response, the public health officials issued a quarantine order that applied only to Chinese residents, which prevented them from leaving the city, and also ordered the inoculation of all Chinese residents.¹³ When these orders were challenged, the court concluded the public officials violated constitutional principles of equal protection for two reasons: (1) because the orders reflected discrimination on the basis of ethnic origin; and (2) because the scope of the orders was not reasonably related to the control of the risk presented by the diagnosed cases.¹⁴ Despite the court's receptiveness to the constitutional challenge, it is not clear whether this case is effective authority to justify higher judicial scrutiny in government public health decisions. Indeed, although the court did not specifically refer to bad faith on the part of San Francisco public health officials, it seems clear that the court concluded that the city's action involved something besides a good-faith effort to control a public health crisis.

II. THE LAW GOVERNING THE AUTHORITY TO ORDER QUARANTINES AND ISOLATION

At all levels of government in the United States, quarantine and isolation orders are the product of authority created by statutes and regulations. For the most part, legislatures have enacted statutes creating broad authority for specified agencies to take any measures reasonably necessary to control the spread of communicable

10. *Id.*

11. JARED P. COLE, CONG. RESEARCH SERV., FEDERAL AND STATE QUARANTINE AND ISOLATION AUTHORITY 7-10 (Oct. 9, 2014), <http://www.fas.org/sgp/crs/homsec/RL33201.pdf>.

12. *See Jew Ho v. Williamson*, 103 F. 10, 12 (N.D. Cal. 1900).

13. *See id.* at 13.

14. *Id.* at 26.

diseases.¹⁵ Those agencies are generally given policy and rule-making authority along with enforcement power.¹⁶ Consequently, the issuance of orders for quarantines and isolation is entirely an aspect of administrative law.

A. Federal Quarantine Law

The federal power to impose quarantines and issue isolation orders comes from the Commerce Clause, which gives Congress the authority “[t]o regulate Commerce with foreign Nations, and among the several States[.]”¹⁷ Pursuant to its Commerce Clause power, Congress enacted the Public Health Service Act (“PHSA”).¹⁸ Section 264 of the PHSA grants the Secretary of Health and Human Services (“the Secretary”) the authority to make and enforce regulations necessary “to prevent the introduction, transmission, or spread of communicable diseases from foreign countries into the States or possessions, or from one State or possession into any other State or possession.”¹⁹ To this end, the law also gives the Secretary expansive authority to apprehend, detain, or conditionally release a person in connection with the authority to control the transmission and spread of communicable diseases.²⁰

The PHSA establishes significant limits on the Secretary’s ability to exercise this authority. It provides that the Secretary may use this regulatory and enforcement authority only with respect to communicable diseases identified by executive order.²¹ The executive order currently in place gives the Secretary authority to deal with the following diseases: cholera, diphtheria, infectious tuberculosis, plague, smallpox, yellow fever, viral hemorrhagic fevers (including Ebola), severe acute respiratory syndrome (SARS), and influenza viruses, which all have the potential to cause a pandemic.²² In 2000, the Secretary transferred his statutory authority to order quarantines to the Director of the Centers for Disease Control and Pre-

15. See, e.g., 42 U.S.C. § 241 (2012); see also Cole, *supra* note 11, at 1-7 (discussing federal and state law pertaining to quarantine).

16. See Cole, *supra* note 11, at 1-7 (discussing federal and state law pertaining to quarantine).

17. U.S. CONST. art. I, § 8, cl. 3.

18. 42 U.S.C. § 201; see also Cole, *supra* note 11, at 1-7 (discussing federal and state law pertaining to quarantine).

19. 42 U.S.C. § 264(a). According to § 271, violation of federal quarantine and isolation regulations is a criminal misdemeanor, punishable by fine or imprisonment or both.

20. *Id.* § 264(b).

21. *Id.*

22. Exec. Order No. 13295, 68 Fed. Reg. 17,255 (Apr. 4, 2003) (amended Jul. 31, 2014).

vention (“CDC”).²³ After this transfer, the CDC now has control over both interstate and foreign quarantine measures through its Division of Global Migration and Quarantine.²⁴

