# EBOLA PANIC—WHEN PUBLIC HEALTH CONCERNS CONFRONT THE CONSTITUTION

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**CHAPTER 4**

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# EBOLA PANIC—WHEN PUBLIC HEALTH CONCERNS CONFRONT THE CONSTITUTION

*Abstract: This article discusses the constitutional implications of public health strategies to combat infectious disease outbreaks, with a particular focus on the recent worldwide Ebola virus scare.*

## I. INTRODUCTION

In early 2014, an outbreak of the deadly Ebola virus began in a small village in Guinea in West Africa. *Origins of the 2014 Ebola Epidemic*, WORLD HEALTH ORG., http://www.who.int/csr/disease/ebola/one-year-report/virus-origin/en/. Previously called Ebola hemorrhagic fever, this communicable disease was first discovered in 1976 near the Ebola river in what now is the Democratic Republic of Congo. There are, at present, no proven treatments for Ebola or vaccines to prevent it.

The Ebola outbreak quickly spread to several urban areas, including Guinea's capital, Conakry. *Id.* Unlike previous Ebola outbreaks that occurred in isolated rural areas and were contained quickly, this Ebola outbreak spread to densely-populated cities in a fast-moving epidemic, jumping across national borders into the neighboring countries of Liberia and Sierra Leone. *Factors that Contributed*, WORLD HEALTH ORG., http://www.who.int/csr/disease/ebola/one-year-report/factors/en/. *Id.*

As the global health community mobilized to address the Ebola outbreak, fears arose that the disease would spread outside of West Africa. Because of the 21-day long Ebola incubation period, public concern arose that cross border travel, including international air travel, could spread the disease around the world.

As the Ebola outbreak grew, media attention about it in the United States also grew. A U.S. public already familiar with the public health threats caused by prior outbreaks of dangerous diseases such as Severe Acute Respiratory Syndrome ("SARS"), H1N1 influenza and Hantavirus, as well as the multitude of popular movies, television shows and novels addressing cataclysmic public health disasters, like *World War Z*, *The Stand, 28 Days Later* and *Contagion*, just to name a few, turned their attention to a new threat: Ebola. Public officials issued statements about the outbreak, and the media ran countless stories about it, feeding fears of a possible pandemic.

The public health response to the arrival of the Ebola virus in the U.S., as well as media coverage about the disease and of those individuals affected by it, became an almost inescapable part of the daily news. With a multitude of stories about the dangers of Ebola, its ability to be transmitted within a population and the lack of available treatments for those infected by it, it was nearly impossible to escape information (and misinformation) about the outbreak.

Around this time, media attention turned to two U.S. health care workers who had been working in West Africa to try to control the Ebola outbreak and were infected with the disease in Liberia. These doctors were transported back to the U.S. after they became sick in early August, 2014 for treatment at Emory University Hospital in Atlanta, Georgia. Both survived.

Then, on September 20, 2015, Thomas Eric Duncan traveled from Liberia to Dallas, Texas to visit his family there. Mr. Duncan had been exposed to the Ebola virus in West Africa and may or may not have known that he was infected with it when he traveled to the U.S. Shortly after his arrival in Dallas, Mr. Duncan became quite ill with Ebola, was hospitalized and died, becoming the first (and only) person to date to die from Ebola in the U.S.

Two nurses who treated Mr. Duncan at the Dallas hospital became infected with the disease. One was transported to Emory University Hospital for treatment. The other was sent to the National Institute of Health Clinical Center in Bethesda, Maryland for treatment. Both survived.

Mr. Duncan's family also was exposed to the Ebola virus, but were not infected. A large number of health care workers have returned to the U.S. after working in parts of West Africa with severe Ebola contagion without contracting the disease.

Faced with news of the arrival of Ebola in the U.S. and the dearth of medical treatment for the disease, the country looked on as federal, state and local officials worked to address this new public health threat. Panic gripped the country for a number of weeks, and officials in many states prepared for and responded to the crisis in varying ways.

While government officials and public health workers have scientific and medical resources to combat the outbreak of a disease, they often face strong public and political pressure about how to use them. Moreover, the regulations available to address an outbreak vary on a state-by-state basis.

During the Ebola outbreak, three states – Texas, New Jersey and Maine – addressed the outbreak and took somewhat different approaches to it. These varying approaches offer current examples of how existing law addressing public health emergencies can be applied to the outbreak of a dangerous infectious disease, like Ebola. They also can serve as a basis for a constitutional analysis of how government officials may address a modern public health threat.

