

PANDEMIC PREPAREDNESS: A RETURN TO THE RULE OF LAW

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“As for our common defense, we reject as false the choice between our safety and our ideals.” Inauguration Address of President Barack Obama, January 20, 2009.

I. INTRODUCTION¹

On January 15, 2009, US Airways flight 1549 apparently struck a flock of birds shortly after taking off from New York’s LaGuardia airport and lost power in both of its engines.² The pilot, Chesley Sullenberger, made a skillful emergency landing in the Hudson River, and all 150 passengers and five crew members safely evacuated the plane.³ The passengers calmly helped each other out onto the wings and into the plane’s life rafts. Local ferries, seeing the plane coming down, sped to the site and took the passengers on board.⁴ What might have been a fatal disaster in the eighteen degree Fahrenheit temperature was in fact a fairly typical example of Americans’ response to emergencies.

Historically, Americans have reacted to emergencies with remarkable common sense, demonstrating that one can be

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1. Aspects of this article are based on GEORGE J. ANNAS, WENDY K. MARINER & WENDY E. PARMET, PANDEMIC PREPAREDNESS: THE NEED FOR A PUBLIC HEALTH APPROACH—NOT A LAW ENFORCEMENT/NATIONAL SECURITY—APPROACH, *American Civil Liberties Union* (Jan. 2008), available at <http://www.aclu.org/privacy/medical/33642pub20080114.html>.

2. Robert D. McFadden, *All 155 Aboard Safe as Crippled Jet Crash-Lands in Hudson*, N.Y. TIMES, Jan. 16, 2009, at A1.

3. *Id.*

4. Michael Wilson & Al Baker, *In Icy Water, a Quick Rescue Kept Death Toll at Zero*, N.Y. TIMES, Jan. 16, 2009, at A1.

frightened and rational at the same time.⁵ Although reporters asked whether the survivors were “terrified” or “panicked,” the passengers interviewed insisted that everyone remained calm and just got the job done.⁶ Several factors undoubtedly helped turn the potentially fatal emergency into a story of survival. The passengers cooperated with each other. As noted by the University of Pittsburgh’s respected Center for Biosecurity, “members of the public are first responders and outbreak managers, too.”⁷ Here, the “first responders” were the plane’s crew, its passengers, and nearby civilians such as commercial ferry operators and fishermen. Official emergency crews from New York’s police and fire departments and the Coast Guard arrived a bit later.

Another key factor was that everyone involved had tools for survival at their disposal. The plane was equipped with life vests and rafts.⁸ Crews of both the plane and ferry operators were trained in rescue operations, having practiced as a routine part of their work. Captain Sullenberger demonstrated quick thinking. Air traffic controllers offered runways at Teeterboro and Newark airports, but Sullenberger realized there was not enough time to fly over a thickly settled urban area and instead brought the plane down in the river.⁹ That he managed to land the plane afloat was probably a combination of his extraordinary skill, clear weather, and the river’s relative calm. Had the weather been stormy, the plane could easily have tipped under the water.¹⁰

5. Ben Sheppard et al., *Terrorism and Dispelling the Myth of a Panic Prone Public*, 27 J. PUB. HEALTH POL’Y 246, 247-49 (2006).

6. Eric Moskowitz & Maria Cramer, *Golf Trip Friends from Mass. Among Plane Crash Survivors*, THE BOSTON GLOBE, Jan. 16, 2009, at A6; Michael Wilson & Russ Buettner, *After Splash, Nerves, Heroics and Even Comedy*, N.Y. TIMES, Jan. 17, 2009, at A1.

7. WORKING GROUP ON CMITY. ENGAGEMENT IN HEALTH EMERGENCY PLANNING, CTR. FOR BIOSECURITY, MAJOR FINDINGS, 1 (2007), available at http://www.upmc-biosecurity.org/web/site/focus/community_engage/2007_working_group/findings.html

8. McFadden, *supra* note 2, at A24.

9. Susan Carey, *US Air Pilots Thought of New York, New Jersey Airports Before Ditching in River*, WALL ST. J., Feb. 6, 2009, at A5, available at <http://online.wsj.com/article/SB123384802390852577.html>.

10. See, e.g., AMIT PATEL & RICHARD P. GREENWOOD, JR., U.S. DEP’T OF TRANSP., REP. NO. DOT/FAA/AR-95/54, TRANSPORT WATER IMPACT AND DITCHING PERFORMANCE 5 (1996), available at <http://www.tc.faa.gov/its/worldpac/techrpt/ar95-54.pdf>. For current data on airline emergency landings and ditching, see Aviation Safety Network, Aviation Safety Database, <http://aviation-safety.net/database/dblist.php?Event=REED&lang=&page=1> (last visited Mar. 14, 2009).

Surviving US Airways flight 1549 depended on trusting one's fellow human beings and the kind of readiness that comes from everyday experience, access to necessary resources, and common sense. Current discussions of emergency preparedness would do well to heed its lessons. This Article examines what past emergencies can teach us about preventing and controlling epidemics of infectious disease. It begins in Part II with a brief summary of the types of resources necessary for minimizing the damage from epidemics – what has recently become known as “preparedness.” Chief among these is a healthy population, which is resilient and able to resist infection or respond well if it arrives.¹¹ Thus, effective emergency preparedness depends heavily on sustainable systems of medical care and public health working together.

Since September 11, 2001, emergency preparedness policies have shifted their focus from public health to national security, bioterrorism, and personal responsibility. Part III of this Article argues that this shift is both contradictory and ineffective. Part IV then critiques proposals for law reform that increase personal responsibility for health, while reducing official accountability. Such proposals can distort the rule of law in general, while doing little, if anything, to prevent public health emergencies. Laws governing bioterrorism cannot be limited to emergencies because responding to bioterrorism is essentially the same as responding to naturally occurring epidemics; the same law necessarily governs all public health emergencies.¹² The Article concludes that effective emergency preparedness depends on prevention and the availability of appropriate resources and planning, not on laws specially designed for emergencies.

11. N. Howard-Jones, *Origins of International Health Work*, 1 BRIT. MED. J. 1032, 1034 (1950) (“[Q]uarantine barrier methods are of very limited value and . . . resistance of a community to infection is dependent upon its internal conditions.”).

12. Wendy K. Mariner, *Law and Public Health: Beyond Emergency Preparedness*, 38 J. HEALTH L. 247, 283 (2005). See generally OREN GROSS & FIONNUALA NÍ AOLÁIN, *LAW IN TIMES OF CRISIS: EMERGENCY POWERS IN THEORY AND PRACTICE* (2006).

II. REAL EMERGENCY PREPAREDNESS

An epidemic—and especially a pandemic—can wreak havoc. Yet, unlike nuclear weapons or exploding airplanes, epidemics are not recent innovations in human history.¹³ Both medical and public health professionals, as well as the general public, understand the fundamentals of what should be done to minimize the spread of disease.¹⁴ In the late nineteenth and early twentieth century, government organized programs that purified the water supply to prevent the spread of cholera, built sewage systems to remove sources of disease, and pasteurized milk to make the food supply safer.¹⁵ Quarantines prevented ships arriving from epidemic countries from unloading infected cargo. Health departments distributed vaccines as they became available. Individuals avoided contact with people who were contagious, and those who fell ill usually sought help from physicians. States created licensure boards to ensure at least a minimum quality of competence for hospitals, physicians, and other health providers. This period also saw the rise of movements for women's suffrage, birth control, and abolition of child labor.¹⁶ Later, Congress established regulatory agencies to approve food, drugs, and cosmetics, reduce environmental pollution, make the workplace safer, and reduce the hazards of consumer products.¹⁷ These

13. See generally JOHN M. BARRY, *THE GREAT INFLUENZA: THE EPIC STORY OF THE DEADLIEST PLAGUE IN HISTORY* (2004); HOWARD MARKEL, *QUARANTINE! EAST EUROPEAN JEWISH IMMIGRANTS AND THE NEW YORK CITY EPIDEMICS OF 1892* (1997); JIM MURPHY, *AN AMERICAN PLAGUE: THE TRUE AND TERRIFYING STORY OF THE YELLOW FEVER EPIDEMIC OF 1793* (2003); CHARLES E. ROSENBERG, *THE CHOLERA YEARS* (1962).

14. See generally DAVID ROSNER & GERALD MARKOWITZ, *ARE WE READY?—PUBLIC HEALTH SINCE 9/11* (2006).

15. WENDY E. PARMET, *POPULATIONS, PUBLIC HEALTH AND THE LAW* (2009); JOHN DUFFY, *THE SANITARIANS: A HISTORY OF AMERICAN PUBLIC HEALTH 89-91* (1990); THOMAS MCKEOWN, *MEDICINE IN MODERN SOCIETY: MEDICAL PLANNING BASED ON EVALUATION OF MEDICAL ACHIEVEMENT* 51 (1965); Elizabeth Fee, *The Origins and Development of Public Health in the United States*, in 1 OXFORD TEXTBOOK OF PUBLIC HEALTH 35-54 (Roger Detels et al., eds., 3d. ed. 1997).

16. See generally JAMES A. MORONE, *HELLFIRE NATION: THE POLITICS OF SIN IN AMERICAN HISTORY* (2003).

17. See NICHOLAS A. ASHFORD & CHARLES C. CALDART, *TECHNOLOGY, LAW AND THE WORKING ENVIRONMENT*, 91-98 (Island Press, 1996); see also Consumer Product Safety Commission Act, 15 U.S.C. § 2053 (2004) (establishing the Consumer Product Safety Commission); Federal Food, Drug, and Cosmetic Act, 21 U.S.C. §§ 301-399 (2004); Occupational and Health

efforts required organized, collective action, and they brought many infectious diseases under control, improving the health of the general population. Between 1900 and 2005, life expectancy increased from forty-seven to seventy-eight years.¹⁸

Today, most public health experts recognize that a healthy population depends upon safe environments, a safe food supply, and access to medical care to treat illness and injury. Public health programs make it possible for people to avoid disease and stay healthy. These efforts are rarely glamorous. They often require a sustained effort over time, with dedicated personnel working quietly out of the limelight. They also entail working with communities, giving them the information and resources they need to help themselves and their neighbors. Community engagement is both a watchword and the most effective way to create a population that is resilient enough to resist disease and care for its members.¹⁹ Moreover, a healthy population that is prepared to resist disease may be a deterrent to biological attack.²⁰

In the past, many epidemics of contagious diseases, such as influenza and Severe Acute Respiratory Syndrome (SARS), were introduced into the country by travelers from overseas, who typically were unaware of their illness. Preventing a serious pandemic, therefore, requires cooperation with other

Safety Administration Act, Occupational Safety and Health Act, 29 U.S.C. § 651 (2004) (establishing the Occupational Health and Safety Administration); Reorganization Plan No. 3, 35 Fed. Reg. 15,623 (Dec. 2, 1970) (establishing the Environmental Protection Agency).

18. NAT'L CTR. FOR HEALTH STATISTICS, HEALTH, UNITED STATES, 2008, at 203 (2009), available at [http://www.cdc.gov/nchs/data/08/08.pdf#026](http://www.cdc.gov/nchs/data/hus/08/08.pdf#026); see BERNARD J. TURNOCK, PUBLIC HEALTH: WHAT IT IS AND HOW IT WORKS 39 (4th ed. 2007). See generally VICTOR FUCHS, WHO SHALL LIVE? HEALTH, ECONOMICS, AND SOCIAL CHOICE (World Scientific Publ'g Co. 2002) (1998) (arguing that genetic, environmental, and behavioral factors had more influence on health than medical care); GEORGE ROSEN, A HISTORY OF PUBLIC HEALTH (The Johns Hopkins Univ. Press 1993) (1958). But see David M. Cutler, *Declining Disability Among the Elderly*, 20 HEALTH AFF. 11, 18 (2001) (arguing that physicians and medical researchers played a greater role in increasing life expectancy than is generally acknowledged).

19. Monica Schoch-Spana, *Community Resilience for Catastrophic Health Events*, 6 BIOSECURITY & BIOTERRORISM: BIODEFENSE STRATEGY, PRACTICE, & SCIENCE 129, 129-30 (2008). For an extensive collection of references on community engagement and vulnerable populations in disasters, see Univ. of Md. Ctr. for Health and Homeland Security, *Vulnerable Populations: Emergency Preparedness Conference*, http://www.umaryland.edu/healthsecurity/mtf_conference/ (last visited Mar. 15, 2009).

20. COMM'N ON THE PREVENTION OF WEAPONS OF MASS DESTRUCTION PROLIFERATION AND TERRORISM, WORLD AT RISK: REPORT OF THE COMMISSION ON THE PREVENTION OF WEAPONS OF MASS DESTRUCTION PROLIFERATION AND TERRORISM 111 (2008), available at <http://www.preventwmd.gov/report/>.

countries and international organizations to develop the kind of local environments abroad that reduce the possibility of disease. After the SARS epidemic in 2003, the World Health Organization tried to improve its system for alerting countries to the presence of a new or serious contagious disease.²¹ As a practical matter, however, its new rules are likely to depend on voluntary compliance and may not prevent the spread of disease significantly. Moreover, given the speed and volume of global travel and commerce, it is probably impossible to shut out a highly contagious disease such as influenza. Strategies that rely on closing borders are doomed to fail.