Under the PHSA, there is broad authority to deprive a person of liberty in connection with a quarantine order. Section 264 of the PHSA authorizes the apprehension and examination of “any individual reasonably believed to be infected with a communicable disease in a qualifying stage” under two conditions: if the person is reasonably believed (1) “to be moving or about to move from a State to another State;” or (2) “to be a probable source of infection to individuals who, while infected with such disease in a qualifying stage, will be moving from a State to another State.”²⁵ The statutory term “qualifying stage” is defined as a disease (1) “in a communicable stage;” or (2) “in a precommunicable stage, if the disease would be likely to cause a public health emergency if transmitted to other individuals.”²⁶ During wartime, this detention authority extends even further, reaching any individual “reasonably believed (1) to be infected with such disease [as specified in an Executive Order of the President] and (2) to be a probable source of infection to members of the armed forces of the United States or to individuals engaged in the production or transportation of . . . supplies for the armed forces.”²⁷

There are some important limitations on this authority. In general, the regulations governing the apprehension, detention, examination, or conditional release of individuals apply “only to individuals coming into a State or possession from a foreign country or a possession.”²⁸ The Secretary has promulgated regulations to improve the CDC’s capacity to identify persons who might be subject to quarantine orders as they enter the country. These regulations require airline pilots and ship captains to immediately report the presence of ill passengers on board their vessels.²⁹ In addition, pilots of both interstate flights within the U.S. and international flights that arrive in the U.S. are required to report any instances of

23. 42 C.F.R. §§ 70.2-70.8 (2015). Regulations regarding quarantine upon entry into the United States from foreign countries are also administered by the CDC, which are contained in 42 C.F.R. § 71.

24. *See, e.g., Quarantine and Isolation*, CTNS. FOR DISEASE CONTROL & PREVENTION, <http://www.cdc.gov/ncpcid/dgmq/index.html> (last visited Apr. 27, 2016).

25. 42 U.S.C. § 264(d)(1).

26. *Id.* § 264(d)(2).

27. *Id.* § 266.

28. *Id.* § 264(c).

29. 42 C.F.R. § 71.21(a)-(b) (2015).

the illnesses identified in the Executive Order before the flight lands.³⁰ These reports must be directed to the CDC-operated “quarantine station” closest to the destination airport.³¹ There are currently twenty such stations in the United States.³²

Upon receiving such a report, if the CDC finds that a person is infected, he or she may be detained.³³ Because the CDC does not have its own officials at each port of entry, various agencies in the Department of Homeland Security (“DHS”) are authorized to assist the CDC in “the enforcement of quarantine rules and regulations[.]”³⁴

The regulations governing federal quarantine orders contemplate a degree of cooperation between state, local, and federal officials. In addition to having original regulatory authority to issue quarantine orders, the CDC also has authority to supervise the actions of state and local officials in connection with the risk of the interstate transmission of communicable diseases.³⁵ Thus, the Director of the CDC also has authority to take any measures as may be necessary to prevent the spread of a communicable disease from one “[s]tate or possession to any other [s]tate or possession,” if the Director determines state or local health officials have failed to take adequate measures of their own.³⁶ To prevent the spread of diseases between states, the regulations prohibit infected persons from traveling from one state to another “without a permit from the health officer of the [s]tate, possession, or locality of destination, if such permit is required under the law applicable to the place of destination.”³⁷ Additional requirements apply to persons who are in the “communicable period of cholera, plague, smallpox, typhus or yellow fever, or who, having been exposed to any such disease, [are] in the incubation period thereof[.]”³⁸

Section 243 of the PHS Act provides for federal-state cooperative activities to enforce quarantines.³⁹ The federal government may assist states and localities in enforcing their quarantines and other health regulations and, in turn, may accept state and local assistance

30. *Id.* §§ 70.4, 71.21(b).

31. *Id.* § 71.21(a)-(b).

32. *Quarantine and Isolation*, *supra* note 24.

33. 42 C.F.R. § 71.32.

34. 42 U.S.C. § 268 (2012).

35. 42 C.F.R. § 70.2.

36. *Id.*

37. *Id.* § 70.3.

38. *Id.* § 70.5.

39. 42 U.S.C. § 243.

in enforcing federal quarantines.⁴⁰ In addition, the Secretary may request the aid of the Coast Guard and military officers in the execution of quarantines imposed by states on vessels coming into ports.⁴¹ Section 249 of the PHS Act authorizes the PHS to care for and treat persons under quarantine.⁴² When necessary, the PHS can contribute to the cost of enforcing quarantine orders, whether such orders are issued by state or federal officials, meaning the PHS may pay for treatment at public or private medical facilities pursuant to an authorizing order from the appropriate local PHS officer.⁴³