When faced with a public health crisis, three basic questions arise:

- Who's in charge of handling the crisis?
- What can we do to try to solve the crisis?
- What are the limits to what we can do to try to solve the crisis?

The recent Ebola outbreak provides a useful framework for considering these questions. This article will address the crossroads of public health and the Constitution, with a focus on case law addressing prior government responses to contagious disease outbreaks, as well as the public health responses to the Ebola outbreak in Texas, New Jersey and Maine. In order to refine this analysis, this article will focus on what arguably is the most restrictive public health measure: quarantine.

## II. WHO'S IN CHARGE OF HANDLING THE CRISIS?

There is some overlap in public health authority between our state and federal governments. States traditionally have been in charge of regulating public health matters, but federal law increasingly has expanded to address public health matters extending beyond or across state borders.

### A. State Legal Authority

Matters of public health traditionally have been reserved to the states to regulate pursuant to their police powers. *See Gibbons v. Ogden*, 22 U.S. 1, 205 (1824) (recognizing the "power of a State, to provide for the health of its citizens"). Health regulations long have been considered to be at the core of the states' police powers because they are important to the states' role in protecting their citizens. *See Jacobson v. Massachusetts*, 197 U.S. 11, 24-25 (1905).

State laws on matters of public health, particularly relating to contagious disease, vary widely. Until recently, many states' laws were outdated. It was not uncommon for state statutes governing contagious diseases to be nearly a century old, or to refer only to a specific type of disease. Lawrence O. Gostin, *et al.*, *The Law and the Public's Health: A Study of Infectious Disease Law in the United States*, 99 COLUM. L. REV. 59, 101-02 (1999). However, concerns about bioterrorism following the 2001 terrorist attacks on the World Trade Center and Pentagon prompted many public health experts and government officials to assess the adequacy of state legal frameworks for addressing public health emergencies.

In 2001, the Model State Emergency Health Powers Act ("MSEHPA") was drafted to set forth a comprehensive statutory framework for states to use in taking swift action on public health threats. MSEHPA (Ctr. for Law & the Pub.'s Health 2001), *available at* http://www.public healthla.net/MSEHPA/MSEHPA.pdf

MSEHPA establishes reporting and tracking requirements, provides for isolation or quarantine of individuals infected by or exposed to a contagious disease, and details for providing an effective response to a public health threat. *Id.* MSEHPA recognizes the necessity of respecting civil liberties and attempts to protect them "to the fullest extent possible consistent with the primary goal of controlling serious health threats." *Id.* at Preamble.

Under MSEHPA, a state wishing to quarantine people exposed to a contagious disease ordinarily first would have to give notice and provide a hearing to determine whether a preponderance of the evidence shows quarantine is "reasonably necessary to prevent or limit the transmission of a contagious or possibly contagious disease." *Id.* § 605(b).

However, a state would be able to temporarily quarantine individuals without prior notice or hearing if delay "would significantly jeopardize the public health authority's ability to prevent or limit the transmission" of the disease, but the state must then provide a hearing within ten days afterwards. *Id.* § 605(a). Any quarantine would have to be "by the least restrictive means necessary." *Id.* § 604(b). The state would have to monitor the individuals' health status and provide for basic needs, including safe and hygienic conditions. *Id.* The individuals would need to be released when they "pose no substantial risk." *Id.* Failure to obey quarantine orders would constitute a misdemeanor. *Id.* § 604(a).

Thirty eight states have adopted portions of MSEHPA, with some states adopting more than others. *See* The Model State Emergency Health Powers Act Legislative Surveillance Table, Ctr. for Law & the Pub.'s Health (July 15, 2006), http:// www.publichealthlaw.net/MSEHPA/MSEHPA%20Sur veillance.pdf. For example, Montana adopted just one section of MSEHPA, while New Jersey adopted all twenty nine sections. *Id.* MSEHPA's provisions concerning quarantine and isolation were adopted by twenty states. *Id.* Given this inconsistent adoption of MSEHPA across the country, state laws on matters of public health and contagious diseases vary widely from state to state.

Very few MSEHPA provisions have been adopted in Texas. Texas adopted a definition section, the reporting and tracking requirements and a provision providing immunity from liability. *Id.* This may be due, at least in part, to the fact that Texas already has a set of laws addressing public health emergencies, revised and consolidated in 1989, that include basic procedures protecting individual liberty interests. *See*

Gostin, *et al., The Law and the Public's Health*, *supra,* at 108 n.193, 117 n.239.