Once introduced into a country, the harm from a contagious disease with epidemic potential can nevertheless be limited. The medical measures to be taken depend upon the characteristics of the specific virus or pathogen itself: whether it can be transmitted through the air or by casual contact; whether transmission of infection occurs before or after symptoms appear; whether diagnostic tests exist to identify the disease; and whether there is a vaccine to prevent infection or medicine to cure it or reduce its damage. A country with adequate capacity for research on infectious diseases has the singular advantage of answering these critical questions in time to make the right decisions about how to protect its population. Thus, emergency preparedness includes supporting a research enterprise directed at preventing and treating infectious diseases, including emerging diseases, such as possible strains of avian influenza. The development of vaccines to prevent infection may curtail the impact of future diseases, just as vaccines have eradicated once-feared diseases like small pox and polio, and may reduce the cases and severity of others, like measles and mumps. At the same time, the country needs a reliable drug approval process that functions in the public interest to ensure that the drugs and vaccines developed are safe and effective. This means improving the capacity of the Food and Drug Administration to operate independently and expeditiously.

To assure an adequate supply of safe and effective vaccines, medicines, and life-saving medical equipment during an epidemic, it may be necessary for government to create stockpiles. The move to "just in time" inventories may have im-

21. See generally World Health Org., *Revision of the International Health Regulations*, WHA 58.3 (May 23, 2005), available at <http://www.who.int/csr/ihr/en/>.

proved the efficiency of private sector distributors and retailers, but the limited supplies are insufficient in times of emergency.

Most people who get sick go to a hospital, clinic, or physician's office. In an emergency, it will be important for people to have a trusted source of medical care available. This suggests that a key component of emergency preparedness is access to regular medical care, whether in the form of direct service delivery or through health insurance coverage. A population that is already plugged into the medical system, and presumably already attending to its own health needs, is well positioned to act responsibly in a crisis.²² There is ample recognition that people who lack health insurance coverage are at greater risk of illness, disability, and death than the general population.²³ Equally important are the social costs of uninsurance, which leave individuals in precarious circumstances unable to participate fully in society.²⁴ Without ready access to medical care, the uninsured are less likely to have an infectious disease diagnosed and treated to avoid spreading it to others. The lack of universal health insurance also creates strains on hospitals that receive a large influx of patients without the means to pay for their care. Thus, expanding access to health care to the entire population contributes substantially to preparing for emergencies. It is the socioeconomic equivalent of vaccination against disease.²⁵

Of course, hospitals and clinics need to be available to those in need.²⁶ In an emergency, they need not only clean water, safe food, medicines, and equipment, but also a reliable power supply as well as staff trained for surge capacity and continu-

22. See generally INST. OF MED., *SHARED DESTINY: COMMUNITY EFFECTS OF UNINSURANCE* (2003).

23. See generally INST. OF MED., *COVERAGE MATTERS: INSURANCE AND HEALTH CARE* (2001).

24. See generally INST. OF MED., *HIDDEN COSTS, VALUE LOST: UNINSURANCE IN AMERICA* (2003); Vickie J. Williams, *Fluconomics – Preserving our Hospital Infrastructure During and After a Pandemic*, 7 *YALE J. HEALTH POL'Y L. & ETHICS* 99, 106-07 (2007).

25. Thomas A. Glass & Monica Schoch-Spana, *Bioterrorism & the People: How to Vaccinate a City Against Panic*, 34 *CLINICAL INFECTIOUS DISEASES* 217, 217 (2002).

26. This discussion does not address the federal National Disaster Medical System (NDMS), which fields trained teams of medical personnel to provide short-term emergency care in disasters. For an assessment of the NDMS, see generally DISASTER MED. WORKING GROUP NDMS ASSESSMENT PANEL, *STRATEGIC IMPROVEMENTS TO THE NATIONAL DISASTER MEDICAL SYSTEM (NDMS)* (Sept. 2008), available at <http://www.hhs.gov/aspr/conferences/nbsb/ndms-rpt-0809.pdf>.

ity of operations.²⁷ In medical facilities, good infection control practices can make the difference between containing and launching an epidemic. In Toronto, the SARS epidemic was halted after hospitals initiated rigorous infection control procedures, including requiring all staff to wear protective gear and treating infected patients in isolation from others.²⁸ These practices also hold value for everyday medicine, especially since nosocomial infections like Methicillin resistant *Staphylococcus aureus* (MRSA) have been increasing dangerously in recent years.²⁹ Making infection control a routine operation, like routine training in water rescues for ferry crews, enables medical providers to respond quickly and effectively to potentially dangerous novel infections.

When no vaccine or treatment is available, the best way to prevent disease from spreading is to keep people away from sources of infection. This can include limiting or cancelling events with large crowds and even temporarily closing schools and businesses.³⁰ People are generally quite willing, when they are able, to shelter in place by staying at home.³¹ However, they may not be able to do so without support.³² People who cannot afford to lose the income they earn from work should not be forced to choose between their livelihood and their health or the health of others. If government officials

27. See Crystal Franco et al., *Systemic Collapse: Medical Care in the Aftermath of Hurricane Katrina*, 4 BIOSECURITY & BIOTERRORISM: BIODEFENSE STRATEGY, PRAC., & SCI. 135, 136 (2006) (describing New Orleans hospitals without power, because generators were in the flooded basement).

28. Tomislav Svoboda et al., *Public Health Measures to Control the Spread of the Severe Acute Respiratory Syndrome in Toronto*, 350 NEW ENG. J. MED. 2352, 2353-54 (2004).

29. See generally R. Monina Klevens et al., *Invasive Methicillin-Resistant Staphylococcus aureus Infections in the United States*, 298 J. AM. MED. ASS'N 1763 (2007).

30. See generally BARRY, *supra* note 13 (describing examples of social distancing). Evidence on the effectiveness of school closings in reducing the spread of influenza is mixed. Benjamin J. Cowling et al., *Effects of School Closures, 2008 Winter Influenza Season, Hong Kong*, 14 EMERGING INFECTIOUS DISEASES 1660, 1660-61 (2008), available at <http://www.cdc.gov/EID/content/14/10/pdfs/1660.pdf>; World Health Org. Writing Group, *Nonpharmaceutical Public Health Interventions for Pandemic Influenza, National and Community Measures*, 12 EMERGING INFECTIOUS DISEASES 88, 88-89 (2006).

31. Robert J. Blendon et al., *Attitudes Toward the Use of Quarantine in a Public Health Emergency in Four Countries*, 25 HEALTH AFF. W15, W21 (2006), available at <http://content.healthaffairs.org/cgi/reprint/25/2/w15>.

32. See Clete DiGiovanni et al., *Factors Influencing Compliance with Quarantine in Toronto During the 2003 SARS Outbreak*, 2 BIOSECURITY AND BIOTERRORISM: BIODEFENSE STRATEGY, PRAC., & SCI. 265, 267-70 (2004) (discussing the need to help quarantined individuals with their incomes, supplies, and physical care).

recommend that people stay home, then government should be prepared to provide the necessary financial support to make it possible, either directly, or by requiring employers to keep at least low-wage workers on staff and pay them for shelter days.³³ There should also be adequate provision for the necessities of safe food, water, and medicine for those who stay at home, at least beyond a day or two. Most drug benefit plans limit the quantity of prescription drugs patients can obtain to a thirty or sixty day supply. Such plans should be altered to allow patients to stockpile a month's supply in case of emergency.

Beyond necessities, both officials and the general public should be able to communicate with others, ideally via reliable cell phones and computers. This is crucially important regardless of the reason for being separated, whether it is hospitalization, flooding, or simply staying at home. Overloaded and incompatible electronic equipment make communications impossible and can frustrate logistics of all kinds.³⁴ Although variety and choice are as American as apple pie, interoperable means of communicating and adequate backup sources of energy, from batteries to generators to satellites, are essential in an emergency.³⁵

To be effective, all these measures must be developed in consultation with, and understood and accepted by, the public.³⁶ The information that is provided should be culturally

33. During the SARS epidemic, governments in Canada found it necessary to provide income support for those who stayed home because of the disease. See Nola M. Ries, *Public Health Law and Ethics: Lessons from SARS and Quarantine*, 13 HEALTH L. REV. 3, 4 (2004) ("A SARS Assistance Program was also established to offer some financial compensation to people who lost income during periods of quarantine.").

34. HURRICANE KATRINA - A NATION STILL UNPREPARED, S. Rep. No. 109-322, at 287-297 (2006) (Special Report of the Committee on Homeland Security and Governmental Affairs, United States Senate), available at <http://www.gpoaccess.gov/serialset/creports/katrinanation.html>.

35. Donny Jackson, *Survivable Communications: Much More Than Hardened Radios*, URGENT COMMUNICATIONS, Nov. 1, 2005, http://urgentcomm.com/mag/radio_survivable_communications_hardened/.

36. See generally ROZ D. LASKER ET AL., WITH THE PUBLIC'S KNOWLEDGE, WE CAN MAKE SHELTERING IN PLACE POSSIBLE (2007) (discussing how to educate the community and involve them in emergency preparedness, so that they can effectively shelter within their own towns), available at <http://www.redefiningreadiness.net/pdf/sipreport.pdf>; Monica Schoch-Spana et al., *Community Engagement: Leadership Tool for Catastrophic Health Events*, 5 BIOSECURITY AND BIOTERRORISM: BIODEFENSE STRATEGY, PRAC., & SCI. 8 (2007) (discussing the need for community engagement during crisis).

sensitive and available in the different languages that are spoken in a particular community. Mechanisms should be in place to explain what is known, what remains unknown or uncertain, and what the public can do to protect themselves and their families.³⁷ This includes not only the nature of the likely risks, but also the resources that will be made available to those in need and how to access them. During a pandemic, travel presents a special challenge. Governments should warn travelers about real risks through travel advisories and alerts and take measures to reduce the spread of disease by travel.

Even more important, the source of information should be an entity or person that the public can trust.³⁸ Many Americans are no longer willing to rely on official sources of information, such as Federal Emergency Management Agency (FEMA). Most people's first priority during an emergency is the safety of their loved ones. As a New York Academy of Medicine study reported, when asked about their willingness to remain in an officially imposed quarantine location, a majority of individuals said they would go find their families unless they received trustworthy information about their family's safety and could communicate with them.³⁹ The study also found that only forty-three percent of those surveyed would obey official recommendations to go to a vaccination site during a smallpox outbreak; more than half of those expressed concern about the vaccine's safety.⁴⁰ They preferred to talk to a trusted physician unaffiliated with the government.⁴¹ Trust can be developed by involving the community in identifying needed resources, planning response procedures, selecting reliable people for the tasks at hand, and generally creating relevant and useful approaches to improve public health.⁴²

Finally, government officials involved in epidemic control programs should remain accountable for their actions. It is difficult to place one's faith in official pronouncements and ac-

37. This should include undocumented persons, who are often ignored in formal planning processes.

38. George J. Annas, *Puppy Love: Bioterrorism, Civil Rights, and Public Health*, 55 FLA. L. REV. 1171, 1178-79, 1181 (2003).

39. ROZ D. LASKER, REDEFINING READINESS: TERRORISM PLANNING THROUGH THE EYES OF THE PUBLIC 31-33 (2004), available at <http://www.nyam.org/library/docs/sipreport.pdf>.

40. *Id.* at 8-9.

41. *Id.*

42. See generally Schoch-Spana et al., *supra* note 36.

tions if those in charge are not held responsible for abuses of authority or even gross negligence. Proposals to grant officials, emergency workers, volunteers, and pharmaceutical makers immunity from liability are counterproductive. Not only does it leave the victims of a disaster worse off, but it significantly undermines public trust in the public health response system.

These measures require money more than law. To be sure, effective pandemic planning will require some legal changes. For example, the jurisdictional boundaries among federal and state agencies raise legal issues that could benefit from clarification.⁴³ Several measures, such as allowing patients to stockpile prescription drugs, might require specific legislation on prescription quantities and insurance coverage. To the extent that infection control practices are not universally required of medical facilities, licensure regulations may need amending. The most comprehensive legal change would be legislation providing for universal access to health care or health insurance coverage.

For the most part, however, the laws required to prepare for emergencies are laws authorizing the expenditure of funds to support measures like expanding health insurance, providing necessities, keeping hospitals and clinics open, training medical staff, conducting research, stockpiling medications, and providing information to the public. Few of these measures differ in quality from those needed to protect the health of the public in the absence of emergencies. And that is precisely the point. Emergency preparedness requires a well-functioning public health system. A healthy, well-informed population can survive the challenge of disease with the same common sense used by the passengers on US Airways flight 1549.

III. UNREAL EMERGENCY PREPAREDNESS

When President Bush declared a Global War on Terror after the attacks on September 11, 2001, he intensified a new paradigm in public health policy. Although explosives were and

43. Michael Greenberger, *Yes, Virginia: The President Can Deploy Federal Troops to Prevent the Loss of a Major American City from a Devastating Natural Catastrophe*, 26 MISS. C. L. REV. 107, 108 (2006) (describing some confusion over federal authority to respond to natural disasters without state consent).

remain the weapon of choice for those who seek to terrorize Western countries,⁴⁴ many in the administration began to worry about the possibility that bioweapons also could be used.⁴⁵ The “Dark Winter” simulation⁴⁶ may have convinced Vice President Cheney that the country was defenseless against bioterrorism, spurring him to recommend that everyone in the country be immunized against small pox,⁴⁷ contrary to the advice of medical experts, including the administration’s top expert on smallpox, Dr. D.H. Henderson.⁴⁸ In *The Bush Tragedy*, Jacob Weisberg describes President Bush’s fear that a second wave of terrorist attacks would follow 9/11 and that the anthrax incidents could be that wave.⁴⁹ Later, fears of bioterrorism were central to the Administration’s justification for the invasion of Iraq.⁵⁰ For an administration prone to imagining catastrophe,⁵¹ it was a short step to considering

44. Mark Wheelis & Masaaki Sugishima, *Terrorist Use of Biological Weapons*, in *DEADLY CULTURES - BIOLOGICAL WEAPONS SINCE 1945*, at 284, 284-85, 301-302 (Mark Wheelis et al. eds., 2006).

