PANDEMIC PREPAREDNESS

THE NEED FOR A PUBLIC HEALTH

– NOT A LAW ENFORCEMENT/NATIONAL SECURITY–

APPROACH

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The Need for a Public Health

– Not a Law Enforcement/National Security –

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The lessons from history should be kept in mind whenever we are told by government officials that `tough, liberty-limiting actions are needed to protect us from dangerous diseases. Specifically:

> Coercion and brute force are rarely necessary. In fact they are generally counterproductive they gratuitously breed public distrust and encourage the people who are most in need of care to evade public health authorities.
>
> On the other hand, effective, preventive strategies that rely on voluntary participation do work. Simply put, people do not *want* to contract smallpox, influen a or other dangerous diseases. They want positive government help in avoiding and treating disease. As long as public officials are working to help people rather than to punish them, people are likely to engage willingly in any and all efforts to keep their families and communities healthy.
>
> Minorities and other socially disadvantaged populations tend to bear the brunt of tough public health measures.

The Problem with Post-9/11 Pandemic Plans

Current pandemic planning policies fail to heed history's lessons. Since 9/11, the Bush Administration has adopted an all-ha ards, one-si e-fits-all approach to disaster planning. By assuming that the same preparedness model can be applied to any kind of disaster whether biological, chemical, explosive, natural or nuclear the all-ha ards approach fails to take into account essential specifics of the nature of the virus or bacteria, how it is transmitted, and whether infection can be prevented or treated. Following this flawed logic, several state-based proposals have sought to address any `public health emergency, ignored effective steps that states could take to mitigate an epidemic, such as reinvigorating their public health infrastructure, and instead resorted to punitive, police-state tactics, such as forced examinations, vaccination and treatment, and criminal sanctions for those individuals who did not follow the rules.

Specific pandemic flu plans have also been adopted by the federal government and nearly every state and locality. The plans are poorly coordinated and dangerously counterproductive. By assuming the `worst case scenario, all of the plans rely heavily on a punitive approach and emphasi e extreme measures such as quarantine and forced treatment. For example, the U.S. Department of Health and Human Service's Pandemic Influenza Plan posits a `containment strategy that calls for massive uses of government force, for example to ban public gatherings, isolate symptomatic individuals, restrict the movement of individuals, or compel vaccination or treatment.

Toward a New Paradigm for Pandemic Preparedness

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INTRODUCTION

The spread of a new, deadly strain of avian influen a (H5N1), has raised fears of a potential human pandemic. This highly pathogenic and fast-mutating virus has already spread around the world, killing tens of millions of birds. Hundreds of millions more have been slaughtered in an attempt to limit the virus' spread. While the virus is not easily transmissible to humans, human cases and deaths have occurred, primarily among people in close contact with infected birds.[1] If the virus were to mutate to be more highly contagious to or between humans a possibility whose probability is unknown an influen a pandemic could occur.

In the last century, three influen a pandemics have struck. The 1918-1919 outbreak was the most lethal human pandemic since the Black Death in the Middle Ages. This extremely infectious strain claimed the lives of an estimated 50-100 million people worldwide, many of whom were young adults and otherwise healthy.

Communicable diseases are, by their nature, public harms. While individuals can take some measures to reduce their risk of infection, their efforts cannot fully succeed, nor can a community's risk be significantly reduced, without concerted action. Therefore, there is a significant and appropriate role for the government in pandemic preparedness and mitigation.

Unfortunately, many policymakers today believe that protecting public health re uires suppressing individual rights. President Bush's first suggestion to contain a bird flu pandemic was to call in the military to uarantine large sections of the United States.[2]

The notion that we must `trade liberty for security is both false and dangerous. It is false because coercive actions are seldom conducive to public health protection. It is dangerous because it provides a never-ending ustification for the suppression of civil liberties while failing to safeguard public health.

Public health is not a law enforcement or national security problem.

This report examines why that is so. It looks at the relationship between civil liberties and public health in contemporary U.S. pandemic planning. Part One reviews this relationship in a historical context, examining in particular the disastrous conse uences of public health policies built around a vision of sick people as the enemy. Part Two summari es post-9/11 plans intended to protect the nation against a possible influen a epidemic and how these plans rely upon the false premise that public health is a law enforcement or national security problem that can be solved by limiting the rights and liberties of affected individuals. Part Three provides a series of recommendations for an improved paradigm for pandemic preparedness one that protects both public health and civil liberties.

For millennia, governments have sought to protect their populations from epidemics. Frequently that response was positive, aimed at establishing an environment in which people could be healthy. Thus in the nineteenth century, cities prevented cholera by instituting sanitary measures and providing their residents with clean water. Later, governments provided vaccines and anti-toxins, improved urban housing, and regulated the safety of the food supply. These public health measures made an enormous difference, dramatically increasing life expectancies.