Under Texas law, health authorities have the power to implement "control measures that are reasonable and necessary to prevent the introduction, transmission, and spread of the disease." Tex. Health & Safety Code Ann. § 81.083(b). "Control measures" includes immunization, isolation, quarantine, and a variety of other measures. *Id.* § 81.082(f). To implement these control measures, health authorities must deliver a written order to the individual, and may seek a court order as well if that individual does not comply, or in the event of a public health disaster. *Id.* § 81.083(c), (d), (e).

The Texas law sets forth a fairly comprehensive framework of procedures that must be followed to obtain a court order for a control measure, including notice, hearing, appointment of counsel, provisions for disclosure of information to the individual's attorney, the right to a jury in some instances and the right to appeal. *Id.* §§ 81.151–.212.

If an "outbreak of communicable disease" occurs in Texas, health authorities also are allowed to "impose an area quarantine coextensive with the area affected" but it would seem the procedural protections for court orders do not apply. *Id.* § 81.085(a). Failure to comply with a quarantine order carries criminal penalties, either a misdemeanor for refusing to perform most control measures, *id.* § 81.087(b), or in some cases a third-degree felony, *id.* § 81.085(h).

### B. Federal Legal Authority

Despite the police power of the states to regulate public health, the federal government has increased its authority in this area over time. *See* Arjun K. Jaikumar, Note, *Red Flags in Federal Quarantine: The Questionable Constitutionality of Federal Quarantine Laws After NFIB v. Sebelius*, 114 COLUM. L. REV. 677, 684-96 (2014). The federal government has its own statutes to address public health emergencies, usually promulgated under the Commerce Clause due to the ability of public health matters to cross state lines and affect interstate commerce. *See id.* (noting this stated basis of authority, but arguing recent Commerce Clause jurisprudence calls into question federal authority to implement quarantines).

Provisions within the Public Health Safety Act, 42 U.S.C. § 201, *et. seq.* ("PHSA") relating to communicable diseases allow the federal government, acting through the Centers for Disease Control and Prevention ("CDC"), to prevent the spread of disease from foreign countries into the United States, or from one state to another. 42 U.S.C. § 264(a). Practically speaking, this standard could be applied to almost any infectious disease in today's globally connected world.

Under the PHSA, the CDC can make regulations for "the apprehension and examination of any individual reasonably believed to be infected with a communicable disease in a qualifying stage" if they are "moving or about to move from a State to another State" or are "a probable source of infection to individuals who . . . will be moving" between states. 42 U.S.C. § 264(d)(1). A "qualifying stage" includes not just contagious diseases, but diseases "in a precommunicable stage, if the disease would be likely to cause a public health emergency if transmitted to other individuals." *Id.* § 264(d)(2).

The federal government therefore has fairly broad statutory authority to quarantine and isolate individuals. The diseases that can result in quarantine or isolation are listed in a series of executive orders, and include Ebola, in addition to diseases such as tuberculosis, plague, smallpox and SARS. Exec. Order No. 13,295, 68 Fed. Reg. 17,255 (Apr. 9, 2003). These regulations specify that the CDC can intervene when local control measures are inadequate, including by implementing isolation or quarantine. 42 C.F.R. §§ 70.2, 70.6.

## III. WHAT CAN WE DO TO SOLVE THE CRISIS?

When an infectious disease with no known treatment is in danger of spreading, the ultimate goal is to prevent it from spreading. This often can be accomplished by vaccination, but for diseases like Ebola for which there is no proven vaccination, one of the few ways to prevent the spread of the disease is to prevent contagious people from having contact with others.

History shows that, whatever is to be done to try to prevent the spread of a contagious disease, quick action is crucial. *See* Coco Masters, *Study: Quarantines Work Against Pandemics*, TIME (Aug. 7, 2007), http://content.time.com/time/printout/0,8816,1650634,00.html.

Quarantine and isolation can provide such quick action and have been used to conduct public health emergencies for centuries. *See generally* Eugenia Tognotti, *Lessons from the History of Quarantine, from Plague to Influenza A*, 19 EMERGING INFECTIOUS DISEASES 254 (Feb. 2013), http://wwwnc.cdc.gov/eid/article/19/2/pdfs/12-0312.pdf. Quarantine and isolation are two different, closely-related strategies to protect public health. Isolation is keeping sick, contagious individuals away from the general population. Quarantine is directed toward asymptomatic individuals who may be contagious. This article focuses on quarantine, but the principles discussed herein could apply to either strategy.