45. See David P. Fidler, *Caught Between Paradise and Power: Public Health, Pathogenic Threats, and the Axis of Illness*, 35 *MCGEORGE L. REV.* 45, 84 (2004) (arguing that international diplomacy has vacillated between deeming epidemics as a threat to national power and an opportunity for global cooperation).

46. See generally Tara O’Toole, Michael Mair & Thomas V. Inglesby, *Shining Light on “Dark Winter,”* 34 *CLINICAL INFECTIOUS DISEASES* 972 (2002) (describing the design, execution and results of the “Dark Winter” program, a governmental exercise in preparation for a possible bioterroristic attack).

47. BARTON GELLMAN, *ANGLER: THE CHENEY VICE PRESIDENCY* 343-344 (2008).

48. See *COMM. ON SMALLPOX VACCINATION PROGRAM IMPLEMENTATION* BD. ON HEALTH PROMOTION & DISEASE PREVENTION, *REVIEW OF THE CENTERS FOR DISEASE CONTROL AND PREVENTION’S SMALLPOX VACCINATION PROGRAM IMPLEMENTATION, LETTER REPORT #4*, at 18-19 (2003) (“In the absence of any current benefit to individual vaccinees and the remote prospect of benefit in the future (as such benefit would be realized only in the event of a smallpox outbreak, and the outbreak occurred in the vaccinee’s region), the balance of benefit to the individual and risk to others (through contact with the vaccinee or through disruption of other public health initiatives) becomes unfavorable.”), available at http://books.nap.edu/openbook.php?record_id=10788&page=R1; JACOB WEISBERG, *THE BUSH TRAGEDY* 189-90 (2008).

49. WEISBERG, *supra* note 48, at 189-90; see also LEONARD A. COLE, *THE ANTHRAX LETTERS* 137, 144, 240 (2003) (discussing the Bush Administration’s belief that biological weapons are potentially the most dangerous weapons in the world, and the Administration’s increased concern over an Iraqi biological weapons arsenal).

50. E.g., Judith Miller, *Threats and Responses: Germ Weapons; CIA Hunts Iraq Tie to Soviet Smallpox*, *N.Y. TIMES*, Dec. 3, 2002, at A4 (discussing the Bush Administration’s concern over potential Iraqi possession of smallpox as communicated by a Soviet informant).

51. See generally RONALD SUSKIND, *THE ONE-PERCENT DOCTRINE: DEEP INSIDE AMERICA’S PURSUIT OF ITS ENEMIES SINCE 9/11* (2006) (describing the idea that a one percent risk should be responded to as though it were a certainty and detailing the differing levels of the federal government’s response to the 9/11 terrorist attacks).

natural epidemics of contagious diseases as a threat to national security.⁵²

The so-called preemption doctrine advanced by the Bush administration leached into policies governing pandemic preparedness.⁵³ The idea that the federal government should use force to prevent enemies from developing weapons to attack the United States found parallels in public health programs.⁵⁴ Converting the well-known risk of epidemics into the equivalent of war on the American people enabled the federal government to exert a degree of control over individual patients that was unprecedented in the modern era, and to spend federal dollars to encourage states to do the same.⁵⁵ Surveillance of Americans' health conditions, from tuberculosis to cancer and diabetes, expanded in a manner similar to the National Security Agency's surveillance to identify terrorists.⁵⁶ Federal

52. George J. Annas, *The Statue of Security: Human Rights and Post-9/11 Epidemics*, 38 J. HEALTH L. 319, 320-21 (2005); see JACK L. GOLDSMITH, *THE TERROR PRESIDENCY: LAW AND JUDGMENT INSIDE THE BUSH ADMINISTRATION* 72, 189 (2007) (claiming that Bush's presidency will be defined by his constant fear of a devastating attack); see also WORLD HEALTH ORG., *A SAFER FUTURE: GLOBAL PUBLIC HEALTH SECURITY IN THE 21ST CENTURY* 45 (2007) (describing pandemic flu as "the most feared security threat" in the world), available at http://www.who.int/whr/2007/whr07_en.pdf. See generally IN THE WAKE OF TERROR: MEDICINE AND MORALITY IN A TIME OF CRISIS (Jonathan D. Moreno ed., 2003) (addressing the threat of bioterrorism and the spread of disease). One reason why epidemics raise such a fearful specter today is that they have become such rare events in the western industrialized world, largely because of past successes in eradicating diseases like small pox and keeping other diseases, like measles, to a minimum with childhood vaccinations; see Aaron Wildavsky & Karl Drake, *Theories of Risk Perception: Who Fears What and Why?*, 119 DAEDALUS 41 (1990) (describing factors influencing risk perception).

53. WHITE HOUSE, NAT'L SEC. COUNCIL, *THE NATIONAL SECURITY STRATEGY OF THE UNITED STATES OF AMERICA* 6-7 (2002), available at <http://www.globalsecurity.org/military/library/policy/national/nss-020920.pdf> ("This strategy will turn adversity into opportunity. For example, emergency management systems will be better able to cope not just with terrorism but with all hazards. Our medical system will be strengthened to manage not just bioterror, but all infectious diseases and mass-casualty dangers. Our border controls will not just stop terrorists, but improve the efficient movement of legitimate traffic."); WHITE HOUSE, NAT'L SEC. COUNCIL, *THE NATIONAL SECURITY STRATEGY OF THE UNITED STATES OF AMERICA* 12-13, 23-24 (2006), available at <http://www.marforres.usmc.mil/docs/nss2006.pdf> ("The place of pre-emption in our national security strategy remains the same.").

54. See, e.g., David Brown, *Military's Role in Flu Pandemic: Troops Might Be Used to "Effect a Quarantine," Bush Says*, WASH. POST, Oct. 5, 2005, at A05 (noting that President Bush suggested a mass quarantine, carried out through military intervention, in the event of an influenza epidemic).

55. Crystal Franco, *Billions for Biodefense, Federal Agency Biodefense Spending, FY 2008-2009*, 6 BIOSECURITY AND BIOTERRORISM: BIODEFENSE STRATEGY, PRAC., & SCI. 131, 131 (2008). See generally *Pandemic and All-Hazards Preparedness Act*, Pub. L. No. 109-417, 120 Stat. 2831 (2006) (codified in scattered sections of 6, 38, 42 U.S.C.).

56. Wendy K. Mariner, *Mission Creep: Public Health Surveillance and Medical Privacy*, 87 B.U.

agencies advocated expanding state and federal powers of involuntary detention to include people who simply may have visited a place where the disease might be found.⁵⁷ Paradoxically, however, conceptualizing epidemics as national security threats did not translate into federal provision of assistance to those most at risk of illness, as our history and sound public health policy counsel. The Administration's preference for market-based health care left individuals to fend for themselves.⁵⁸

The signature catch-phrase of this approach was that we must "trade liberty for security."⁵⁹ This misguided maxim, carried over from the war on terror, equated those who were sick with the nation's enemies and failed to heed history's lessons. Too often, government officials have used the fear of epidemics to abuse their power. For example, when bubonic plague appeared in San Francisco in 1900, the Surgeon General ordered people of Chinese ancestry to be vaccinated with the risky and unpopular Haffkine vaccine that could cause severe side effects.⁶⁰ A federal court found the vaccination order un-

L. REV. 347, 349-350 (2007); James Risen & Eric Lichtblau, *Bush Lets U.S. Spy on Callers Without Courts*, N.Y. TIMES, Dec. 16, 2005, at A1; see also ROBERT O'HARROW JR., NO PLACE TO HIDE 8 (2005) ("[G]overnment's ability to examine our lives is only going to increase in coming years."); KATHLEEN M. SULLIVAN, *Under a Watchful Eye: Incursions on Personal Privacy*, in THE WAR ON OUR FREEDOMS: CIVIL LIBERTIES IN AN AGE OF TERRORISM 128, 128-130 (Richard C. Leone & Greg Anrig, Jr. eds., 2003).

57. New federal regulations were proposed in 2005, but have not been adopted to date. Control of Communicable Diseases, 70 Fed. Reg. 71892 (proposed Nov. 30, 2005) (to be codified at 42 C.F.R. pt. 70 & 71), available at <http://www.cdc.gov/ncidod/dq/nprm/>. Public comments were largely critical of the proposed changes. See generally JENNIFER B. NUZZO ET AL., COMMENTS FROM THE CENTER FOR BIOSECURITY OF UNIVERSITY OF PITTSBURGH MEDICAL CENTER ON PROPOSED REVISIONS TO 42 CFR 70 AND 71 (QUARANTINE RULES) (2006) (expressing general criticism of the proposed changes to the CFR), available at http://www.cdc.gov/ncidod/dq/nprm/comments/2006Jan28_UPMC.pdf; NEW ENGLAND COAL. FOR LAW & PUB. HEALTH, COMMENTS ON THE INTERSTATE AND FOREIGN QUARANTINE REGULATIONS PROPOSED BY THE CENTERS FOR DISEASE CONTROL AND PREVENTION, DEPT. OF HEALTH AND HUMAN SERVICES, CONTROL OF COMMUNICABLE DISEASES, 42 C.F.R. PARTS 70 AND 71, PROPOSED RULEMAKING, RIN 0920-AA03 (2006) (critiquing the proposed regulations' omission of constitutional protections and likelihood that they would not aid the public health), available at http://www.cdc.gov/ncidod/dq/nprm/comments/2006Feb3_NECLPH.pdf.

58. Wendy E. Parmet, *Unprepared: Why Health Law Fails to Prepare Us for a Pandemic*, 2 J. HEALTH & BIOMEDICAL L. 157, 179-83 (2006).

59. David Luban, *Eight Fallacies About Liberty and Security*, in HUMAN RIGHTS IN THE "WAR ON TERROR" 242, 242 (Richard Ashley Wilson ed., 2005); David Cole, *Their Liberties, Our Security: Democracy and Double Standards*, 31 INT'L J. LEGIS. INFO. 290, 291 (2003).

60. MARILYN CHASE, THE BARBARY PLAGUE: THE BLACK DEATH IN VICTORIAN SAN

constitutional.⁶¹ In response, the San Francisco board of health ordered San Francisco's Chinese quarter quarantined. This, too, was held unconstitutional.⁶² The federal appeals court found it to be "unreasonable, unjust, and oppressive,"⁶³ infringing on the liberty protected by the Due Process Clause of the Fourteenth Amendment; confining everyone, whether healthy or sick, together irrationally facilitated the spread of infection instead of containing it. The ordinance also violated the Equal Protection Clause, because the quarantine unjustifiably confined only residents of the "Chinese race."⁶⁴ The quarantine fence that sealed off the area serpented around the homes and businesses of Caucasians, leaving them free to come and go as they pleased.⁶⁵ The court rejected health officials' argument that the Chinese were particularly susceptible to plague and concluded that the ordinance was the product of "an evil eye and an unequal hand."⁶⁶

Marilyn Chase recounts the postscript to the quarantine fiasco in her history of San Francisco's recurrent battle against plague.⁶⁷ A new federal health officer, Rupert Blue, abandoned imperious mandates and began to work with the community, explaining how fleas on rats and rodents carried plague and engaging residents to clean up their neighborhood. His painstaking efforts took time, but they did end the epidemic.⁶⁸

Experience with smallpox follows a similar pattern. In 1894, Milwaukee tried to stop a smallpox epidemic by forcing immigrants and indigent residents into a quarantine hospital. The "patients" reacted with mistrust and rioting.⁶⁹ Not long thereafter, the Boston health department sought to halt a recurrence of the disease by requiring vaccination against small pox. Despite a policy that forbade actually forcing the vaccine

FRANCISCO 48, 61 (2003).

61. *Wong Wai v. Williamson*, 103 F. 1, 9-10 (C.C.D. Cal. 1900).

62. *Jew Ho v. Williamson*, 103 F. 10, 24 (C.C.D. Cal. 1900).

63. *Id.* at 26.

64. *Id.* at 14.

65. *Id.* at 23; CHASE, *supra* note 60, at 18.

66. *Jew Ho*, 103 F. at 24 (quoting *Yick Wo v. Hopkins*, 118 U.S. 356, 373 (1886)).

67. CHASE, *supra* note 60, at 48.

68. *Id.* at 125-195.

69. Judith Walzer Leavitt, *Public Resistance or Cooperation: A Tale of Smallpox in Two Cities*, 1 BIOSECURITY AND BIOTERRORISM: DEFENSE STRATEGY PRAC. & SCI. 185, 186-88 (2003).

on anyone, health officials, accompanied by police, set about forcibly vaccinating African-Americans and residents living in the poorer parts of the city.⁷⁰ These actions may have fueled the anti-vaccination movement in the state.