State, local, and federal officials all have access to certain legal instruments to impose travel restrictions in the name of controlling the spread of communicable diseases. The CDC and DHS have recently allowed the creation of a “Do Not Board” (“DNB”) list, through which domestic and international health officials request that persons with communicable diseases be restricted from boarding commercial aircraft departing from or arriving in the United States when such persons meet specific criteria and pose a serious threat to the public.⁴⁴ A state or local official can place a person on the DNB list by contacting the local CDC Quarantine Station.⁴⁵ The CDC then determines if the person is: (1) likely contagious with a communicable disease that presents a serious public health threat; (2) unaware of or likely not to comply with public health recommendations and medical treatment; and (3) likely to try boarding a commercial aircraft.⁴⁶ The DNB list applies only to air travel.⁴⁷ There are no equivalent regulations for forms of ground transportation such as buses or trains.

40. *Id.*

41. *Id.* § 97.

42. *Id.* § 249(a).

43. *Id.* § 249(c).

44. See 14 C.F.R. § 382.21 (2015) (authorizing airlines to refuse to board passengers with communicable diseases under specified circumstances); U.S. GOV'T ACCOUNTABILITY OFF., GAO-09-58, PUBLIC HEALTH AND BORDER SECURITY: HHS AND DHS SHOULD FURTHER STRENGTHEN THEIR ABILITY TO RESPOND TO TB INCIDENTS 28 (Oct., 2008).

45. Ctrs. for Disease Control & Prevention, *Federal Air Travel Restrictions for Public Health Purposes — United States, June 2007— May 2008*, MORBIDITY & MORTALITY WKLY. REP. (Sep. 19, 2008), http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5737a1.htm?s_cid=mm5737a1_e.

46. *Id.*

47. *Id.*

B. State Quarantine Law

Because federal authority regarding quarantines is limited by the scope of an Executive Order, state and local officials are often at the forefront of efforts to control disease by using their authority to order quarantines or isolation. Accordingly, the CDC has asserted a policy of deferring to state authority. As the CDC has explained:

In general, CDC defers to the state and local health authorities in their primary use of their own separate quarantine powers. Based upon long experience and collaborative working relationships with our state and local partners, CDC continues to anticipate the need to use this federal authority to quarantine an exposed person only in rare situations, such as events at ports of entry or in similar time-sensitive settings.⁴⁸

The authority of state governments to order quarantines varies widely. In general, state laws provide that a public health agency can issue a quarantine order in accordance with certain statutory conditions.⁴⁹ When a quarantine policy requires individual detention, some states mandate that a court must issue the detention order.⁵⁰ Many states use statutes to identify the diseases for which quarantines may be enforced.⁵¹ Other states delegate the authority to identify such diseases to a public health agency.⁵²

Regardless of how they are structured, state laws governing quarantine authority do have one thing in common: they tend to be very old. Many of the relevant statutes are between forty and one hundred years old.⁵³ Not surprisingly, the older statutes “often do not reflect contemporary scientific understandings of disease, [or] current treatments of choice[.]”⁵⁴ Indeed, many of these more antiquated state laws were drafted to address particular epidemics of

48. Ctrs. for Disease Control & Prevention, *Questions and Answers on the Executive Order Adding Potentially Pandemic Influenza Viruses to the List of Quarantinable Diseases*, <http://www.survivalring.org/pandemic/index.php?file=Questions%20and%20Answers%20on%20the%20Executive%20Order%20.pdf> (last visited Apr. 27, 2015).

49. Cole, *supra* note 11, at 6; Paula Mindes, Note, *Tuberculosis Quarantine: A Review of Legal Issues in Ohio and Other States*, 10 J.L. & HEALTH 403, 409 (1995).

50. Mindes, *supra* note 49, at 409.

51. *Id.*

52. *Id.*

53. See e.g., Lawrence O. Gostin et al., *The Law and the Public's Health: A Study of Infectious Disease Law in the United States*, 99 COLUM. L. REV. 59, 101-02 (1999); *State Quarantine and Isolation Statutes*, NAT'L CONF. OF ST. LEGISLATURES, <http://www.ncsl.org/research/health/state-quarantine-and-isolation-statutes.aspx> (last visited Apr. 27, 2016).

54. Gostin, *supra* note 53, at 106.

particular diseases; therefore, they are not well suited to provide the kind of flexible authority required to respond to a wide range of diseases threatening to spread from a wide variety of sources.⁵⁵

C. *Cases Studies in Quarantine Law*

Two recent events illustrate some of the potential problems with the use of quarantine and isolation authority in the United States. In both of these cases, government officials sought to control the activity of a person exposed to a dangerous, contagious disease. But, in both cases, government officials failed to achieve both their own objectives and, arguably, the best outcome for the public health from the perspective of public health policy. These two cases demonstrate what can go wrong when government officials are called upon to use their power to control contagious disease, and they provide an idea of what must be changed so things can go right.