Likewise, when smallpox arrived in Boston in 1902, health officials, accompanied by police officers, forcibly vaccinated immigrants and African Americans. Although the Supreme Court later upheld the authority of a city to fine individuals who refused vaccination during an epidemic,[8] the Court never approved forcibly vaccinating people.

In contrast, New York City relied on a different approach in 194 , one that viewed the public as the client rather than the enemy of public health. When smallpox reappeared in the city after a long absence, the city educated the public about the problem and instituted a massive *voluntary* vaccination campaign. Not surprisingly, no coercion was needed. Provided with information about the need for and benefits of vaccination, and reassurance that the city was helping rather than attacking them, the citi ens of the New York turned out en masse for one of the world's largest voluntary vaccination campaigns. The campaign was successful, and the epidemic was ashed before it had a chance to spread broadly in the city or beyond.

Lessons Forgotten

Unfortunately, past lessons appear to have been forgotten. In the post-9/11 climate, public health policy has increasingly been viewed through the prism of, and indeed as a part of, law enforcement and national security. Rather than focusing on how government can work *with* individuals and their communities to be healthy, public health policymakers now often emphasi e the need to take tough, coercive actions *against* the very people they are charged to help. This approach not only targets people as the enemy instead of the disease, but also encourages health officials to believe that government cannot do much to help peo-ple in an epidemic. Little thought is therefore given to what society can and should do to help people prevent and mitigate epidemics. In effect, individuals are viewed as personally responsible for the spread of illness as well as for their own care.

This law enforcement/national security strategy shiosonal ec

For example, Section 502 of the model as originally proposed authori ed mandatory medical examinations and testing:

> Any person refusing to submit to the medical examination and/or testing re ired by a public health official, is liable for a misdemeanor. .the public health authority may sub ect the refusing person to isolation or uarantine. . Any . . health care provider refusing to perform a medical examination or test as authori ed herein shall be liable for a misdemeanor. ..an order of the public health authority. .shall be immediately enforceable by any peace officer.

Section 504 provides for compulsory treatment, something that has been soundly repudiated in the decades since at least 60,000 Americans were forcibly sterili ed in the early 20th Century[9]:

> Individuals refusing to be vaccinated or treated shall be liable for a misdemeanor. The refusing person may be sub ect to isolation or uarantine. . An order of the public health authority given to effectuate the purposes of this Section shall be immediately enforceable by any peace officer.

The Bush CDC's recommended law would have returned us to the late 19th and early 20th centuries when state `police powers in health were sometimes enforced by police officers, and people who were sick were fre uently treated as if they had committed a crime. But the CDC's plan would have set us back even further. It applied its penalties to people who did not have any contagious disease and to people who would never expose anyone else to disease. Moreover, it included provisions to make all public health personnel, and those acting under their orders, immune from liability for any in ury even if forced vaccination or other mandated treatments killed the `patient.

At the same time, the Act ignored effective steps that states could take to mitigate an epidemic, such as reinvigorating their public health infrastructure and increasing access to health care. Although state public health departments saw some budget increases following 9/11, most of that money was for bioterrorism preparedness activities, leaving public health agencies even more resource-starved. As a result, although some states now have new laws that more precisely specify their power to isolate or uarantine people during an emergency, they are less capable than ever of actually helping people or controlling an epidemic.

These proposals were modified and the criminal sanctions removed in response to public protest. But at least one state, Florida, enacted the `model law nonetheless, and went even further, authori ing forced treatment of an individual if the state had no uarantine facility available for confinement. Despite criticism by public health lawyers, the Bush CDC nonetheless continues to recommend that all states `update their laws to provide for mandatory surveillance, examination, isolation, and uarantine. In the real world, of course, laws that e uate medicine and public health with law enforcement severely undercut public confidence in public health and are likely to lead people to avoid public health officials rather than to seek out and follow their guidance.

was turned over to the Sheriff and treated as if he were a ail inmate. He remained in solitary confinement in the ail ward for nearly a year without access to showers or hot water, or even a view of the outdoors. His mail was censored, he was not permitted reading materials, and he was monitored by a video camera 24 hours a day, with no respite for private activities.

As in the Speaker case, the treatment of Daniels was utterly counterproductive. Instead of being treated, he was sub ect to unhealthful and psychologically depressing conditions that reduced his likelihood of recovery, and placed in a ail which did not have the facilities (such as ventilation systems) for the proper treatment of an infectious respiratory disease.