By the middle of the twentieth century, coercive methods of controlling disease seemed a distant memory. When small pox appeared in New York in 1947, the city organized a substantial public education campaign to explain the risks of infection and the benefits of vaccination.⁷¹ Assured that officials wanted to protect, not persecute, them, thousands of people lined up to receive the vaccine in a massive voluntary immunization program offered by the city.⁷² The program was a success, and small pox soon disappeared from New York.⁷³

More recently, the SARS epidemic demonstrated the value of providing the public with accurate information and using modern infection control techniques in hospitals.⁷⁴ In Toronto, Canada, SARS was primarily a nosocomial disease that also spread to patients' household contacts.⁷⁵ The government invoked Ontario's Emergency Management Act, which gave it authority to regulate local governments and facilities to ensure that essential services were provided—a form of surge capacity.⁷⁶ Hospitals temporarily suspended elective and outpatient services, created isolation wards for SARS patients, required all staff to use protective gloves, gowns, eyewear and respirators when seeing patients, and screened all staff, patients, and visitors for SARS symptoms.⁷⁷ Once these measures were put

70. *Workmen Vaccinated*, BOSTON HERALD, March 16, 1902, at 10; Wendy E. Parmet et al., *Individual Rights Versus the Public's Health—100 Years After Jacobson v. Massachusetts*, 352 N. ENG. J. MED. 652, 653 (2005).

71. Leavitt, *supra* note 69, at 185-86.

72. *Id.* at 189-90.

73. *Id.* at 181-91.

74. See generally Robert A. Weinstein, *Planning for Epidemics – The Lessons of SARS*, 350 N. ENG. J. MED. 2332 (2004).

75. Monali Varia et al., *Investigation of a Nosocomial Outbreak of Severe Acute Respiratory Syndrome (SARS) in Toronto, Canada*, 169 CAN. MED. ASS'N J. 285, 285 (2003); see also, e.g., Svoboda et al., *supra* note 28, at 2352, 2359.

76. See Svoboda et al., *supra* note 28, at 2353.

77. See INST. FOR BIOETHICS, HEALTH POL'Y & LAW, UNIV. OF LOUISVILLE SCH. OF MED., QUARANTINE AND ISOLATION: LESSONS LEARNED FROM SARS (2003), <http://www2a.cdc.gov/php/docs/Quarantine-Isolation-Lessons-Learned-from-SARS.pdf> (discussing how Asian countries like Singapore, Vietnam, and China responded similarly to Toronto in taking drastic measures to contain the spread of SARS in hospitals). Income support was also provided to those who stayed at home. See *supra* note 33.

in place, the infections stopped spreading.⁷⁸ The United States had far fewer suspected and confirmed cases of, and no deaths from, SARS.⁷⁹ With advice from public health officials to avoid public settings where the disease could be transmitted—social distancing—people were able to prevent exposure. Most people who might have been already exposed tended to stay at home.⁸⁰ Although these responses were often described as “quarantine,” they almost never relied on any court or administrative order.⁸¹ Of little value, however, were attempts to use thermal screening—taking the temperature of people suspected of fever—to identify cases, especially at airports,⁸² despite public support for the measure.⁸³

These examples, typical of the country’s experience with epidemics, teach two lessons. First, the public’s health is best protected when government treats people like clients rather than enemies of public health.⁸⁴ People do not want to get sick, and they do not want to make other people sick. Given accurate information and the means to protect themselves from disease, almost everyone will take appropriate precautions. To be sure, there will always be a few who are unable or unwilling to control their behavior, but these are the exceptions to the rule. Successful public policies cannot be based on the exception. Moreover, current laws authorizing the involuntary confinement of those who have a contagious disease

78. Svoboda, *supra* note 28, at 2359-70; Varia et al., *supra* note 75, at 291.

79. World Health Org., *Summary of Probable SARS Cases with Onset of Illness from 1 November 2002 to 31 July 2003*, http://www.who.int/csr/sars/country/table2004_04_21/en/index.html (last visited Apr. 6, 2009); Ctr. for Disease Control, *Revised U.S. Surveillance Case Definitions for Severe Acute Respiratory Syndrome (SARS) and Update on SARS Cases – United States and Worldwide, December 2003*, 52 MORBIDITY AND MORTALITY WKLY. REP. 1202, 1203 (2003), available at <http://www.cdc.gov/mmwr/PDF/wk/mm5249.pdf>; Annas, *supra* note 52, at 334.

80. George J. Annas, *Blinded by Terrorism: Public Health and Liberty in the 21st Century*, 13 HEALTH MATRIX 33, 65 (2003).

81. Reports of quarantines in the literature do not uniformly distinguish between voluntary self-isolation and court-ordered involuntary confinement, and some use the term “quarantine” to mean any separation from others. See, e.g., David M. Bell & World Health Organization Working Group, *Public Health Intervention and SARS Spread*, 2003, 10 EMERGING INFECTIOUS DISEASES 1900, 1901 (2004); M.L. Lee et al., *Use of Quarantine to Prevent Transmission of Severe Acute Respiratory Syndrome-Taiwan, 2003*, 52 MORBIDITY & MORTALITY WKLY. REP. 680, 680-683 (2003), available at <http://www.cdc.gov/mmwr/PDF/wk/mm5229.pdf>.

82. X. Pang et al., *Evaluation of Control Measures Implemented in the Severe Acute Respiratory Syndrome Outbreak in Beijing, 2003*, 290 J. AM. MED. ASS’N 3215, 3219-20 (2003).

83. Blendon et al., *supra* note 31, at W18.

84. Annas, *supra* note 80, at 64-65.

and are likely to spread it to others (typically persons with a mental illness or substance abuse disorder who cannot appreciate the need for precautions or control their behavior) are sufficient to protect the public from infection.⁸⁵ Mandating confinement and vaccinations by fiat is more likely to engender mistrust than cooperation. Highhanded orders too often lead people to avoid public health programs.⁸⁶ In April 2003, residents of a rural Chinese town ransacked a school building that was being converted into a quarantine facility for urban SARS patients or those at risk for SARS.⁸⁷ Almost a quarter of a million people fled Beijing when the government announced a mandatory quarantine to prevent the spread of SARS.⁸⁸ By dispersing throughout the country, they may have exacerbated the epidemic. Moreover, studies indicate that quarantines of geographic areas have almost never halted an epidemic.⁸⁹ At best, they might delay the worst for a short time.⁹⁰ In the meantime, even voluntary quarantine can cause stress and impose significant economic costs.⁹¹

The second lesson is that coercive measures invite abuse and exacerbate social divisions. Measures like quarantine, surveillance, and behavior control have historically been targeted at people who are already disadvantaged, those on the margins of society, especially immigrants, the poor, and people of

85. See *infra* Part 4. However, as discussed *infra*, the discriminatory impact of such measures can be problematic.

86. Many African Americans remain skeptical of government health advice, see Blendon et al., *supra* note 31, at W22, in part, perhaps, because of the government's handling of the Tuskegee experiment. See JAMES H. JONES, *BAD BLOOD: THE TUSKEGEE SYPHILIS EXPERIMENT* 220-41 (1981).

87. Erik Eckholm, *The SARS Epidemic: Fear; SARS Is the Spark for a Riot in China*, N.Y. TIMES, Apr. 28, 2003, at A1.

88. Annas, *supra* note 80, at 65; C. Hutzler, *China Reverts to Top-Down Rule with Heavy Hand to Fight SARS*, WALL ST. J., May 8, 2003, at A8; Joseph Kahn, *Quarantine Set in Beijing Areas to Fight SARS*, N.Y. TIMES, Apr. 25, 2003, at A1.

89. Joseph Barbera et al., *Large-Scale Quarantine Following Biological Terrorism in the United States*, 286 J. AM. MED. ASS'N 2711, 2715-16 (2001). See generally Howard-Jones, *supra* note 11.

90. Bell, *supra* note 81, at 1900-01.

91. See Robert J. Blendon et al., *The Public's Reaction to Severe Acute Respiratory Syndrome in Toronto and the United States*, 38 CLINICAL INFECTIOUS DISEASES 925, 925 (2004) (studying psychological and economic effects of SARS outbreak); L. Hawryluck et al., *SARS Control and Psychological Effects of Quarantine, Toronto, Canada*, 7 EMERGING INFECTIOUS DISEASES 1206, 1206 (2004). See generally, Jong-Wha Lee & Warwick J. McKibben, *Estimating the Global Economic Costs of SARS*, in *LEARNING FROM SARS* 92 (Stacey Knobler et al. eds., 2004) (discussing the economic effects of global SARS outbreaks), available at http://www.nap.edu/catalog.php?record_id=10915.

color.⁹² As Priscilla Wald details in *Contagious*, an analysis of popular literature and movies, public officials often characterized people with contagious diseases as threats to society.⁹³ In their view, the best way to counter the threat was to give science control, not simply to discover the source of infection or develop vaccines, but to monitor and manage people, requiring them to obey strict regimens of isolation or treatment. Wald calls this the “outbreak narrative,”⁹⁴ arguing that officials often interpreted the facts to fit their theory of risk and response.⁹⁵ Not surprisingly, the people who were most often believed to need controlling were those who deviated from prevailing social norms.⁹⁶ Even well-respected physicians and public health leaders held the view that the “lower classes” spread disease because they practiced poor hygiene.⁹⁷ To these opinions might be added the widely-held suspicion that people of color and the poor in general were prone to laziness, violence, intoxication, and sexual deviancy, which could only be kept in check by official intervention.⁹⁸ Although we may believe ourselves more enlightened now—and today’s public health practitioners are indeed sensitive to cultural differences—the targets of most disease prevention programs are typically the same groups that were blamed for epidemics in the past. For example, at least ninety percent of those subjected to involuntary commitment for tuberculosis (TB) in New York in the 1990s were people of color.⁹⁹ Thus, it will be

92. See generally ALAN M. KRAUT, *SILENT TRAVELERS: GERMS, GENES, AND THE “IMMIGRANT MENACE”* (1994); BARRON H. LERNER, *CONTAGION AND CONFINEMENT: CONTROLLING TUBERCULOSIS ALONG THE SKID ROAD* (1998); Alice Fothergill & Lori A. Peek, *Poverty and Disasters in the United States: A Review of Recent Sociological Findings*, 32 NAT. HAZARDS 89 (2004); Wendy E. Parmet, *Quarantine Redux: Bioterrorism, AIDS, and the Curtailment of Individual Liberty in the Name of Public Health*, 13 HEALTH MATRIX 85 (2003).

93. PRISCILLA WALD, *CONTAGIOUS – CULTURES, CARRIERS, AND THE OUTBREAK NARRATIVE* (2008).

94. *Id.* at 2.

95. See generally *id.*

96. *Id.* at 82-113.

97. See generally *id.*; JOHN EITLING, *THE GERM OF LAZINESS* (1981); JUDITH WALZER LEAVITT, *TYPHOID MARY: CAPTIVE TO THE PUBLIC’S HEALTH* (1996); C.-E.A. WINSLOW, *THE LIFE OF HERMANN M. BIGGS, M.D., D.SC., LL.D. PHYSICIAN AND STATESMAN OF THE PUBLIC HEALTH* (1929); Kraut, *supra* note 92.

98. See generally JAMES A. MORONE, *HELLFIRE NATION: THE POLITICS OF SIN IN AMERICAN HISTORY* (2003).

99. See generally M. Rose Gasner et al., *The Use of Legal Action in New York City to Ensure Treatment of Tuberculosis*, 340 NEW ENG. J. MED. 359 (1999) (a study of involuntary commit-

important to take care that government measures intended to protect the public health do not fall prey to unrecognized prejudices.

Together, these lessons argue for policies governing emergency preparedness in which government assumes a societal responsibility for enabling people to stay healthy and make sensible decisions about protecting themselves from harm. This entails providing the public with accurate information about risks, providing materials and services that are not efficiently made available privately, ensuring that everyone has access to health care, earning the public's trust and confidence by acting transparently, respecting the Constitution and the rule of law, and ensuring accountability for its actions.

These lessons have been largely ignored since 9/11. Instead, the federal government has emphasized the personal responsibility of individual Americans, reinforcing the age-old assumption that those who become sick must have done something to deserve their illness.¹⁰⁰ Federal agencies wrote numerous emergency preparedness plans and checklists.¹⁰¹ Most contain noble sentiments and some sensible provisions. In reality, however, they offered little of the assistance necessary to respond to an epidemic or other disaster,¹⁰² as most poignantly seen in the federal response to Hurricane Katrina.¹⁰³ The Ad-

ments in New York from 1993-1995).

100. Department of Health and Human Services Secretary Michael Leavitt noted that "Communities that fail to prepare, expecting the federal government to come to the rescue, will be tragically mistaken." Michael Leavitt, Secretary, Health and Human Services, Address to the Pandemic Influenza Leadership Forum (June 13, 2007), *available at* <http://archive.hhs.gov/news/speech/2007/sp20070613a.html>. Department of Homeland Security Secretary Michael Chertoff told the annual National Hurricane Conference in Orlando, Florida, "I believe [people] have a civic responsibility to take some sensible steps to get ready for hurricane season. . . . People should be able to sustain themselves for up to 72 hours after a disaster. . . . that means individuals—especially those in the Gulf states—need to have an emergency plan and an emergency kit with adequate supplies of food, water, and other essentials like a flashlight, first-aid, and medicines." CHRISTOPHER COOPER & ROBERT BLOCK, *DISASTER: HURRICANE KATRINA AND THE FAILURE OF HOMELAND SECURITY* 306 (2006).

101. *See, e.g.*, HOMELAND SEC. COUNCIL, NATIONAL STRATEGY FOR PANDEMIC INFLUENZA: IMPLEMENTATION PLAN (2006) *available at* <http://www.pandemicflu.gov/plan/federal/strategyimplementationplan.html>.