1. Andrew Speaker and Drug-Resistant Tuberculosis

Physicians diagnosed Andrew Speaker with pulmonary tuberculosis (“TB”) in March 2007.⁵⁶ At first, those physicians thought he could be treated with standard anti-TB medications.⁵⁷ Further testing revealed that Speaker’s TB was multi-drug resistant, which meant there was a risk not only that his treatment could prove difficult, but also that he could infect others and be “patient zero” in a far wider outbreak.⁵⁸ In May 2007, county health officials orally advised Speaker to seek specialized treatment and refrain from traveling.⁵⁹

Speaker was planning a wedding and honeymoon, and he was disinclined to follow the officials’ advice about travel.⁶⁰ Accordingly, he did the opposite of what they advised, advancing his travel plans by two days and flying from Atlanta, Georgia, to Paris, France, on May 12.⁶¹ While Speaker was doing this, local officials

55. Cole, *supra* note 11, at 7.

56. Howard Markel et al., *Extensively Drug-Resistant Tuberculosis: An Isolation Order, Public Health Powers, and a Global Crisis*, J. AM. MED. ASS’N, July 4, 2007, at 83, 83; John Schwartz, *Tangle of Conflicting Accounts in TB Patient’s Odyssey*, N.Y. TIMES, June 2, 2007, at 1A; David Brown & Spencer Hsu, *Officials Detail Errors in TB Case; Travel Followed Lack of Cooperation, Late Reaction, Weak Safeguards*, WASHINGTON POST, June 7, 2007, at A6.

57. Markel, et al., *supra* note 56, at 83.

58. *See id.*

59. *Id.*

60. *Id.*

61. *Id.*

unsuccessfully tried to serve him with written notice that travel would be against medical advice and would risk the health of others.⁶² In fact, those officials were still trying to serve him with that notice in Georgia after he had already arrived in France.⁶³ During the time Speaker was getting married and honeymooning in Europe, doctors confirmed that he had drug-resistant TB and informed state and federal public health officials.⁶⁴

Speaker went ahead with his wedding and honeymoon plans, traveling to France, Greece, and then Rome.⁶⁵ While in Rome, the CDC, the chief federal public health agency, informed him by phone that he had drug-resistant TB and instructed him to report to Italian health authorities.⁶⁶ The CDC specifically instructed him not to travel on commercial airlines and to wait for word from U.S. officials about how he could return home without risking others' health.⁶⁷ Speaker utterly ignored those instructions.⁶⁸ He took commercial flights to Prague and then to Montreal, Canada.⁶⁹ From Montreal, Speaker attempted to drive to the United States.⁷⁰

While Speaker was disregarding the CDC's instructions, the CDC placed his name on a health surveillance list, which was circulated to the U.S. Border Patrol.⁷¹ Despite the CDC's warning, a U.S. border guard, who had seen Speaker's name on the list, nevertheless allowed Speaker into the United States.⁷² After Speaker returned to the United States, the CDC invoked federal quarantine law and ordered him to report to Bellevue Hospital in New York City.⁷³ First, Speaker was subject to a provisional isolation order under federal law, which permitted the CDC to detain him in New York for three days.⁷⁴ After that, the CDC transported him to Atlanta, where he was detained under a regular isolation order—the first issued by the federal government since 1963.⁷⁵ Eventually,

62. *Id.*

63. Markel, et al., *supra* note 56, at 83.

64. *Id.*

65. *Id.*

66. *Id.*

67. *Id.*

68. *Id.*

69. Markel, et al., *supra* note 56, at 83.

70. *Id.*

71. *Id.*

72. *Id.*

73. *Id.*

74. *Id.*

75. Markel, et al., *supra* note 56, at 83.

Speaker was transferred under escort by a CDC quarantine officer to the National Jewish Medical Center in Denver, Colorado, where he was treated.⁷⁶