He was finally released for medical treatment and surgery to remove a lung in Denver after ACLU lawyers filed suit protesting the inhumane and unconstitutional conditions of his confinement.[11] Eventually, physicians discovered that Daniels, like Andrew Speaker, had a less dangerous form of TB than was initially suspected.

Even after he was treated and no longer contagious, Daniels continued to be handled like a criminal. Sheriff Joe Arpaio publicly threatened him with prosecution for the pre- uarantine events, and Daniels was forced to return to Phoenix in July 200 under a court order, where he lived in a motel and was to remain under supervision of the county health department for the next year-and-a-half. But Daniels had had enough of Phoenix; in October 200 he fled back to Russia to be with his wife and 6-year-old son.

The Daniels and Speaker cases are cautionary tales that illustrate the counterproductive nature of a punitive, law enforcement approach to preventing the spread of disease. Instead of recogni ing these dangers, however, both Congressional leaders and the media presented these cases as demonstrating a need for even tougher new laws that permit aggressive and punitive action against individuals. In so doing, they did not note the futility of stopping a disease as widely prevalent as tuberculosis by detaining one single traveler, nor did they recogni e the need to develop more rapid and accurate diagnostic tests and more effective TB treatments. Nor did they mention that existing treatments are not currently available to everyone with the disease. Rather, the spotlight remained on the alleged need to enact new laws to provide officials with more power to `get tough with individual patients. This is unfortunate because:

It's ineffective. The law enforcement approach has not and cannot prepare us for serious epidemics. Effective public health efforts, whether aimed at pandemic influen a or more common diseases such as TB and HIV/AIDS, are neither cheap nor glamorous. They are costly and difficult. These efforts re uire working with rather than against communities, providing communities with as healthy an environment as possible, health care if they need it, and the means to help themselves and their neighbors. Most importantly, to protect public health, public health policies must aim to help, rather than to suppress, the public.

It's dangerous for civil liberties. The law enforcement approach to public health offers a rationale for the endless suspension of civil liberties. The `Global War on Terror may go on for a generation, but the war on disease will continue until the end of the human race. There will always be a new disease, always the threat of a new pandemic. If that fear ustifies the suspension of liberties and the institution of an emergency state, then freedom and the rule of law will be permanently suspended.

It's usually un ustly a

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A similar attitude prevails with respect to pandemics. Although primary responsibility for pandemic planning was ultimately transferred to the Department of Health and Human Services, where it belongs, ultimate responsibility remains with the general public in `all ha ards. HHS Secretary Michael Leavitt, for example, has observed, `Communities that fail to prepare, expecting the federal government to come to the rescue, will be tragically mistaken. Leavitt made this statement even though the federal government has been given new authority to call in the U.S. military (and, apparently, private security forces) to restore order in an emergency without the consent of the governor of a state.

Of course it makes sense for both individuals and communities to plan to protect themselves in the event of an emergency. But as the New York Academy of Medicine concluded in its 200 study, *With the Public's Knowledge, We Can make Sheltering in Place Possible:*

> 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.

Current government planning for pandemic flu remains oriented around a law enforcement/national security approach that will both limit the effectiveness of a governmental response and put the civil liberties of Americans at great risk. That approach renders them not only useless but dangerously counterproductive.

There are a large number of pandemic flu plans in circulation. The federal government, almost every state and locality, many schools and businesses, and the World Health Organi ation, all have their own plans. Yet there is little coordination itself a confirmation of President Eisenhower's observation that `plans are useless.

A ma or reason why most current plans (which continue to evolve) are useless is that they assume the worst case scenario. Worst case scenario planning encourages counterproductive overreactions in which law-enforcement techni ues and drastic anti-civil liberties measures are used as the first resort, rather than the last resort. Although it is widely recogni ed that there were three flu pandemics in the past century (1918, 195 , and 1968), and that another pandemic seems inevitable at some point, all plans assume the `worst case, i.e., that the model to plan for is 1918, and not the more recent and less catastrophic pandemics of 195 and 1968. This means there is little or no planning for measures to help the population in lesser, and more fre uent, emergencies.

The problems with current plans include:

A reliance on coercion. Although most of the verbiage in these plans is vapid and virtually without content, and based on assumptions that will inevitably turn out to be mistaken, the one commonality they all possess is reliance on coercive actions such as uarantine and forced treatment. This is despite the fact that such measures are generally acknowledged by experts to be either completely ineffective or only potentially marginally effective in the case of flu. But law enforcement and national security continue to be the key elements, perhaps not surprising given President Bush's first suggestion to contain a bird flu pandemic: calling out the military to uarantine large sections of the United States to prevent flu from spreading across the country.