102. MD. LAW SCHOOL CTR. FOR HOMELAND SEC. & HEALTH, REPORT OF THE CONFERENCE ON VULNERABLE POPULATIONS AND EMERGENCY PREPAREDNESS (forthcoming 2009) (manuscript on file with the authors).

103. *See generally* DOUGLAS BRINKLEY, *THE GREAT DELUGE: HURRICANE KATRINA, NEW ORLEANS, AND THE MISSISSIPPI GULF COAST* (2006); Michael Greenberger, *The Alfonse and Gaston of Governmental Response to National Public Health Emergencies: Lessons Learned From Hurri-*

ministration generally preferred to keep information secret and resisted questioning about federal policies.¹⁰⁴ Agencies declined to take responsibility for their actions or the harms they may have caused and instead called for immunity from liability for those who act on behalf of both public and private entities.¹⁰⁵ They interpreted executive power broadly and personal freedoms narrowly.¹⁰⁶ As with the “War on Terror,” there is no evidence that the country is demonstrably safer from disease.¹⁰⁷

The case of Andrew Speaker illustrates the unfortunate consequences of blaming people for illness. Speaker, a lawyer who had traveled in Asia, was diagnosed with multi-drug resistant tuberculosis (MDR-TB) in May 2007.¹⁰⁸ He planned to begin more extensive treatment after his June wedding in Greece. Although county health officials told him that traveling was not advisable, he had already had four months of treatment for TB and appeared not to be contagious, and they

cane Katrina for the Federal Government and the States, 58 ADMIN. L. REV. 611 (2006).

104. See Marc Rotenberg, *Privacy and Secrecy After September 11*, 86 MINN. L. REV. 1115, 1124-25 (2002) (discussing reduced access to public records and closed hearings after September 11); Peter P. Swire, *Privacy and Information Sharing in the War on Terrorism*, 51 VILL. L. REV. 951 (2006); Peter P. Swire & Lauren B. Steinfeld, *Security and Privacy After September 11: The Health Care Example*, 86 MINN. L. REV. 1515 (2002).

105. George J. Annas, *Bioterrorism, Public Health, and Civil Liberties*, 346 NEW ENG. J. MED. 1337, 1341 (2002) (discussing the immunity provision in the proposed Model State Emergency Health Powers Act). See generally BRINKLEY, *supra* note 103.

106. See THE TORTURE PAPERS: THE ROAD TO ABU GHRAIB (Karen J. Greenberg & Joshua L. Dratel eds., 2005).

107. See JOHN MUELLER, *OVERBLOWN: HOW POLITICIANS AND THE TERRORISM INDUSTRY INFLATE NATIONAL SECURITY THREATS, AND WHY WE BELIEVE THEM* (2006) (estimating federal government expenditures on homeland security to range from \$64 million to \$600 million for every life saved); MARC SIEGEL, *FALSE ALARM: THE TRUTH ABOUT THE EPIDEMIC OF FEAR* (2005); Ann Mongoven, *The War on Disease and the War on Terror: A Dangerous Metaphorical Nexus?* 15 CAMBRIDGE Q. HEALTHCARE ETHICS 403, 407-08 (2006). See also Kenneth Anderson, *The Assumptions Behind the Assumptions in the War on Terror: Risk Assessment as an Example of Foundational Disagreement in Counterterrorism Policy*, 54 WAYNE L. REV. 505, 513-15 (2008) (noting that interpretation of risks may be colored by unexpressed assumptions based on ideology).

108. MDR-TB is a form of tuberculosis that is resistant to two or more drugs to treat TB. It is very rare in the United States, where TB ordinarily can be cured by one or two drugs. Generally, patients are not contagious after about two months, but continue taking the drugs to eliminate the bacillus and to avoid developing drug resistance and more severe future illness. Am. Thoracic Soc’y, CDC, and Infectious Diseases Soc’y of America, *Treatment of Tuberculosis*, 52 MORBIDITY & MORTALITY WKLY. REP. 1 (2003). Treatment for MDR-TB requires taking a combination of drugs for a period of up to two years, although the time to cure remains uncertain. Joia S. Mukherjee et al., *Programmes and Principles in Treatment of Multidrug-Resistant Tuberculosis*, 363 LANCET 474, 477 (2004).

did not order him to stay home or isolate himself from others. If that were the end of the story, no one would have heard of Andrew Speaker. After he left the country, however, a Centers for Disease Control and Prevention (CDC) laboratory concluded (incorrectly, as it turned out) that Speaker had a more severe form of tuberculosis, extensively resistant TB (XDR-TB), which is resistant to most TB drugs. Suddenly, the official posture changed. The CDC issued a federal order of isolation for the first time in four decades.¹⁰⁹ CDC officials contacted Speaker in Italy and told him to stay there or hire a private plane to fly home (at an estimated cost of \$140,000). Faced with difficult choices and fearing he would be abandoned to die without treatment, Speaker stopped listening to the CDC and found another way to get back the United States. He and his wife flew to Canada on a commercial airline flight and drove across the border into New York, where they reported to the health department, and Speaker was placed under a federal quarantine order. Soon thereafter, Speaker began specialized treatment in Denver as originally planned.¹¹⁰ Ironically, the Denver experts found that he did not have XDR-TB after all, and Speaker was responding well to treatment in 2008.

Speaker's flight to Canada provoked memorable controversy. The CDC asked the Department of Homeland Security to put Speaker on the "no-fly" list, which was created to keep terrorists out of the United States.¹¹¹ Although Speaker's actions may not have been ideal, they were a predictable, human response to being treated like an enemy. Many news reports and some journal articles demonized Speaker, and some lawmakers called for tougher laws. All missed the real problem. Georgia law already authorized involuntarily confinement for

109. Wendy E. Parmet, *Legal Power and Legal Rights--Isolation and Quarantine in the Case of Drug-Resistant Tuberculosis*, 357 NEW ENG. J. MED. 433, 433 (2007). The last order was reviewed in *United States ex rel. Siegel v. Shinnick*, 219 F. Supp. 789, 790-91 (E.D.N.Y. 1963) (upholding isolation order for woman who visited Stockholm when cases of smallpox were in Sweden).

110. Colleen Slevin, *TB Patient Released From Hospital*, WASH. POST, July 26, 2007, <http://www.washingtonpost.com/wp-dyn/content/article/2007/07/26/AR2007072601048.html?hpid=moreheadlines>.

111. See generally Parmet, *supra* note 109. The CDC has since updated its restrictions on air travel. C.D.C., *Federal Air Travel Restrictions for Public Health Purposes--United States, June 2007-May 2008*, 57 MORBIDITY AND MORTALITY WKLY. REP. 1009 (2008), available at <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5737a1.htm>.

anyone who had active, contagious TB and would behave so as to infect other people.¹¹² Local health officials did not invoke that law to keep Speaker in the United States, either because he was not contagious or not likely to spread infection or both. Indeed, to date, no one is known to have been infected by Speaker. If there were any legal obstacle, it may have been the bureaucratic requirements for (or expense of) providing private transport for Speaker to return home.

More important, the public debate ignored the futility of stopping a disease as prevalent as TB by grounding one person. More than fourteen million people around the world have TB.¹¹³ Despite visa restrictions, many board international flights, sometimes unaware of their condition. In these circumstances, it is remarkable that disease transmission in-flight is so very rare.¹¹⁴ Far more successful ways to protect public health would be to develop better and faster diagnostic tests, more effective and faster-acting drugs with fewer unpleasant side effects, and more efficient ventilation and filter systems in public transportation of all types.

These examples suggest that the post-9/11 focus on national security and personal responsibility distorted public health policy. These twin approaches encouraged laws to expand the grounds for conducting surveillance,¹¹⁵ controlling individual behavior, and confining people who were sick.¹¹⁶ History

112. GA. CODE ANN. §31-14-2 (2006) (Petition for commitment authorized where the “person has active tuberculosis and is violating the rules and regulations promulgated by the department . . . and thereby presents a substantial risk of exposing other persons to an imminent danger of infection . . .”).

113. WORLD HEALTH ORG., WHO REPORT 2008: GLOBAL TUBERCULOSIS CONTROL: SURVEILLANCE, PLANNING, FINANCING 3 (2008), available at http://www.who.int/entity/tb/publications/global_report/2008/pdf/fullreport.pdf.

114. See Thomas A. Kenyon et al., *Transmission of Multidrug-resistant Mycobacterium Tuberculosis During a Long Airplane Flight*, 334 NEW ENG. J. MED. 933, 937 (1996) (noting that there is a relatively low risk of transmission of TB on U.S. commercial flights); see also Sonja J. Olsen et al., *Transmission of the Severe Acute Respiratory Syndrome on Aircraft*, 349 NEW ENG. J. MED. 2416, 2421 (2003) (noting that there is likely a low overall risk of transmission of SARS on flights); Annelies Wilder-Smith et al., *Low Risk of Transmission of Severe Acute Respiratory Syndrome on Airplanes: The Singapore Experience*, 8 TROP. MED. INT’L HEALTH 1035, 1036 (2003). See generally Alexandra Mangili & Mark A. Gendreau, *Transmission of Infectious Diseases During Commercial Air Travel*, 365 LANCET 989 (2005).

115. See generally Kathleen M. Sullivan, *Under a Watchful Eye: Incursions on Personal Privacy, in THE WAR ON OUR FREEDOMS: CIVIL LIBERTIES IN AN AGE OF TERRORISM* 128 (Richard C. Leone & Greg Anrig, Jr. eds., 2003).

116. Wendy E. Parmet, *Dangerous Perspectives: The Perils of Individualizing Public Health Problems*, 30 J. LEGAL MED. 83, 95-98 (2009); see Public Health Security and Bioterrorism Pre-

shows, however, that the more difficult and time-consuming tasks of building service programs have offered the best protection. As the New York Academy of Medicine concluded in a 2007 study, "Currently, planners are developing emergency instructions for people to follow *without* finding out whether it is actually possible for them to do so or whether the instructions are even the most protective action for certain groups of people to take."¹¹⁷

These mistakes were compounded by the paucity of federal assistance for access to the medical care needed to prevent or cure illness. Instead, funding once used to support essential public health services was shifted to new bioterrorism programs.¹¹⁸ Despite periodic calls for improving the public health patchwork infrastructure, public health has always received a negligible share of national health spending.¹¹⁹ Given the current recession and the pressures on state budgets, public health funding is likely to decline significantly.¹²⁰ Yet even meagerly funded programs enabled people to forge connections with important health resources and prevent debilitating illness.¹²¹ Supplanting such programs with narrowly defined projects on "emergency preparedness" has left the country less prepared for both ordinary and emergency public health problems, including the possibility of a pandemic.

One explanation for the failure to take a public health approach to "preparedness" may be the pressure to "do something." Since 9/11, federal agencies and state legislatures have been called upon to demonstrate their commitment to prevent-

paredness and Response Act of 2002, 42 U.S.C. § 1320b-5(b) (2000); 42 C.F.R. §§ 71.1-71.56 (2008); 42 C.F.R. §§ 70.1-70.9 (2008).

117. ROZ D. LASKER ET AL., WITH THE PUBLIC'S KNOWLEDGE, WE CAN MAKE SHELTERING IN PLACE POSSIBLE 26 (2007), available at <http://www.nyam.org/library/docs/sipreport.pdf>.

118. See generally ROSNER & MARKOWITZ, *supra* note 14 (arguing that so much public health funding was earmarked for bioterrorism and emergency preparedness that basic public health programs were starved for resources); Elin Gursky, Progress and Peril: Bioterrorism Preparedness Dollars and Public Health 50 (2003) (unpublished manuscript) (same), available at http://www.tcf.org/Publications/HomelandSecurity/Gursky_Progress_Peril.pdf.

119. INST. OF MED., THE FUTURE OF THE PUBLIC'S HEALTH IN THE 21ST CENTURY 21 (2003). See generally LAURIE GARRETT, BETRAYAL OF TRUST: THE COLLAPSE OF GLOBAL PUBLIC HEALTH (2000); INST. OF MED., THE FUTURE OF PUBLIC HEALTH (1988).

120. NICHOLAS JOHNSON ET AL., CTR. ON BUDGET & POL'Y PRIORITIES, AT LEAST 34 STATES HAVE IMPOSED CUTS THAT HURT VULNERABLE RESIDENTS, BUT THE FEDERAL ECONOMIC RECOVERY PACKAGE IS REDUCING THE HARM 3 (2009), available at <http://www.cbpp.org/3-13-08sfp.pdf>.

121. See generally Turnock, *supra* note 18.

ing future attacks. In the health field, this translated into developing programs to prepare for bioterrorism and pandemics. But, as described above, developing a healthy, resilient community takes time and money. It is easier and quicker to draft laws mandating confinement or treatment than to provide resources. Legislators can express genuine support for protecting the community without spending scarce resources. Moreover, their legal advisors also are probably more familiar with drafting simple mandates than the technical expertise needed to create a complex system of resources for health care, prevention, and response to emergencies. Many health lawyers may have the expertise to examine laws governing civil commitment, malpractice liability, and professional licensure, but little familiarity with the administrative law or conflict of laws issues which govern allocating and coordinating responsibility for programs and resources to respond to emergencies, not to mention the practical, logistical details that make responding possible. However understandable these penchants may have been, they have not produced proposals that are relevant to the country's needs.¹²² They have missed the opportunity to address the real problems of preparing for bioterrorist attacks, pandemics, or ordinary disease outbreaks.