2. Kaci Hickox and Ebola

Kaci Hickox, a U.S. citizen and a nurse, returned to the United States in October 2014, after treating Ebola patients for Doctors Without Borders in Sierra Leone.⁷⁷ According to federal guidelines promulgated by the CDC, persons at risk for developing Ebola were advised—but not required—to isolate themselves from others for twenty-one days.⁷⁸ The CDC and the Obama Administration concluded that health care workers returning from West Africa need not be subject to mandatory quarantine restrictions, although at the time, the federal government required that U.S. military personnel returning from West Africa be subjected to mandatory quarantine for twenty-one days.⁷⁹

Many states, including New York and New Jersey, declined to follow these federal guidelines, preferring stricter controls under their own law.⁸⁰ When Hickox arrived in New Jersey while traveling to her home in Maine, New Jersey officials ordered that she be quarantined in a tent in a Newark hospital.⁸¹ Hickox resisted the New Jersey order and was eventually permitted to be privately transported back to Maine.⁸² Once in Maine, officials there imposed their own restrictions on Hickox's movements, which included preventing her from using public conveniences, such as public transportation, movie theatres, and shopping malls.⁸³

Maine's efforts to enforce those restrictions wound up in federal district court.⁸⁴ The chief judge of a state district court, Charles LaVerdiere, rejected the state's request to enforce the restrictions, holding "[t]he state has not met its burden at this time to prove by clear and convincing evidence that limiting [Hickox's] movements

76. *Id.*

77. Betsy McKay, et al., *CDC Rejects Mandatory Ebola Quarantines*, WALL ST. J. (Oct. 27, 2014, 7:43 PM), <http://www.wsj.com/articles/federal-ebola-quarantine-guidelines-released-by-cdc-1414443143>.

78. *Id.*

79. Warren Richey, *Ebola Quarantine: Why Judge Sided with Nurse Kaci Hickox*, CHRISTIAN SCI. MONITOR (Oct. 31, 2014), <http://www.csmonitor.com/USA/Justice/2014/1031/Ebola-quarantine-why-judge-sided-with-nurse-Kaci-Hickox-video>.

80. See McKay, *supra* note 77.

81. *Id.*

82. *Id.*

83. Richey, *supra* note 79.

84. *Id.*

to the degree requested is necessary to protect other individuals from the dangers of infection[.]”⁸⁵ The court noted that Hickox had agreed to twice-daily monitoring by state health officials, and the court provided that the state’s more stringent restrictions could be imposed to isolate Hickox if her condition changed for the worse.⁸⁶ Even so, Maine officials insisted that this was not enough and that Hickox should be subject to stricter restrictions because, in their judgment, she posed a threat to the health of others—even if the risk of infection had passed and she hadn’t yet manifested any symptoms of infection.⁸⁷

3. Issues Raised

The Speaker and Hickox cases show that there are significant legal problems with the administrative law regime for ordering quarantines and isolation to control the spread of communicable disease. The principal problems pertain to a lack of coordination between federal and state disease-control policy and to ambiguity and conflicts within the legal structure for ordering quarantines and isolation at both the federal and state levels.

The problem with failing to coordinate is primarily evident in the Hickox case. There, Hickox was caught between dramatically conflicting approaches to the risks arising from her exposure to Ebola patients. For its part, the federal government apparently did not believe her exposure presented a dramatic risk to public health. Accordingly, the federal government only issued advisory guidelines to Hickox, and those guidelines only imposed modest restrictions on her personal liberty. By contrast, state officials in both New Jersey and Maine seemed to view her situation with alarm, seeking to impose much more restrictive controls. Because this conflict involved only a single individual, it was possible to solve it through a judicially compelled compromise. If the conflict had involved a significant number of persons in different situations, however, it may have been more difficult, if not impossible, under the current legal and administrative structure to find a single solution that addressed all of the dimensions of the public health problem, but also resolved all of the competing federal and state agency policy prerogatives and interests.

85. *Id.* (alteration in original).

86. *Id.*

87. *Id.*

In Speaker's case, the most evident problem was the fact that Speaker evaded any meaningful control by CDC officials when he traveled throughout Europe, into Canada, and back into the United States. Speaker's actions greatly exacerbated the risk of spreading a very dangerous disease that was extraordinarily difficult to treat. Despite the capacity of the CDC to enlist airlines and other government agencies in the enforcement of a travel ban, the ban proved ineffective. With respect to Speaker, the problem was not determining the right action to take to control the risk; the problem was communicating the CDC's decision to the private entities and agencies responsible for effecting that action.

Although they differ in some respects, the Speaker and Hickox cases have one important thing in common: they both illustrate that the current legal and administrative structure for defining, issuing, and enforcing quarantine and isolation orders falters when rapid execution of policy decisions is required. Because each case involved an individual, the consequences of such faltering were not significant. But, if a similar problem of execution arose in a more extensive disease outbreak, the consequences for the public health could be grave.