A lack of specifics. Because these plans do not give those in charge any specific, useful tasks to perform (beyond distributing stockpiled drugs and vaccines, if and when they are developed and produced), public authorities are apt to take useless and counterproductive anti-civil liberties actions to demonstrate that they are `doing something to respond to the crisis.

A loss of privacy. Planning for the worst case encourages health officials to view symptoms of almost any illness as the potential beginning of a pandemic. Pressure to find the first possible case of flu as fast as possible has encouraged wide-ranging surveillance systems to permanently monitor individual medical records and pharmacy purchases and link them to data bases in law enforcement, homeland security, agriculture, bank-

ing, customs and immigration. As a result, the punitive all-ha ards approach encourages the wide-spread, unnecessary and permanent violation of individuals' privacy.

Current Government Plans: Two Examples

An example of these flaws is the *Pandemic Influen a Plan* of the U.S. Department of Health and Human Services (last revision, May 200), which posits a `containment strategy based on a massive use of force by all levels of government:

> Containment attempts would re uire stringent infection-control measures such as bans on large public gatherings, isolation of symptomatic individuals, prophylaxis of the entire community with antiviral drugs, and various forms of movement restrictions possibly even including a uarantine. .if a containment attempt is to have a chance of succeeding, the response must employ the assets of multiple partners in a well coordinated way.[14]

The Implementation Plan of the Homeland Security Council's *National Strategy for Pandemic Influen a* (May 2006), consistent with an `all-ha ards approach, views pandemic influen a planning as an ad unct to homeland security planning, the plan being designed to `combat pandemic influen a.[15] Its executive summary accurately identifies the development of `rapid diagnostic tests (as well as uicker methods to develop a flu strain-specific vaccine) as being critical to an effective response. Nonetheless, it places emphasis on the restrictions of movement of people in the U.S., referencing with approval CDC recommendations for increasing uarantine authority, including its Orwellian proposal for authority to impose `provisional uarantine on travelers, which have been almost universally criti ed as arbitrary and useless.

All of this emphasis on containment and uarantine during a flu pandemic is particularly disturbing given the almost complete lack of success of any uarantines anywhere in the world for pandemic flu (the one exception: the island of American Samoa during the 1918 pandemic). The Institute of Medicine took note of advice by Donald A. Henderson, of the University of Pittsburgh Medical Center, who `cautioned against relying on models that do not take into consideration the adverse effects or practical constraints that such public health interventions like uarantine would entail. Accepting such models uncritically, he warned, could result in policies that 'take a perfectly manageable epidemic and turn it into a national disaster.' [16]

A Presidential Directive

Nonetheless, planning for pandemic flu has become part of `biodefense, with the military's role in public health programs increasing. For example, an October 18, 200 Presidential Directive on `Public Health and Medical Preparedness pasing uars, c pa0rity toari(natio

Sciences. This new academic program is to `lead federal efforts to develop and propagate core curricular, training, and research related to medicine and public health in disasters. [18]

The Directive also calls for building a national `biosurveillance system using electronic health information systems to collect information (presumably personally identifiable) about unspecified diseases and medical conditions. Although the system is to `protect patient privacy by restricting access to identifying information to the greatest extent possible

In short, plans that promote and rely on a law enforcement/national security model that assumes effective responses are a function of harsh police actions will likely fail to protect the public's health and needlessly trample civil liberties. Plans that democratically engage the community and rely on voluntary actions, including funding research for new drugs and vaccines, are the most likely to succeed.

Both history and current events demonstrate the need for a new, positive paradigm for pandemic preparedness, one that harnesses the talents of all Americans to take effective action to protect the health of all, instead of punishing those who fall ill. This new paradigm should be based on four fundamental principles: Health, Justice, Transparency, and AcAcency, and
Both hist5m

viduals are the immediate first responders in an emergency and ordinarily the best judges of their own resources and needs. Civic engagement harnesses the problem-solving talents of individuals, organizations and networks to develop plans for emergencies; and people participate more freely and efficiently in plans they help formulate and implement. The more government officials try to control events, the more they will be blamed for not preventing disasters or for the inevitable mistakes in responding.

Transparency is an essential prerequisite for gaining public trust. People are more likely to cooperate with reasonable requests when they are confident that government officials are being honest about the probabilities of risk and outcomes, and are willing to acknowledge uncertainty and admit mistakes.

4. **Accountability.** *Everyone, including private individuals and organizations and government agencies and officials, should be accountable for their actions before, during and after an emergency.*

The rule of law demands protection of rights and duties, even when they are most unpopular. The prospect of accountability is often the only check on temptations to act unjustly during emergencies. The more latitude government officials are granted during emergencies, the more important it is to hold them accountable for significant errors, arbitrary actions and abuses of power.