IV. PRINCIPLES FOR JUST AND EFFECTIVE EMERGENCY PREPAREDNESS

In January 2009, Admiral Dennis C. Blair, now the director of national intelligence, pledged to operate counterterrorism programs "in a manner consistent with our nation's values, consistent with our Constitution and consistent with the rule of law."¹²³ This levelheaded and very American sensibility should guide the nation's approach to the law affecting public health and pandemic preparedness. Because the goal of emergency response is to protect Americans, the public should be treated with respect rather than as potential enemies of the state. Although emergencies sometimes require prompt actions in conditions of uncertainty, emergencies should not become a pretext for the abuse of power.

122. See generally Parmet, *supra* note 58.

123. Scott Shane, *Blair Pledges New Approach to Counterterrorism*, N.Y. TIMES, Jan. 22, 2009, <http://www.nytimes.com/2009/01/23/us/politics/23blaircnd.html?hp=&pagewanted>.

As the federal Commission on the Prevention of Weapons of Mass Destruction Proliferation and Terrorism concluded, the most important way to protect the nation against terrorist biological attacks is to strengthen our foreign policy initiatives with countries like Russia, Pakistan, and Iran that have the potential to develop biological weapons, prevent terrorists from entering the United States, and ensure the security of laboratories and research with biologics.¹²⁴ Most domestic bioterrorism and pandemic preparedness programs, in contrast, are designed for damage control. They operate to minimize harm after disease has been introduced into the country.

The potential harm from the spread of an infectious or contagious disease is the same, regardless of its initial source—whether a laboratory accident, a deliberate criminal or terrorist act, the natural cycle of organisms, or global travel patterns. Initially, there may be no way to know which of these is responsible. But, the response by health professionals has not depended (and cannot depend) on how a disease emerged.¹²⁵ For this reason, it is especially important to ensure that the laws governing disease control are not distorted by fears of terrorism. The power granted or assumed by government to halt bioterrorism or a dangerous pandemic can and probably will be used to control all epidemics, including perhaps the annual appearance of influenza, for fear it could be the harbinger of another 1918 pandemic. Therefore, arguments that the risk of bioterrorism justifies extraordinary measures are arguments to permanently suspend constitutional protections.¹²⁶

Laws applicable to epidemics are ordinary laws governing disease control. It is important to get the law right, because policies governing civil rights become entrenched over time and shape judicial interpretation of the government's powers

124. See generally COMM'N ON THE PREVENTION OF WEAPONS OF MASS DESTRUCTION PROLIFERATION & TERRORISM, *WORLD AT RISK: THE REPORT OF THE COMMISSION ON THE PREVENTION OF WMD PROLIFERATION AND TERRORISM* (2008), available at <http://documents.scribd.com/docs/15bq1nr19aerfu0yu9qd.pdf>.

125. The response does depend on the biology and pathology of the disease agent. And, of course, if the source is criminal, law enforcement can pursue and prosecute the perpetrators, but that does not affect the treatment of people who may be exposed to disease.

126. See generally GOLDSMITH, *supra* note 52. For arguments that bioterrorism and pandemic preparedness should include suspensions or dilutions of civil rights, see Lawrence O. Gostin, *The Model State Emergency Health Powers Act: Public Health and Civil Liberties in a Time of Terrorism*, 13 HEALTH MATRIX 3, 27-29 (2003).

and individuals' rights.¹²⁷ Responsible planning should ensure that the law is not thoughtlessly distorted to set aside constitutional protections for liberty and privacy.¹²⁸ Instead, the law should ensure that people are protected not only from avoidable disease but also from unwarranted governmental intrusions. In most cases, this does not require amending existing laws, even those adopted long ago, because all must be interpreted and applied in light of current constitutional doctrine.

The following highlights several legal principles (summarized in Table 1) that should inform any consideration of law directed at imposing individual responsibility—instead of social responsibility—for responding to pandemics.

Quarantine and Isolation. Quarantine is the measure most often associated with epidemics. The term is often used to mean very different things. Among public health practitioners, quarantine usually denotes protecting a geographic location, like a neighborhood, to prevent the spread of disease.¹²⁹ It has also been used to mean sealing off a home or a ship that houses infected residents, passengers, or cargo to prevent them from entering the general population. In addition, the term quarantine is often used colloquially to mean the segregation of individuals. A more precise usage would be isolation, which can be voluntary or compulsory. Patients with contagious diseases routinely agree to be treated in voluntary isolation in hospitals or at home as part of ordinary medical care. Involuntary detention or commitment requires a court order and is rarely used.

The U.S. Supreme Court has made clear that “[f]reedom from bodily restraint has always been at the core of the liberty protected by the Due Process Clause from arbitrary governmental action.”¹³⁰ State courts have used the Supreme Court’s

127. See Jack M. Balkin & Sanford Levinson, *The Processes of Constitutional Change: From Partisan Entrenchment to the National Surveillance State*, 75 *FORDHAM L. REV.* 489 (2006).

128. See Wendy E. Parmet, *Liberalism, Communitarianism, and Public Health: Comments on Lawrence O. Gostin’s Lecture*, 55 *FLA. L. REV.* 1221 (2003).

129. See, e.g., *Zemel v. Rusk*, 381 U.S. 1, 15-16 (1965) (stating that right to travel “does not mean that areas ravaged by flood, fire or pestilence cannot be quarantined when it can be demonstrated that unlimited travel to the area would directly and materially interfere with the safety and welfare of the area or the Nation as a whole.”).

130. *Foucha v. Louisiana*, 504 U.S. 71, 80 (1992) (citing *Youngberg v. Romeo*, 457 U.S. 307, 316 (1982)); see also *Jones v. United States*, 463 U.S. 354, 361 (1983); *Addington v. Texas*, 441 U.S. 418, 425 (1979) (“[C]ivil commitment for any purpose constitutes a significant deprivation of liberty that requires due process protection.”) (citations omitted).

two-part test for civil commitment for mental illness¹³¹ as a model for the constitutional requirements for civil commitment for contagious disease.¹³² In this context, the model requires clear and convincing evidence that an individual is: (1) infected with a dangerous, contagious disease (not the common cold), and (2) likely to expose others to infection (either deliberately or because of an inability to control behavior or avoid contact with others).¹³³ There are few reported cases applying this test, none at the Supreme Court level. Recent decisions cluster around the rise of TB in the late 1980s and early 1990s.¹³⁴

The federal government has the power to close its borders to persons and cargo that carry dangerous diseases.¹³⁵ However, even the most careful border controls cannot guarantee that a virus will not slip in undetected. Thus, the federal government also has the authority to detain persons at the border to prevent certain diseases, specified by Executive Order, from entering the country.¹³⁶ States may also request federal assistance to suppress communicable diseases and enforce state quarantines for up to six months.¹³⁷ The Stafford Act permits the President to implement health and safety measures when

131. *Foucha*, 504 U.S. at 75-76 (The Due Process Clause requires that the State “prove by clear and convincing evidence the two statutory preconditions to commitment: that the person sought to be committed is mentally ill and that he requires hospitalization for his own welfare and protection of others); see also *Kansas v. Hendricks*, 521 U.S. 346, 358 (1997) (“We have sustained civil commitment statutes when they have coupled proof of dangerousness with the proof of some additional factor, such as a ‘mental illness’ or ‘mental abnormality.’ These added statutory requirements serve to limit involuntary civil confinement to those who suffer from a volitional impairment rendering them dangerous beyond their control.”) (internal citations omitted); *O’Connor v. Donaldson*, 422 U.S. 563, 576 (1975) (“[A] State cannot constitutionally confine without more a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends.”).

132. *City of Newark v. J.S.*, 652 A.2d 265, 268 (N.J. Super. Ct. Law Div. 1993) (upholding civil commitment of man with active TB because he was homeless and unable to avoid contact with others); *Greene v. Edwards*, 263 S.E.2d 661, 662-63 (W. Va. 1980) (due process requires that counsel be provided before commitment hearing).

133. See *J.S.*, 652 A.2d at 270-71; *Greene*, 263 S.E.2d at 662.

134. *Parmet*, *supra* note 92, at 98.

135. 42 U.S.C. § 264(a) (2006).

136. *Id.* § 264(b)-(d) (2006); Exec. Order No. 13,375; 70 Fed. Reg. 17,299 (April 15, 2005) (Amending the list of diseases in Executive Order 13,295 of April 3, 2003, and adding “[i]nfluenza caused by novel or reemerging influenza viruses that have the potential to cause a pandemic.”). See generally 42 U.S.C. § 247d-1 to 7f (2006).

137. 42 U.S.C. § 243 (2006).

necessary to respond to a disaster.¹³⁸ The John Warner National Defense Authorization Act allows the President to employ the armed forces to “restore public order and enforce the laws of the United States” during a “serious public health emergency.”¹³⁹ Thus, despite ambiguity in some statutory language, the federal government has ample power to take forceful action, both at the border and within the states, to halt disease.

Nonetheless, a few proposals for new emergency laws have urged even stronger measures. Among the more controversial are proposals to empower both state and federal agencies to involuntarily confine individuals who are merely suspected of harboring an infectious disease, without the evidence previously required that the person either has a disease or is a threat to public health, and precluding the person from petitioning for a writ of *habeas corpus*.¹⁴⁰ The idea is that if a new and dangerous disease appeared, it might not be possible to determine whether anyone is actually infected before deciding whether the person should be confined. It is true that diseases like avian flu can induce respiratory symptoms, such as sneezing, coughing, and fever, that are similar to ordinary, self-limiting illnesses, like the common cold.¹⁴¹ However, more than mere belief on the part of an untrained official is required before subjecting anyone to detention. The absence of evidentiary standards invites abuse. That approach carries a whiff of the arbitrariness seen in the detention of enemy combatants at Guantanamo. Although courts generally defer to medical judgments about disease, the few reported decisions authorizing involuntary confinement in the modern era have been

138. *Id.* § 5121.

139. John Warner National Defense Authorization Act, Pub. L. No. 109-364, § 1076, 120 Stat. 2083, 2404 (2006). See Greenberger, *supra* note 43, at 107-08 (explaining how the law gives the federal government more discretion to assist states in an emergency situation).

140. See generally Control of Communicable Diseases, 70 Fed. Reg. 71,892 (proposed Nov. 30, 2005) (to be codified at 42 C.F.R. pt. 70 & 71), available at <http://www.cdc.gov/ncidod/dq/nprm/>; Lawrence O. Gostin et al., *The Model State Emergency Health Powers Act: Planning for and Response to Bioterrorism and Naturally Occurring Infectious Diseases*, 288 J. AM. MED. ASS'N 622 (2002) (proposing new state laws). In addition to eliminating a substantive standard for civil commitment, these proposals would reduce or omit essential procedural due process protections.

141. Writing Comm. of the Second World Health Org., *Update on Avian Influenza A (H5N1) Virus Infection in Humans*, 358 NEW ENG. J. MED. 261, 266 (2008), available at <http://content.nejm.org/cgi/reprint/358/3/261.pdf>.

based on evidence of infection.¹⁴²

Moreover, no one presents any threat unless he or she is unable or unwilling to take precautions to avoid infecting other people, like voluntarily staying at home or wearing a face mask in public places.¹⁴³ To eliminate half of the test would be tantamount to inviting preventive detention of everyone merely suspected of illness, a concept rightfully abhorred in a constitutional democracy.¹⁴⁴

We should keep in mind the SARS experience, in which a miniscule fraction of individuals found to have symptoms similar to SARS actually had the disease; most who did might have already been identified because they reported their own exposure to the illness or reported other more specific symptoms.¹⁴⁵ Fears of the unknown may encourage the public to believe that extraordinary measures are needed to halt a possible epidemic. Nevertheless, more severe consequences are the predictable result of overreaching.¹⁴⁶

The case of Hongkham Souvannarath illustrates the risks of failing to provide public health services and the danger of substituting involuntary commitment for relevant treatment.¹⁴⁷ Ms. Souvannarath, who had voluntarily accepted TB treatment for several months, was jailed for failing to complete treatment, largely because of a delay in her expected move to her son's home and the health department's lack of anyone who spoke Laotian, her native language. After ten months in prison, she received an attorney and was released unconditionally.¹⁴⁸ The health department had lobbied against the

142. See, e.g., *City of Milwaukee v. Washington*, 735 N.W.2d 111, 121, 131 (Wis. 2007) (Wisconsin statute allows for involuntary confinement of a person with documentation of "infectious tuberculosis," "noninfectious tuberculosis but is at a high risk of developing infectious tuberculosis," or "suspect tuberculosis" marked by symptoms and laboratory tests); *City of Newark v. J.S.*, 652 A.2d 265, 277-79 (N.J. Super. Ct. Law Div. 1993); *Greene v. Edwards*, 263 S.E.2d 661, 662 (W. Va. 1980).

143. See *O'Connor v. Donaldson*, 422 U.S. 563, 575 (1975) (rejecting the argument that mental illness alone is sufficient justification for civil commitment).

144. See *Kansas v. Hendricks*, 521 U.S. 346, 360 (1997) (finding that dangerous alone is not sufficient for civil commitment, because persons subject to civil commitment must be distinguished "from other dangerous persons who are perhaps more properly dealt with exclusively through criminal proceedings").