III. PROPOSALS FOR REFORM

A. *The Model State Emergency Health Powers Act*

Commentators and policy analysts have long recognized that coordination and a lack of uniform policymaking are problems throughout the entire system of public health administration, not simply when issuing orders for quarantine and isolation. The cases discussed above demonstrate as much. One response to those systematic problems is the proposal of model uniform public health legislation for all states. The leading proposal of such a model law was the Model State Emergency Health Powers Act ("MSEHPA"), which was first drafted in late 2001 in response to the anthrax attacks⁸⁸ that occurred earlier that year.⁸⁹ After a period of com-

88. Because anthrax cannot be spread from person to person, it is not the kind of communicable disease that is typically addressed by quarantine and isolation orders. To the extent that the MSEHPA was a response to the anthrax attacks, it reflected an awareness that acts of bioterrorism could cause outbreaks of communicable disease, but not the conclusion that the anthrax attack could have been one such outbreak.

89. Lawrence O. Gostin, et al., *The Model State Emergency Health Powers Act: Planning for and Response to Bioterrorism and Naturally Occurring Infectious Diseases*, J. AM. MED. ASS'N Aug., 7, 2002, at 622, 622.

ment, MSEHPA was slightly revised in 2002, and thirty-eight states eventually adopted it in some form.⁹⁰

Like other model acts, MSEHPA was designed to create a uniform system of rules for public agencies, to avoid conflicts of law among the states, and to simplify the process of designing an administrative law structure in public health matters for individual state governments.⁹¹ It succeeded in many important respects. The MSEHPA certainly brought the promised uniformity to state law by standardizing the patchwork of administrative law systems that had prevailed among the states for nearly a century. The MSEHPA also had some salutary political effects; it represents a significant response to developing public awareness and concern about the risk of widespread disease outbreaks, whether caused by natural events or bioterrorism. Nevertheless, the statute had significant drawbacks, especially when it came to improving the legal structure for ordering quarantines and isolations to control the spread of communicable disease.

In the event of a public health crisis, the MSEHPA provides for expansive executive powers. These provisions are triggered when a state's governor declares a "state of public health emergency."⁹² The MSEHPA defines a "public health emergency" as "an occurrence or imminent threat of an illness or health condition[.]" caused by a variety of public health threats that pose a substantial risk of a significant number of human fatalities or incidents of permanent or long-term disability.⁹³

Once a state of emergency is declared, the MSEHPA authorizes state public health officials to take control of all health care facilities in the state, issue orders to physicians, order citizens to submit to examinations and treatment, and—where necessary—to quarantine or isolate.⁹⁴ So empowered, public health officials may "require a health care facility to provide services or the use of its facility if such services or use are reasonable and necessary [for emergency response,]" and such authorized use "may include transferring the management and supervision of the health care facility to the public health authority[.]"⁹⁵ The MSEHPA also grants im-

90. Markel, et al., *supra* note 56, at 84.

91. See Gostin, *supra* note 89.

92. MODEL STATE EMERGENCY HEALTH POWERS ACT § 402 (CTR. FOR LAW & PUB. HEALTH AT GEORGETOWN & JOHNS HOPKINS UNIV. 2001), <http://www.publichealthlaw.net/MSEHPA/MSEHPA2.pdf>.

93. *Id.* § 104(m).

94. *Id.* § 502.

95. *Id.*

munity from liability to all of the officials who exercise these expansive powers.⁹⁶ Only actions constituting gross negligence or willful misconduct are excluded from this blanket grant of immunity.⁹⁷

The MSEHPA provides severe consequences for any person who does not defer to state officials' exercise of these broad powers.⁹⁸ In the initial draft of the model legislation, a person who failed to obey an order to submit to examination or treatment was guilty of a misdemeanor.⁹⁹ The revised draft removed the criminal sanction but still provided that a person who disobeyed an order for examination or treatment would be detained in another way—in quarantine or isolation.¹⁰⁰

B. *Criticism of the Model State Emergency Health Powers Act*

The MSEHPA is a powerful instrument for addressing widespread public health emergencies, but it is something of a blunderbuss. It is easy to see that it was designed with acts of bioterrorism in mind. The broad powers created by the MSEHPA—and the draconian consequences for resisting such powers—suggest the drafters were anticipating the application of the law in a situation where a terrorist group infected a group of persons with a highly communicable disease, such as smallpox, thereby creating the risk of a rapidly spreading pandemic with high rates of mortality.