Because of the need to act swiftly, many government officials first act to try to prevent the spread of a disease, using measures such as quarantine, and worry about the constitutional rights of the individuals involved in the quarantine later. This practical reality necessitates that clear legal principles be in place for leaders to consider and use when managing an emergency public health situation.

## IV. WHAT ARE THE LIMITS TO WHAT WE CAN DO TO SOLVE THE CRISIS?

The outbreak of an infectious disease in the U.S. is not a new public health threat. We have faced a number of serious public health threats – such as tuberculosis, small pox and polio – before. As a result, established legal precedent exists that can serve as a framework for handling a public health crisis like the recent Ebola outbreak. However, most applicable case law in this area is quite old, predating modern air travel, the 24-hour news cycle and electronic media.

Today's interconnected world increases the risk that a pandemic could spread across populations and borders more quickly than ever before. Because an individual infected with a disease in one part of the world can travel by plane across the globe before feeling sick or becoming symptomatic, the U.S. faces an ongoing threat of a pandemic, despite the remarkable advances in medicine and public health that have occurred over the past century.

As the recent Ebola cases show, even if multiple government units have the statutory authority to act in response to a new public health threat, the practical decision of who will be the primary or lead actor can remain unclear. But once authority is established, however, and a plan is prepared to curb contagion, the primary issue becomes the limits on the government's authority to effectuate its public health strategies.

Effective public health strategies in combating disease can raise a number of constitutional issues. People forced into quarantine or isolation to prevent the spread of a communicable disease may object to interference with their physical liberty. People forced to accept testing, treatment or prevention methods, such as vaccination, may object to an interference with their right to control their own medical decisions. People may face restrictions on their religious freedom or their speech. Individuals may have their privacy rights impinged by public health officials sharing their personal or medical information.

There also may be inequality in which segments of the population are bearing the burden of the public health response. This concern has arisen during several prior public health responses. *See* Michelle A. Daubert, Comment, *Pandemic Fears and Contemporary Quarantine: Protecting Liberty Through a Continuum of Due Process Rights*, 54 BUFF. L. REV. 1299, 1311-13 (2007).

Focusing on due process considerations relating to quarantine, the next section of this article reviews relevant precedent and applies it to the recent U.S. Ebola response.

### A. Public Health Case Law

Because of advancements in science and health care during the modern era, we are fortunate to have had little need over the past fifty years to confront the legality and constitutionality of stringent public health measures. *See* Jaikumar, *supra,* at 695. Though this is a blessing, it also is in some ways a curse, as the constitutional limits of public health measures such as quarantine and forced vaccination remain largely undefined as a result.

In the event of a potential pandemic, like the recent Ebola scare, officials therefore must act without knowing with any reasonable degree of certainty whether they are violating constitutional rights. This uncertainty could yield a public health calamity or the widespread trampling of individual rights.

The primary case on the topic of a state's power to respond to a public health crisis was decided over one hundred years ago. In *Jacobson v. Massachusetts*, 197 U.S. 11 (1905), the defendant challenged an order by a board of health for Cambridge, Massachusetts, issued under the authority of state statute, requiring residents to be vaccinated against smallpox or face a fine.

Although challenged in part on due process grounds, this case arose before the now-familiar due process considerations of tiers of scrutiny and tailoring. In fact, the phrase "due process" appears only once in the decision. *Id.* at 13. Instead, the Court discusses the defendant's "liberty" rights and states that "the liberty secured by the Constitution of the United States to every person within its jurisdiction does not import an absolute right in each person to be, at all times and in all circumstances, wholly freed from restraint." *Id.* at 26.

While this and other similarly vague statements noting the competing individual and public rights and interests that can arise during a public health emergency are relevant today, the Court does not set forth any sort of clear rules for today's courts and government officials to follow. Indeed, is not even entirely clear why the Court upheld the state action.

The Court intermittently emphasizes the necessity of the state public health regulation, as well as the utilitarian aspect of rules protecting the many at the expense of the few, but seems to rely on a basic right of the state to regulate public health as the basis for its decision. *Id.* at 26, 28, 29, 31. Thus, while the *Jacobson* decision may be a helpful, general guide to the high level of deference courts may give to the

actions of states faced with a public health crisis, the Court's legal analysis is antiquated and does not give clear direction today.

Similarly, the relatively small number of other cases analyzing public health measures to combat contagious disease generally uphold significantly restrictive measures, giving great deference to state authority in the public health area. But nearly all of these cases also predate advances in both modern medicine and modern civil liberties jurisprudence.