Specific Recommendations

These four general principles are the foundation for the following more specific recommendations concerning measures to prepare for a pandemic:

Protecting Health

1. The government should ensure stockpiling and fair and efficient distribution of vaccines, medications, food, water, and other necessaries in the event of a pandemic.

2. Distribution and rationing decisions for vaccination and treatment should be based on the goal of minimizing the detrimental health effects of the pandemic.

. Public health measures must not be based on race, color, ethnicity, national origin, religion, gender or sexual orientation and can be based on age or disability only if there is good reason to believe particular groups are either at much higher risk of death or have a much higher likelihood of spreading the disease if not vaccinated or treated.

4. Access to vaccination or treatment should not be conditioned on a waiver of one's constitutional rights.

5. The government and the private sector should encourage and support the development of rapid, accurate diagnostic tests for infectious diseases that reduce the possibility for error in identifying individuals who have a dangerous contagious disease.

6. Non-emergency programs to protect the public's health should be supported in order to develop and preserve a healthy population that can optimally survive emergencies.

. Government plans for responding to a pandemic should be based on the concept of community engagement, rather than individual responsibility.

Protecting Liberty

8. In a pandemic, governments should rely primarily on voluntary social distancing measures, including school closings and voluntary home quarantines, in preference to mandatory quarantines. In order to improve the effectiveness of voluntary social distancing measures, governments should enact laws to protect the jobs and income of people who stay at home, or whose workplaces are closed, under the advice of medical or public health personnel.

9. Governments should ensure that individuals who follow public health advice and stay at home during a pandemic receive food, medicine, and all other necessities.

10. Coercive measures should be imposed only when there is a sound scientific and constitutional basis for so doing and only when they are the least restrictive alternative and are imposed in the least restrictive manner.

11. Individuals who are proposed for detention should be provided with counsel and an expeditious judicial hearing to ensure that their detention is in fact legally justified. The

19. 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 the individual.

20. Federal agencies should not condition funding on the existence of state laws requiring patient names or other personally identifiable medical information to be reported to any state or federal agency or private entity.

Protecting Democr

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I. Public Health Surveillance and Medical Privacy

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C. Legal Principles Protecting Medical Privacy

1. State Statutory and Common Law

State case law, legislation, and some state constitutions recogni e general and specific individual rights of privacy in personal medical information and impose duties of confidentiality on physicians and other care providers, which forbid disclosing identifiable patient information without the patient's consent. States must also meet constitutional standards for exercising the police power in order to enact legislation overriding individual privacy interests.

2. Invasions of Privacy: The Due Process Clause, Amendments V and IV

The Supreme Court has recogni ed that the Due Process Clause protects an `indi-

without individuali ed suspicion or a warrant in order to detect epidemics (or conduct research). Unlike business records, the Court has said that 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. [5] The contrary view that consent to diagnostic testing for medical care creates a voluntary record which could be reported to government without constituting a search or sei ure is implausible, because it would authori e government to sei e medical records for any reason at all. [6] This argues for the necessity of an independent ustification for reporting.

The closest analogy may be the Supreme Court decisions concerning suspicionless drug testing. These cases have upheld suspicionless drug testing (searches) when government demonstrates a `special need *unrelated to law enforcement* to identify individuals

federal pandemic plans suggest use of isolation and quarantine to buy time during a pandemic.[41] Moreover, history warns that vulnerable populations may well be subjected to unnecessary and arbitrary detentions if a pandemic strikes.

The same point is applicable to vaccinations. The problem will not be that force is needed to vaccinate the population, rather that vaccine will be unavailable or in limited supply and will have to be rationed while people line up to demand access. Nonetheless it is worth emphasizing to public officials that the Supreme Court has ruled that competent individuals have a right to refuse any medical treatment, including life-sustaining treatment, and this includes vaccinations. Experimental vaccines can likewise always be refused, but once proven safe and effective, parents may have an obligation to have their children vaccinated, and governments have an obligation to make vaccine available to those in their custody, their workforce, and citizens unable to protect themselves. In addition, if it is reasonable for public health officials to find that an individual poses a significant risk to others by refusing examination or treatment by a qualified, licensed physician, quarantining that person would probably be constitutionally acceptable.

B. State and Federal Authority

Traditionally, public health protection has been viewed as within the states' police powers. Within each state, specific statutes govern isolation and quarantine. Historically, these statutes gave health officials broad authority and specified few procedural protections for affected individuals. Newer statutes often detail the procedures that a health department must follow when detaining individuals. Some state statutes now make clear that individuals cannot be detained unless there is no less restrictive alternative, such as voluntary confinement at home. In the past, the federal government has only detained individuals for health reasons at the border or at quarantine stations on navigable waters. Recently, however, the federal government has begun to plan for domestic detentions, and in the 200 case of Andrew Speaker mandated isolation for what was thought to be DR-TB.