While the MSEHPA has some advantages in addressing bioterrorist acts that pose an immediate threat to whole populations, it is not well-adapted to other kinds of public health threats arising from communicable diseases. As one commentator has noted, “the authority to respond to a bioterrorist attack or a new epidemic that the model act provides is much too broad, since it applies to not just real emergencies such as a smallpox attack but also to nonemergency conditions as diverse as annual influenza epidemics and the AIDS epidemic.”¹⁰¹ In particular, the MSEHPA is not well-adapted to the kind of problem presented by the Speaker or Hickox cases, which principally involve questions about how to treat one person who has suffered a unique and isolated exposure to a com-

96. *Id.* § 804(a).

97. *Id.*

98. MODEL STATE EMERGENCY HEALTH POWERS ACT § 604.

99. *Id.*

100. George J. Annas, *Bioterrorism, Public Health & Civil Liberties*, 346 NEW ENG. J. MED. 1337, 1341 (2002).

101. *Id.*

municable disease and to assure the individual's exposure does not create a risk for others.

For example, the MSEHPA does not provide specific authority for state public health officials who need to respond to something less than a full-blown state of emergency. The extraordinary powers created by the model act are binary. That is, they are either "on" in the event of a widespread crisis, or they are "off."¹⁰² There is no significant provision for scaling specific powers to fit the particular problem.

In addition, even when there is a widespread public health emergency, it may not always make sense to put public health officials in charge of the response.¹⁰³ As one commentator has pointed out:

[T]he tasks of identifying affected persons, reporting them, treating them, and taking preventive actions will be performed by physicians, nurses, emergency medical personnel, and hospitals. The primary role of public health authorities will usually be, as it was in the wake of the anthrax attacks, to provide guidance to the public and other government officials in identifying and dealing with the disease and to provide laboratory facilities where exposure can be evaluated and diagnoses definitively established.¹⁰⁴

Here again, the MSEHPA does not provide for much middle ground. It seems to anticipate that public health powers to control communicable diseases will only be needed in situations where officials will control all medical decisions and also that physicians, hospital administrators, and other private actors will merely serve as agents who execute the officials' plan. The MSEHPA does not leave much room for collaboration between public health officials and decision-makers about the treatment of communicable disease.

Along the same lines, the model act seems to expect doctors, nurses, and other health care professionals will need to be forcibly coerced into following the policy prescriptions of state public health officials. Given the MSEHPAs provisions for taking patients' liberty if they do not follow orders, the same assumption is made for patients and those who are not yet sure whether they have been infected. But recent experiences with threatened outbreaks of disease suggest that resistance to examination and treatment will not

102. MODEL STATE EMERGENCY HEALTH POWERS ACT § 401 (providing for extraordinary powers only in the event of an officially declared state of emergency).

103. Annas, *supra* note 100, at 1341-42.

104. *Id.*

be the only problem that officials and treatment providers face. To be sure, some persons will resist, but others will clamor for examination, testing, and treatment—even if there is no particular reason to think they will need it.¹⁰⁵

With respect to quarantine powers, the MSEHPA misses the mark because it operates on the premise that there will likely be a need to detain large numbers of people in quarantine, regardless of the form the public health crisis takes. But,

there is no empirical evidence that draconian provisions for quarantine, such as those outlined in the model act, are necessary or desirable. Persons with smallpox, for example, are most infectious only after fever and a rash have developed, and then they are usually so sick that they are likely to accept whatever care is available. Moreover . . . the long incubation period (10–17 days) almost ensures that some persons who are infected in the [smallpox] attack will have traveled great distances from the site of the exposure before the disease is recognized or quarantine could be implemented. The key to an effective public health response is identifying and helping those who have been exposed. Even with a sufficient supply of smallpox vaccine, a quarantine enforced by the police would probably not be effective in controlling an outbreak of smallpox.¹⁰⁶

The model act's quarantine powers are problematic in another way, one that implicates constitutional considerations. In the original version of the MSEHPA, and even in its revised draft, the provisions covering quarantine lend themselves to arbitrary action by state officials. According to the original version, officials can order a quarantine if they are “uncertain regarding whether [a person refusing to undergo medical examination or testing] has been exposed to or is infected with a contagious or possibly contagious disease or otherwise poses a danger to public health.”¹⁰⁷ Unfortunately, the revised draft makes this problem worse. It provides that quarantine can be ordered when the person's refusal to be examined or tested “results in uncertainty regarding whether he or she has been exposed to or is infected with a contagious or possibly contagious disease or otherwise poses a danger to public health.”¹⁰⁸ As a commentator pointed out, “[t]his is no standard at all; it simply permits public health authorities to quarantine anyone who refuses to

105. Annas, *supra* note 100, at 1342.

106. *Id.* (alteration in original) (footnotes, citations, and internal quotations omitted).