145. See generally INST. FOR BIOETHICS, HEALTH POL'Y & LAW, *supra* note 77.

146. See Parmet, *supra* note 109, at 433-43.

147. See generally, PUB. HEALTH INST., SOUVANNARATH CASE STUDY (2003), available at www.phlaw.org/docs/souvannarath.pdf.

148. *Souvannarath v. Hadden*, 116 Cal. Rptr. 2d 7, 11 (Cal. Ct. App. 2002).

state statute prohibiting confining TB patients in jail, arguing that it might not have funds to pay for hospital isolation wards.¹⁴⁹ The California court rejected that argument on statutory grounds, ordering the health department to cease housing TB patients in jail.¹⁵⁰ Ultimately, Fresno County settled Ms. Souvannarath's claims for violation of her civil rights for \$1.2 million.¹⁵¹ Indeed, patients should not be confined like convicted criminals. The Supreme Court has emphasized the importance of distinguishing between someone who is dangerous because he has committed a crime and someone who is dangerous because of mental illness and inability to control his conduct, even in the case of sex offenders, "lest 'civil commitment' become a 'mechanism for retribution or general deterrence'—functions properly those of criminal law, not civil commitment."¹⁵² More important, however, was the health department's failure to make it possible for Ms. Souvannarath to continue treatment by bringing her a new supply of drugs and ensuring accurate translation.¹⁵³ Without resources, the department fell back on force and literally turned a simple delay in treatment into a federal case of civil rights violations.

Treatment. The value of bodily integrity—not forcing treatment on people—has been so strong that even the rare person who has been involuntarily confined retains the right to bodily integrity and cannot be forced to take medication or undergo other treatment.¹⁵⁴ In general, the goal of preventing

149. See *id.* at 9, 16; INST. OF MED., ENDING NEGLECT: THE ELIMINATION OF TUBERCULOSIS IN THE UNITED STATES 2 (Lawrence Geiter ed., 2000) ("[W]ithout question the major reason for the resurgence of tuberculosis was the deterioration of the public health infrastructure essential for the control of tuberculosis.").

150. *Souvannarath*, 116 Cal. Rptr. 2d at 13. But see *City of Milwaukee v. Washington*, 735 N.W.2d 111, 131 (Wis. 2007) ("[A] circuit court may take into account the cost of placement options when determining the place of confinement . . . but only after determining that two or more placement options fulfill the statutory requirements of proper medical treatment and disease prevention, and that none of these options is significantly less restrictive than the other(s).").

151. PUB. HEALTH INST., *supra* note 147, at 3.

152. *Kansas v. Crane*, 534 U.S. 407, 412-13 (2002) (citing *Kansas v. Hendricks*, 521 U.S. 346, 372-73 (1997) (Kennedy, J. concurring)).

153. PUB. HEALTH INST., *supra* note 147, at 2.

154. See, e.g., *City of Newark v. J.S.*, 652 A.2d 265, 278-79 (N.J. Super. Ct. Law Div. 1993). Courts have recognized an exception when necessary for maintaining security within the institution. For example, state and federal prisons may require TB tests for inmates. *Sample v. Angelone*, No. 98-7421, 1999 U.S. App. LEXIS 1664, at *3 (4th Cir. Feb. 5, 1999) (per curiam); *Fox v. Poole*, 06CV148, 2008 U.S. Dist. LEXIS 33833, at *18 (W.D.N.Y. Apr. 24, 2008) (Inmate

the spread of contagious disease can be served by segregating a person from others.

In the United States, the right to make one's own decisions about medical treatment has deep roots.¹⁵⁵ The Massachusetts Bay Colony laws forbade physicians from treating patients without consent in 1649,¹⁵⁶ and common law decisions have uniformly insisted that no competent adult can be treated without informed consent.¹⁵⁷ Adults who are not legally competent have the same substantive rights; a surrogate decision-maker or health care proxy must act in accordance with the patients' own wishes or, if their wishes are not known, in the patients' best interest. The United States Supreme Court confirmed this well-settled law in *Cruzan*, which considered the right to make medical decisions for oneself to be a dimension of liberty protected by the Fourteenth Amendment to the Constitution.¹⁵⁸

States, of course, have laws that require children to be immunized against certain contagious diseases. These laws are justified despite the general right of self-determination largely as an exercise of the state's *parens patriae* power to protect children.¹⁵⁹ They also serve a public health function to prevent the spread of disease.¹⁶⁰ In 1905, the U.S. Supreme Court upheld the constitutionality of a Massachusetts compulsory small pox vaccination statute with respect to healthy adults.¹⁶¹ That law did not authorize holding people down and injecting the vaccine into them, but instead penalized the unwilling by a \$5

who had tested positive for TB in past and refused to be tested upon entering prison was put in medical isolation); *Neal v. Watts*, No. 07-0915 (JR), 2008 U.S. Dist. LEXIS 20163, at *9-10 (D.D.C. Mar. 17, 2008).

155. See GEORGE J. ANNAS, *THE RIGHTS OF PATIENTS* 113 (3d ed. 2004). See generally RUTH R. FADEN & TOM L. BEAUCHAMP, *A HISTORY AND THEORY OF INFORMED CONSENT* (1986).

156. *Surgeons, Midwives, Physicians, Massachusetts Bay Colony, 1649* (1660 ed.).

157. See, e.g., *Canterbury v. Spence*, 464 F.2d 772, 779, 783-85 (D.C. Cir. 1972) (holding that not revealing the possibility of paralysis after the surgery was a *prima facie* case of a violation of the physician's duty to disclose the material risks of the surgery); *Cobbs v. Grant*, 502 P.2d 1, 7-8 (Cal. 1972) (analyzing the doctor's duty to obtain informed consent, through both battery and negligence frameworks).

158. *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 276-80 (1990).

159. See generally Walter J. Wadlington, *Medical Decision Making for and by Children: Tensions between Parent, State, and Child*, 1994 U. ILL. L. REV. 311 (1994).

160. See generally Ross D. Silverman, *No More Kidding Round: Restructuring Non-Medical Childhood Immunization Exemptions to Ensure Public Health Protection*, 12 ANNALS HEALTH L. 277 (2003).

161. *Jacobson v. Massachusetts*, 197 U.S. 11, 37 (1905).

fine.¹⁶² Today, childhood immunization laws are enforced by keeping unvaccinated children out of school, not by having them forcibly vaccinated. Furthermore, the public is more familiar with vaccines, as well as medicines, and their benefits. In an epidemic, the public is more likely to demand access to medications than to resist them, as happened after the anthrax attacks in 2001.

Currently, the concept of epidemics has expanded among public health professionals to encompass non-contagious conditions like obesity, diabetes, and cancer.¹⁶³ Thus, if the general goal of preventing the spread of disease – or more loosely, improving the public's health – were sufficient to justify compelling the general public to submit to specific treatment, there would be nothing left of the right to refuse treatment.¹⁶⁴ At the same time, proposals for laws forcing individuals to submit to treatment ignore the need to provide care for all those who want and need it.¹⁶⁵

Privacy. Since 9/11, surveillance to detect terrorist attacks and surveillance to detect contagious diseases have become virtually indistinguishable.¹⁶⁶ A focus on emergencies encourages officials to view the symptoms of many illnesses as the possible beginning of a pandemic. Pressure to identify any case of infectious or contagious disease as soon as possible already has encouraged wide-ranging surveillance systems that continuously monitor individual medical records, pharmacy sales, and other sources and link them to databases in law enforcement, homeland security, agriculture, banking, customs,

162. *Commonwealth v. Pear*, 66 N.E. 719, 722 (Mass. 1903). Five dollars in 1905 was the equivalent of about \$116 in 2008. The Federal Reserve Bank of Minneapolis, *What is a Dollar Worth?*, http://www.minneapolisfed.org/community_education/teacher/calc/ (last visited May 21, 2009).

163. See, e.g., Thomas R. Frieden, *Editorial, Asleep at the Switch: Local Public Health and Chronic Disease*, 94 AM. J. PUB. HEALTH 2059, 2060 (2004), available at <http://www.pubmedcentral.nih.gov/picrender.fcgi?artid=1448589&blobtype=pdf> (arguing that public health should control chronic diseases with the same kind of measures applied to contagious diseases in the past).

164. See Wendy K. Mariner, *Medicine and Public Health: Crossing Legal Boundaries*, 10 J. HEALTH CARE L. & POL'Y 121, 132 (2007).

165. See generally Wendy E. Parmet, *Terri and Katrina: A Population-Based Perspective on the Constitutional Right to Reject Treatment*, 15 TEMP. POL. & CIV. RTS. L. REV. 395 (2006).

166. See generally Colleen A. Bradley, et al., *BioSense: Implementation of a National Early Event Detection and Situational Awareness System*, 54 MORBIDITY & MORTALITY WKLY. REP. 11 (2005), available at <http://www.cdc.gov/mmwr/preview/mmwrhtml/su5401a4.htm>.

and immigration.¹⁶⁷ While it is important to detect a possible epidemic as early as possible, it is not necessary for government to have daily access to everyone's entire medical record with personally identifiable information.¹⁶⁸

State case law, legislation, and some state constitutions recognize general and specific individual rights of privacy in personal medical information and impose duties of confidentiality on physicians and other care providers that forbid disclosing identifiable patient information without the patient's consent.¹⁶⁹ The Health Insurance Portability and Accountability Act Privacy Rule permits, but does not require, "covered entities" to disclose identifiable patient information to health departments for certain public health purposes without the patient's authorization.¹⁷⁰ Covered entities like physicians and hospitals have no legal duty to report identifiable information in the absence of a valid law that itself requires reporting. The duty to report, therefore, depends upon the constitutionality of the state reporting law.

States must also meet federal constitutional standards for exercising the police power to override individual privacy interests. The U.S. Supreme Court has recognized that the Due Process Clause protects an "individual interest in avoiding disclosure of personal matters," without fully defining its scope.¹⁷¹ The Court has never reviewed a mandatory disease reporting law.¹⁷² Two of its decisions in abortion cases upheld laws requiring reporting abortion procedures without patient names for the purpose of monitoring physician compliance with abortion restrictions and to review medical outcomes where this could plausibly contribute to "the preservation of maternal health."¹⁷³

167. See generally Mariner, *supra* note 56.

168. See Robert A. Weinstein, *Planning for Epidemics – The Lessons of SARS*, 350 NEW ENG. J. MED. 2332, 2334 (2004) (recent epidemics, including SARS, West Nile virus, and Anthrax, were detected by alert physicians, rather than formal surveillance systems).

169. Mariner, *supra* note 56, at 372 n.115 (summarizing relevant law).

170. Standards for Privacy of Individually Identifiable Health Information, 45 C.F.R. §§ 160, 164 (2007); 45 C.F.R. § 164.512(b) (2001).

171. *Whalen v. Roe*, 429 U.S. 589, 599 (1977) (upholding a New York law requiring that a copy of Schedule II drug prescriptions be submitted by the prescribing physician to the state health department, because the state had a legitimate interest in deterring and investigating unlawful drug diversion).

172. Mariner, *supra* note 56, at 376.

173. *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 900 (1992) (upholding a Penn-

These cases suggest that states can require mandatory reporting without names or other individually identifiable information for the purpose of monitoring the statistical occurrence of diseases. The power to require reporting of identifiable information in the absence of a particular need to investigate individuals remains unsettled. Although several public health agencies argue that states have the power to require any disease reporting without patient consent, recent cases suggest that mandatory reporting may be an invasion of constitutionally protected privacy unless the state can specifically justify its need for identifiable information.¹⁷⁴ Heightened scrutiny is increasingly applied where individuals have reasonable expectations of privacy, as where the information is intimate or personal or its disclosure could chill the exercise of a constitutional right.¹⁷⁵ The Supreme Court's recognition of constitutional protection for patients' medical care choices

sylvania statute that required reporting abortion data without the patient's name); *Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52, 80, 87 (1976) (upholding a Missouri law containing reporting and recordkeeping requirements for statistical purposes because the requirements were "reasonably directed to the preservation of maternal health and properly respect[ed] a patient's confidentiality and privacy"); *see also Thornburgh v. Am. Coll. of Obstetricians & Gynecologists*, 476 U.S. 747 (1986) (striking down earlier Pennsylvania abortion reporting law that required personal information without names and made reports available to the public).

174. *Tucson Woman's Clinic v. Eden*, 379 F.3d 531, 538 (9th Cir. 2004) (holding that patients' informational rights were violated by requiring the disclosure of medical records that were not redacted); *Doe v. City of N.Y.*, 15 F.3d 264, 269 (2d Cir. 1994) (employee had a constitutional right to privacy in his HIV status, "because his personal medical condition is a matter that he is normally entitled to keep private"); *Walls v. City of Petersburg*, 895 F.2d 188, 190, 193-95 (4th Cir. 1990) (ruling that the city had a compelling interest in deterring corruption that outweighed employee's right to privacy and justified its requirement that the administrator of the city's alternative criminal sentencing program disclose her debts and arrests of family members as part of police department background check, but not details of marriages, divorces or births beyond data in the public record); *Thorne v. City of El Segundo*, 726 F.2d 459, 469-70 (9th Cir. 1983), *cert denied*, 469 U.S. 979 (1983) (city violated the right to privacy of applicant for police force by questioning her about off-duty sexual relations and miscarriages unrelated to job performance); *Ravin v. State*, 537 P.2d 494, 500 (Ala. 1975) (a private matter does not adversely affect anyone beyond the actor and hence is none of [government's] business).