Despite past practice, the commerce clause gives Congress authority to impose non-pharmaceutical interventions, including isolation and quarantine, within the states. Section 61 of the Public Health Services Act authorizes the federal government (acting through CDC) to promulgate regulations and apprehend, detain, and forcibly examine persons in order to prevent a disease listed by the President from entering the country or crossing state lines.[42] Individuals who are contagious or are `in a precommunicable stage, if the disease would be likely to cause a public health emergency if transmitted to other individuals may be detained.[4] In 2005, the President amended the list of quarantineable diseases to include `influenza caused by novel or reemergent influenza viruses that have the potential to cause a pandemic. [44]

42 U.S.C. 24 permits the federal government, if requested by a state, to suppress communicable diseases and enforce state quarantines and other health laws for up to six months. In addition, the Stafford Act permits the President to implement health and safety measures when a disaster has been declared.[45] Also relevant is the John Warner National Defense Authorization Act which authorizes 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. . [46]

Existing federal regulations provide almost no guidance as to when the federal government may detain individuals or what procedures must be followed.[4] In 2005, CDC pub-

It is unclear ust how expeditious a hearing must be, or when detention can precede a hearing. Second, it is not clear whether courts would demand individuali ed hearings if

tress associated with such measures. .[61] The IHR also prohibit states from imposing measures beyond those called for in the regulations if they are ˜more restrictive of international travel or ˜more invasive or intrusive to persons than reasonably available alternatives that would achieve the appropriate level of health protection. [62]

C. Interstate Travel Restrictions

The right to travel is strongest when applied to interstate travel. The Constitution ˜re gire s that all citi ens be free to travel throughout the length and breadth of our land uninhibited by statutes, rules, or regulations which unreasonably burden or restrict this movement. [6] Because of this, interstate travel restrictions receive strict scrutiny.

Nevertheless, interstate travel may be restricted when there is a direct threat of disease. In *Zemel v. Rusk,* the Court stated the right to interstate 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. [64]

In a pandemic, governments may either impose broad bans on travel or seek to prohibit travel only by individuals who are thought to pose a high risk, perhaps because of their health status or contacts. Reportedly, Florida is now issuing isolation orders to tuberculosis patients who seek to travel.[65] Because the state is targeting *travelers,* strict scrutiny should apply. As a practical matter, however, courts are not likely to review such cases differently than other cases of mandatory isolation.[66] The right to interstate travel is fundamental, but particular modes of travel are not constitutionally protected.[6] Thus a ban on domestic air travel would be sub ected to less scrutiny than a law that simply prohibits traveling across state lines.

D. International Travel

The right to travel internationally is also ˜part of the liberty' protected by due process,[68] but it is afforded less constitutional protection than interstate travel. 6fiedope9a2T16TB0sies of mandator.2404 0 .46 C0 Tw 4.atso69 ore nal 10 0or.

At the Border

If a pandemic arises, the federal government may re quire medical examinations at the border. Although the Fourth Amendment provides less protection at the border, reasonable suspicion is re quired for a `non-routine search, such as an invasive medical examination. A distinction needs to be made, however, between coerced medical examinations of citi ens and travelers with U.S. passports or visas, and medical examinations of those wishing to obtain visas. According to the Fifth Circuit, `over no conceivable sub ect is the legislative power of Congress more complete than it is over admission of aliens. [4] Currently, the Immigration and Nationality Act re quires would-be immigrants and refugees to undergo a medical examination to determine if they have HIV or another `communicable disease of public health significance. [5] The current list of prohibited diseases does not include influenza, but HHS could easily add it to the list.

In a pandemic the federal government may detain individuals at the border or deny them entry to the United States. The `Government's interest in preventing the entry of unwanted persons and effects is at its enith at the international border. [6] And at least one court has recently found that the government only needs a rational basis for detaining citiens at the border. Courts have been even less solicitous of claims by nonciti ens, but even in this case have re quired medical care for those detained. [8]

E. Treatment of Immigrants inside the United States

basic medical ethics and triage rules. One important difference, however, is that with a highly contagious disease it will be necessary to take affirmative steps to prevent the spread of disease within hospitals, and this may re quire isolating parts of the hospital, or even setting up separate facilities for treatment.