107. MODEL STATE EMERGENCY HEALTH POWERS ACT § 602.

108. Annas, *supra* note 100, at 1339-40.

be examined or treated, for whatever reason, since all refusals will result in uncertainty."¹⁰⁹

When acting pursuant to such a statute without delineated standards, it will be difficult, if not impossible, for officials to avoid the appearance that they are acting in an arbitrary and capricious fashion. This appearance could be enough to give rise to an arbitrary exercise of power that could imperil the exercise of any authority pursuant to the model act. As noted in Part I, the judiciary has been broadly deferential to the decision-making and actions of public health officials dealing with emerging threats to public health, overruling the decisions only when they seem to flagrantly depart from the standard of good faith.¹¹⁰ But when a statute provides, in effect, that a person can be deprived of liberty and placed in quarantine just because he or she refused to submit to an examination or test, it makes the officials who are acting under that statute seem as though they are acting without sound reason. Even worse, it provides an opportunity for bad-minded officials to abuse their discretionary authority because it not only provides essentially unbounded authority, but also immunizes officials from liability if they choose to abuse that authority.

The final significant problem with the MSEHPA is that it provides opportunities for state officials to make important policy decisions that should be entirely within the discretionary authority of federal officials at the CDC or the PHS. In general, state officials have shown an impulse to defer to federal officials when there is even a suggestion that a public health problem may involve an act of bioterrorism.¹¹¹ But this is no guarantee that state officials will continue to defer and will not usurp policy prerogatives that should belong primarily to the federal government.¹¹² Indeed, there was an indication of this problem in the Hickox case when state officials in Maine and New Jersey sought to impose a more stringent policy to control Ebola than the federal government thought was advisable.¹¹³

109. *Id.*

110. *See, e.g., Miller v. Campbell Cty.*, 945 F.2d 348 (10th Cir. 1991); *United States v. Shinnick*, 219 F. Supp. 789 (E.D.N.Y. 1963).

111. Annas, *supra* note 100, at 1339-40.

112. *Id.*

113. Richey, *supra* note 79.

C. *An Alternative Proposal for Reform*

Aside from the several problems with the MSEHPA, there is another way that the model act fails to solve a critical problem with quarantine law—the problem of a lack of policy coordination between public health officials at different levels of government. As previously noted, this is a problem because it creates an opportunity for states to trespass in a policymaking province that should belong exclusively to the federal government. But this is not just a problem of federalism, it is also a problem of coherent government action. Regardless of whether a public health problem implicates considerations of national security, it should be met with a coherent policy program if it involves any risk of interstate transmission. The current legal and administrative structure for dealing with public health problems does not ensure such a coordinated response.

But there is a change that could solve this problem: give the PHS and its designees, especially the CDC, exclusive primary jurisdiction over any public health problem involving one of the diseases identified by a federal executive order. In addition, the government should empower these federal agencies to delegate administrative authority to state and local public health agencies to the extent that the federal agencies conclude is necessary.

This kind of jurisdictional structure would solve the two main problems arising from the Speaker and Hickox cases. First, such a structure would assure that basic policy decisions regarding how to address disease outbreaks were made by a single decision-maker who would be concerned with national consequences above all else. This would avoid the problems of policy coordination that were so evident in the Hickox case. Second, a delegation of authority to state officials and their agencies would effectively deputize a wide range of government officials to execute orders designed for the protection of the public. With a greater number of officials at all levels of government in position to carry out orders issued at the federal level, it will be much harder for an individual like Speaker to slip through the cracks and evade regulations and advisories necessary for the public health.

This proposed reform would not make state public health agencies mere adjuncts of the PHS and CDC. These agencies still would retain full independent authority to control all public health problems that do not involve one of the diseases over which the federal government has primary and exclusive jurisdiction. And, they could be authorized to act independently if the PHS or the CDC decided to abjure control over a particular disease outbreak.

Giving federal agencies primary jurisdiction only assures problems of national scope will be addressed by action directed from a single federal source.