175. *See, e.g., Sheets v. Salt Lake County*, 45 F.3d 1383, 1387 (10th Cir. 1995) (finding that a jury could conclude that the plaintiff had a reasonable expectation that his deceased wife's diary would be kept confidential while in police possession and noting, "If an individual has a legitimate expectation of confidentiality, then '[d]isclosure of such information must advance a compelling state interest'"); *Fraternal Order of Police, Lodge No. 5 v. City of Phila.*, 812 F.2d 105, 110 (3d Cir. 1987) ("Most circuits appear to apply an 'intermediate standard of review' for the majority of confidentiality violations, with a compelling interest reserved for 'severe intrusions' on confidentiality") (citations omitted).

strengthens patients' expectations of privacy.¹⁷⁶

None of the Supreme Court decisions interpreting the Fourth Amendment's application to civil laws compelling medical information disclosure involve disease reporting laws.¹⁷⁷ However, compulsory reporting of individually identifiable information should qualify as a search, because it infringes on a patient's reasonable expectation of privacy,¹⁷⁸ or as a seizure, because it interferes with an individual's possessory interests in information content, even in the civil context.¹⁷⁹ The cases also suggest that government must demonstrate a special need for identifiable medical information. The contrary view—that consent to medical care creates a business record that can be submitted to a government agency without the patient's consent—is implausible, because it would authorize government to seize medical records for any reason at all, including research.

Some information systems, such as syndromic surveillance, can collect certain non-identifiable data, such as the number of patients with specific symptoms, for the purpose of detecting an outbreak without creating a data bank of unnecessary, personally identifiable information.¹⁸⁰ Thus, it is possible to de-

176. See *Vacco v. Quill*, 521 U.S. 793, 797 (1997) (holding that a patient is permitted to refuse lifesaving treatment); *Cruzan v. Mo. Dep't of Health*, 497 U.S. 261, 278 (1990) (upholding a Missouri law that requires evidence of an incompetent patient's desire for medical treatment to be proved by clear and convincing evidence).

177. The closest Supreme Court Fourth Amendment cases relating to medical information arose in the context of suspicionless drug testing. See *generally* *Bd. of Educ. of Indep. School Dist. No. 92 v. Earls*, 536 U.S. 822 (2002) (upholding school policy requiring mandatory drug testing of student athletes); *Ferguson v. City of Charleston*, 532 U.S. 67 (2001) (holding unconstitutional the hospital's use of drug screening tests as evidence of criminal conduct); *Chandler v. Miller*, 520 U.S. 305 (1997) (finding unconstitutional a Georgia law requiring candidates for office to certify that they had taken a drug test with a negative result); *Vernonia School Dist. 47J v. Acton*, 515 U.S. 646 (1995) (finding no violation of students' constitutional rights by school's policy of random drug testing of student athletes); *Skinner v. Ry. Labor Executives' Ass'n*, 489 U.S. 602 (1989) (holding that regulations mandating drug tests of employees involved in accidents and allowing testing of employees who violate certain rules did not violate Fourth Amendment).

178. *Ferguson*, 532 U.S. at 78 (patients have a reasonable expectation that the information they provide to their physicians "will not be shared with nonmedical personnel" without the patient's consent).

179. *Soldal v. Cook County*, 506 U.S. 56, 67 (1992) (plaintiffs stated a sufficient cause of action against Cook County deputy sheriffs under the Fourth Amendment, as the sheriffs act of towing the plaintiffs mobile homes was alleged to be a seizure); *United States v. Jacobsen*, 466 U.S. 109, 113 (1984) (holding that the seizure of a package containing drugs sent through Federal Express was reasonable despite the lack of warrant).

180. See *generally* Kenneth D. Mandl et al., *Implementing Syndromic Surveillance: A Practical*

velop surveillance programs to monitor an emerging epidemic while protecting personal privacy.¹⁸¹

Accountability. Both official and private actors are usually accorded some leeway in responding to an emergency.¹⁸² The standard of conduct for negligence and the standard of care for professional liability are judged by reference to available resources.¹⁸³ Thus, people who help others in an emergency outside the hospital, for example, are not held responsible for providing the kind of state of the art care that would be possible in a well-equipped clinical setting. The Federal Volunteer Protection Act, for example, limits the liability of volunteers of nonprofit and governmental entities to “willful or criminal misconduct, gross negligence, reckless misconduct, or a conscious, flagrant indifference to the rights and safety of the individual harmed by the volunteer.”¹⁸⁴ At the same time, the Act preserves liability on the part of the sponsoring organization or entity, both for its own acts and omissions and those of its volunteers.¹⁸⁵ State “Good Samaritan” laws contain similar limits on liability for aid voluntarily offered, generally outside the scope of one’s employment.

Corporations have also sought protection from liability. The Public Readiness and Emergency Preparedness Act provides for total tort immunity for manufacturers of vaccines and drugs for conditions that the Secretary of Health and Human Services has declared to constitute a “public health emergency.”¹⁸⁶ The Secretary has already declared avian influenza to constitute such an emergency justifying immunity for vaccine manufacturers.¹⁸⁷

Guide Informed by the Early Experience, 11 J. AM. MED. INFO. ASS’N. 141, 141 (2004); Arthur Reinhold, *If Syndromic Surveillance Is the Answer, What Is the Question?* 1 BIOSECURITY AND BIOTERRORISM: BIODEFENSE STRATEGY, PRAC. AND SCI. 77 (2004).

181. See generally Michael A. Stoto, *Public Health Surveillance in the 21st Century: Achieving Population Health Goals While Protecting Individuals’ Privacy and Confidentiality*, 96 GEO. L.J. 703 (2008).

182. Existing laws providing limited, qualified and other forms of immunity for the acts and omissions of government officials are beyond the scope of this discussion.

183. See BARRY R. FURROW ET AL., *HEALTH LAW: CASES, MATERIALS AND PROBLEMS* 337-38, 456 (6th ed. 2008). See generally William M. Sage, *Principles, Pragmatism, and Medical Injury*, 286 J. AM. MED. ASS’N 226 (2001).

184. Federal Volunteer Protection Act, 42 U.S.C. § 14503(a) (1997).

185. *Id.* § 14503(c).

186. 42 U.S.C. § 247d-6d (2005).

187. Dep’t of Health and Human Servs., *Pandemic Influenza Vaccine—Amendment*, 73

So far, there is no evidence that immunity from liability has any significant effect on the number of qualified health professionals who volunteer to help in disasters like Katrina or even in an isolated emergency in an airplane or by the side of the road. Physicians sometimes assert that they would prefer not to volunteer unless they received immunity from liability.¹⁸⁸ Yet, such reports tell us little about what happens in practice. After all, given the chance, almost everyone, from securities brokers to peanut producers, would prefer not to be subject to liability at all. There is no evidence that Good Samaritan laws increase the instances in which physicians volunteer to help out in an emergency. Thus, most such laws can be seen as public symbols of the existing principle that people will not be held liable for failing to do the impossible in an emergency.¹⁸⁹

Such symbolism can be counterproductive, however, especially where it extends immunity beyond mere negligence or to paid health professionals. In pandemic planning, where the need for public trust is paramount, it is of special concern. Granting officials immunity from liability suggests that the public cannot trust officials to treat them with at least ordinary care within the limits of the resources available. Moreover, officials are typically granted additional discretion during an emergency. The prospect of accountability is often the only check on the temptation to cut corners and abuse their power. Indeed, the more discretion that officials are granted, the more important it is to hold them accountable for their acts and omissions. Finally, there is the question of principle: Who should bear the cost of injury in a disaster setting – the injured party, the volunteer, the relief organization, an insurer, or the state?¹⁹⁰ During an emergency of any kind, especially a pan-

FED. REG. 61871, 61,871-61,873 (Oct. 17, 2008).

188. STANLEY M. LEMON ET AL., ETHICAL AND LEGAL CONSIDERATIONS IN MITIGATING PANDEMIC DISEASE, WORKSHOP SUMMARY 13, 65 (2007).

189. See Sharona Hoffman, *Responders' Responsibility: Liability and Immunity in Public Health Emergencies*, 96 GEO. L.J. 1913, 1943 (2008) (supporting immunity for symbolic purposes, despite lack of evidence that immunity increases volunteers).

190. In practice, it can be difficult to draft legislation that limits liability without extending immunity to inappropriate situations, as illustrated by recent attempts to draft bills providing for an "altered standard of care" during disasters or epidemics. See, e.g., *Jackson v. Mercy Health Ctr.*, 864 P.2d 839, 845 (Okla. 1993) (holding that a hospital was immune under the Good Samaritan Act from liability for placing a man in a bed without monitoring or security after he became dizzy while observing the birth of his child, because the man himself was not a hospital patient); Nat'l Conference of Comm'rs on Uniform State Laws, *Uniform Emergency*

demic, the government's first priority should be to help Americans in need.

V. CONCLUSION

There is truth in the axiom that prevention is better than cure. An air transportation system that deflects birds away from air routes is better than one that relies on the skills of Captain Sullenberger, his crew, and passengers to survive a crash. Of course, we cannot do without training and resources to respond to unavoidable emergencies, but prevention can greatly reduce the probability that an emergency will happen.

The resources needed for both prevention and response have little to do with the kind of laws that are most commonly taught in law school, especially in public health law classes.¹⁹¹ Public health responds to public needs, not individual liability. The law governing public health, however, has been distorted by a post-9/11 anti-terrorism policy with two features: (1) government control over national security threats; and (2) individual responsibility for risks to one's own health. This approach encouraged the mistaken assumption that the public is prone to panic and in need of government control.¹⁹² It frightened the public without providing people with the means to protect themselves.

Today, scare tactics have lost their force. With renewed attention to the possibility of health system reform, there is an opportunity for a fresh approach—one that can prevent or minimize harm, maximize health, and engage the population in positive ways. Emergency preparedness and public health policy are an integral part of the country's overall health policy. The principles that guide health reform also inform emergency preparedness, because a healthy population is better prepared to prevent or withstand a pandemic or other emergency. A public health approach to emergency preparedness recognizes the positive role for government in making medical

Volunteer Health Practitioners Act, Dec. 6, 2006, available at <http://www.uevhpa.org/Uploads/uevhpafinal.pdf>.

191. William M. Sage, *Relational Duties, Regulatory Duties, and the Widening Gap Between Individual Health Law and Collective Health Policy*, 96 GEO. L.J. 497, 519 (2008).

192. Wilson & Baker, *supra* note 4, at A25 (reporting that the Chief of Emergency Medical Services for the New York Fire Department was "stunned that some of those [Flight 1549] passengers did not appear to have been through an ordeal at all.").

care and public health services accessible to everyone and enabling people do what is best for themselves. There is no need for new laws blaming individuals for spreading disease or absolving officials from accountability. Instead, we can restore public trust in America's health system by developing programs that are "consistent with our nation's values, consistent with our Constitution and consistent with the rule of law."¹⁹³

193. Shane, *supra* note 123.

APPENDIX

Table 1
PANDEMIC PREPAREDNESS PRINCIPLES
FOR LAWS GOVERNING INDIVIDUAL CONDUCT

Protecting Health

Government should ensure universal access to a reliable source of medical care and support public health services to protect the population's health and develop the resilience needed to survive emergencies.

Government should ensure an adequate supply and fair and efficient distribution of vaccines, medications, food, water, and other necessities in the event of a pandemic.

Access to care should not be conditioned on a waiver of one's constitutional rights.

Public health measures must not be based on race, color, ethnicity, national origin, religion, gender, or sexual orientation.

Government plans for responding to a pandemic should be developed with community engagement, rather than individual responsibility, and should respond to community needs.

Governments should ensure that all individuals who follow public health advice and stay home during a pandemic receive food, medicine, and other necessities and are not penalized or deprived of income, medication, or other necessities by private parties, including employers and insurers.

Protecting Liberty

Coercive measures, such as involuntary detention, should be imposed only as a last resort, only where government can demonstrate that there is a sound scientific and constitutional basis for doing so, and only when they are the least restrictive alternative to prevent the spread of an established pandemic.

Individuals proposed for detention should be provided with counsel and an expeditious judicial hearing to ensure that their detention is in fact legally justified. The government should bear the burden of proving by clear and convincing evidence that the person poses a significant risk of danger to others and that that risk cannot be mitigated by less restrictive measures. Individuals who are detained must be housed in a medical facility and never in a correctional facility.

Travel bans should only be imposed where there is a reasonable scientific justification and only to the degree necessary to prevent

the spread of disease. Individuals denied the right to travel should be provided procedural due process, including notice, the right to counsel, and the opportunity for a hearing before an independent decision maker.

Invasive medical examinations, even at the border, should only be conducted where there is sufficient reason to suspect pandemic disease and only with the individual's informed consent.

Protecting Privacy

Disease surveillance generally should be conducted using methods, including syndromic surveillance, that do not collect individual names or other identifiable information without the individual's consent. Compulsory reports of names and other individually identifiable information should be limited to cases in which a person with a dangerous disease poses a credible threat of infecting others and an authorized government agency expects to interview the person in order to investigate the outbreak.

Mandatory reporting laws should specify procedures for keeping individually identifiable information strictly confidential and secure and penalties for failure to maintain confidentiality.

Government agencies that legitimately receive identifiable information should not use that information for any purpose other than investigating disease outbreaks without the individual's prior authorization.

Data collected for purposes of investigating or monitoring the incidence or prevalence of diseases should not be linked with other data that would permit identifying an individual.

Protecting Democracy

All public and private entities should remain accountable for their actions in accordance with the law and should not be relieved of liability for personal injury or civil rights violations.

Every effort should be made to preserve the operation of the judicial system and to protect the lives and health of judges and court personnel needed to preserve the rule of law.

Government should provide clear, accurate, and timely information to the public and honestly report uncertainties in the information available.