Public health rationing of anti-viral medications and vaccines, on the other hand, involves populations, not individuals. Nonetheless, the ethical and legal considerations are similar, although instead of trying to save individual lives, one is trying to save large numbers of unidentified lives. A reasonable public health approach, and one most often advanced on the basis of efficiency or utility, is to allocate vaccine in a way that maximi es the total number of lives saved, or the total number of years of life saved. But these allocation schemes are likely to be unknowable at the beginning of a pandemic (e.g., when it is unknown which populations, such as infants, children, teens, or the elderly are most at risk). Also, while it is likely that almost everyone will want, and even demand, access to vaccine the right to refuse to be vaccinated should be honored. No one should be forced to be vaccinated against their will both because of the constitutional right to refuse treatment, and pragmatically because forced vaccination will deter at least some people from seeking medical help when they need it.

Current U.S. government guidelines suggest that the highest priority for early vaccination be workers involved in vaccine production and medical and public health workers (since these individuals are needed to save others). Vaccine producers get priority because without them there would be no vaccine created for others; likewise, health care workers (and others directly involved in fighting the pandemic) get priority because of their role in helping others, and also because they risk their own lives in so doing. It will also be necessary to provide vaccine to the family members of these groups if we expect them to come to work.

The next tier usually contains those populations most at risk of death from the flu the elderly followed by other populations at risk. Others have argued that the elderly have lived their lives, and that priority should be given to younger people at risk. All of these schemes are legally sustainable, at least as long as they are made by publicly-accountable officials in a transparent manner. In order to obtain the support of the public for any rationing scheme, it must be developed prior to a pandemic, have broad public input, be reasonable, and be sub ect to revision as new information is obtained. What is not legally acceptable, however, is for the government to ration vaccine by race, religion, national origin, since this is a direct violation of the doctrine of e qual protection.

Finally, government has the obligation to protect the health of all its citi en, but has special obligations to those in its custody and to those who cannot protect themselves because of physical or mental conditions. Government entities should do advance planning for vulnerable populations to prevent a recurrence of a `Katrina type disaster where the most vulnerable were simply left to fend for themselves. Constitutional obligations to provide medical care, however, apply directly only to those actually in government custody, who should be near the top of any priority scheme for vaccination and treatment.

[24] For a discussion of involuntary detention, *see* Section III *infra*.

See, e.g., Hill v. Nat'l Collegiate Athletic Ass'n, 865 P.2d 6 , 658 (Cal. 1994); Alberts v. Devine, 4 9 N.E.2d 11 , 118-19 (Mass. 1985).

[25] Whalen v. Roe, 429 U.S. 589, 599 (19). Disclosure occurs (1) when government obtains information and (2) when it is redisclosed to other parties or accidentally or negligently disclosed to the public.

[26] Whalen v. Roe, 429 U.S. 589 (19).

[2] Planned Parenthood of Central Missouri v. Danforth, 428 U.S. 52 (19 6); Bellotti v. Baird, 44 U.S. 622 (19 9); Planned Parenthood of Southeastern Pennsylvania v. Casey, 505 U.S. 8 (1992) *See also* Thornburgh v. American College of Obstetricians and Gynecologists, 4 6 U.S. 4 (1986)(striking down earlier Pennsylvania abortion reporting law that re uired personal information without names and made reports available to the public).

[28] *See* Tucson Woman's Clinic v. Eden, 1 F. d 11 , 11 9, 1192 (9th Cir. 2004); Walls v. City of Petersburg, 895 F.2d 188, 192 (4th Cir. 1990).

[29] *See, e.g.,* Sheets v. Salt Lake County, 45 F. d 1 8 , 1 8 (10th Cir. 1995); Fraternal Order of Police, Lodge No. 5 v. City of Philadelphia, 812 F.2d 105, 110 (d Cir. 198).

[0] Cru an v. Dir, Mo. Dep't of Health, 49 U.S. 261, 2 8 (1990); Vacco v. uill, 521 U.S. 9 , 9 (199).

[1] 429 U.S. 589, 604, n. 2 (19 4).

[2] United States v. Jacobson, 466 U.S. 109, 11 (1984).

Soldal v. Cook County, Ill., 506 U.S. 56, 6 (1992).

[4] United States v. Miller, 425 U.S. 4 5 (19 6). *See also* Smith v. Maryland, 422 U.S. 5 (19 9).

[5] Ferguson v. City of Charleston, 5 2 U.S. 6 , 9 (2001).

[6] Ferguson v. City of Charleston, 5 2 U.S. at 96 (Scalia, J., Rehn uist, C.J. and Thomas, J, dissenting).

See, e.g., Skinner v. Railway Labor Executives' Ass'n, 489 U.S. 602 (1989); Treasury Employees v. Van Raab, 489 U.S. 656 (1989); Bd. of Ed. v. Earls, 5 6 U.S. 822 (2002). *See also* O'Connor v. Ortega, 480 U.S. 09, 25 (198).

[8] *See* Chandler v. Miller, 520 U.S. 05 (199) (`where, as in this case, public safety is not genuinely in eopardy, the Fourth Amendment precludes the suspicionless search, no matter how conveniently arranged.).

[9] *See* Tucson Woman's Clinic v. Eden, 1 F. d 11 , 11 9, 1192 (9th Cir. 2004); Decision of Chief ALJ Raymond Krause (July , 200), http://www.oah.state.mn.us/al Base/09001 586.recon.htm.

[40] Standards for Privacy of Individually Identifiable Health Information, 45 C.F.R. Parts 160 & 164; 42 C.F.R. 164.512(b).

[41] David Brown, *Military's Role in Flu Pandemic: Troops Might be Used to Effect a uarantine, Bush Says,* WASHINGTON POST, Oct. 5, 2005, at A05; Dept. of Health and Human Services, *Pandemic Influen a Implementation Plan, Pt. I*, Nov. 2006, at 102- 04.

[42] 42 U.S.C. 264.

[4] 42 U.S.C. 264 (d).

[44] Ex. Or. 1 5, 0 Fed. Reg. 1 299 (April 11, 2005).

[45] 42 U.S.C. 5121

[46] P.L. 109- 64, 120 Stat. 208 (Oct. 1 , 2006).

[4] *See* 42 C.F.R. 0 et se .

[48] 0 FR 8192 at 0.16 (Nov. 0, 2005).

[49] Jew Ho v. Williamson, 10 F. 10 (C.C.N.D. Cal. 1900).

[50] City of Newark v. J.S., 2 9 N.J. Super 1 8 (199).

[51] Smith v. Avino, 91 F. d 105 (11th Cir. 1995)(curfew following a hurricane).

[52] City of Newark v. J.S., 2 9 N.J. Super. 1 8 (199).

[5] Greene v. Edwards, 26 S.E. 2d 661, 66 (1980)(construing state law).

54 DeShanney v. Winnebago County Dep't Soc. Servs., 489 U.S. 189, 199-200(1989)

55 Madeline Pelner Cosman, *Illegal Aliens and American Medicine,* 10 J. AMER. PHYSICIANS AND SURGEONS 6-8 (2005). *See also* Lawrence Downes, *Editorial Observer: When Demagogues Play the Leprosy Card, Watch Out,* NEW YORK TIMES, June 1 , 200 at http://select.nytimes.com/search/restricted/article res F 0E11F6 E5B0C 48DDDAF0894DF404482.

56 David P. Fidler, *SARS: Political Pathology of the First Post-Westphalian Pathogen,* 1 J. L. MED. & ETHICS 485, 48 (200).

5 World Health Assembly, WHA 58. , Revision of the International Health Regulations, at http://www.who.int/gb/ebwha/pdf files/WHA58/WHA58 -en.pdf (last visited August 10, 200).

58 *Id.* at Art. 12.

59 *Id.* at Art. 2 , Art. 1.

60 *Id.* at Art. 1.

61 *Id.* at Art. 2.

62 *Id.* at Art. 4 .

6 Saen v. Roe, 526 U.S. 489, 499 (1999).

64 81 U.S. 1, 15-16 (1965).

65 John Lauerman, *Tough Laws Make Florida No-Fly Zone for Tuberculosis, (Update 1).* BLOOMBERG.COM, at http://www.bloomberg.com/apps/news pid-206 0001&ref insurance&side a [redacted] d6 (last visited August 8, 200).

66 *See* Section on isolation and quarantine.

6 Miller v. Reed, 1 6 F. d 1202, 1205 (9th Cir. 1999).

68 81 U.S. at 14 (citing Kent v. Dulles, 56 U.S. 115, 125 (1958)).

69 Califano v. A navorian, 4 9 U.S. 1 0, 1 6- (19 8).

0 Regan v. Wald, 468 U.S. 222 (1984); Zemel v. Rusk, 81 U.S. 1 (1965).

1 Weinstein v. Albright, 261 F. d 12 (2d Cir. 2001).

2 Rahman v. Chertoff, 200 U.S. Dist. Lexis 54960 (N.D. Ill. 200).

United States v. Montoya de Hernande , 4 U.S. 5 1 (1985).

4 Rodrigue -Silvia v. INS, 242 F. d 24 , 246 (5th Cir., 2001).

5 8 U.S.C. 1182.

6 United States v. Flores-Montano, 541 U.S. 149 (2004).

See 200 U.S. Dist. Lexis at 54960.

8 Haitian Centers Council, Inc. v. Sale, 82 F. Supp. 1028 (E.D. N.Y. 199), vacated by Stipulated Order Approving Class Action Settlement Agreement (Feb. 22, 1994) (refugees taken into custody on the high