For example, in the first half of the twentieth century, a boatload of healthy people could be kept from landing in a quarantined city. *Compagnie Francaise de Navigation a Vapeur v. Louisiana Bd. of Health*, 186 U.S. 380 (1902). A woman with leprosy who admittedly was not dangerous and only slightly contagious could be confined to her home and eventually forced to move outside city limits. *Kirk v. Wyman*, 65 S.E. 387 (S.C. 1909). A potentially lifelong quarantine of a typhoid carrier was overturned only because the regulation had been enacted by an individual rather than the authorized board. *Illinois ex rel. Barmore v. Robertson*, 134 N.E. 815 (Ill. 1922). Individuals with tuberculous could be confined to sanitariums until cured. *Moore v. Draper*, 57 So. 2d 648 (Fla. 1952). A woman traveling from an historically smallpox-infected area of Stockholm without proof of vaccination was quarantined for fourteen days, even where evidence showed there had been no cases of smallpox in Stockholm while she was there. *United States ex rel. Siegel v. Shinnick*, 219 F. Supp. 789 (S.D.N.Y. 1963).

These cases show that courts are willing to go to great lengths to support the actions of states to combat contagious disease. As stated in one of the cases, "the power of the states to enact and enforce quarantine laws for the safety and the protection of the health of the inhabitants . . . is beyond question." *Compagnie Francaise,* 186 U.S. at 387.

Despite this high level of deference, courts have put some limits on public health regulations, and began to do so even before modern legal standards for due process were established.

First, courts suggested that a regulation had to be related to public health and necessary on some level. *See, e.g.*, *Kirk*, 65 S.E. at 389-90 (allowing "reasonably necessary" regulations that are "reasonably appropriate to the end in view"); *Barmore*, 134 N.E. at 817 (noting courts only will interfere if public health regulations are "arbitrary, oppressive, and unreasonable").

Second, courts have ruled that the conditions of the quarantine had to meet at least some minimal standards. The Supreme Court of South Carolina agreed with lower courts that the manner of isolation, confining a "refined" lady to a hospital without comfort and next to the town dump, was unnecessary to prevent the spread of her mildly contagious, non-dangerous leprosy. The court ruled she instead could be confined to her home until a cottage was prepared outside city limits. *Kirk*, 65 S.E. at 391 ("[E]ven temporary isolation in such a place would be a serious affliction and peril to an elderly lady, enfeebled by disease, and accustomed to the comforts of life."). However, the court indicated that such conditions could be imposed if they were necessary. *Id.*

Third, courts have noted a requirement that at least some scientific evidence be gathered before strict public health measures be enforced. *See, e.g.*, *Barmore*, 134 N.E. at 819 ("A person cannot be quarantined upon mere suspicion that he may have a contagious and infectious disease, but the health authorities must have reliable information . . . .") (citation omitted). In one case, the Supreme Court of Arkansas affirmed lower court findings that there was insufficient evidence of tuberculosis on the record to justify isolating an individual. *Arkansas v. Snow*, 324 S.W.2d 532, 534 (Ark. 1959).

These early cases show great deference by the courts to state officials in their handling of public health matters. But they also acknowledge some limits to the states' powers to address public health concerns. Under modern due process jurisprudence, states likely still will be given wide latitude in their public health activities, but the balance now may be somewhat more in favor of individual rights and procedural protections.

### B. Due Process Analysis of Quarantine

There generally are two aspects to constitutional due process protections. The first is substantive due process, which addresses whether a liberty interest can be infringed at all. The second is procedural due process, which sets the standards for what process is due before certain rights can be limited.

Quarantine clearly limits physical liberty, and thus limits constitutional rights in some way. The questions posed by the due process doctrines are whether government actions involving quarantine are barred entirely, and if not, how much process is due before or after restraining a possibly contagious individual.

#### 1. Substantive Due Process

Substantive due process bars "'certain government actions regardless of the fairness of the procedures used to implement them.'" *County of Sacramento v. Lewis*, 523 U.S. 833, 840 (1998) (quoting *Daniels v. Williams*, 474 U.S. 327 (1986)). The inquiry involves the question of whether a government restriction of liberty is reasonable and sufficiently tailored to the end purpose of the restriction, weighing the individual's liberty interests against the government's interests. *See Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 278 (1990).

Such analysis requires first considering what level of scrutiny is applied to the government action – either strict scrutiny or a rational basis test. Where there is a significant burden on a fundamental liberty interest, the higher standards of the strict scrutiny analysis apply. *See Griswold v. Connecticut*, 381 U.S. 479, 503–04 (1965) (White, J., concurring in the judgment). Strict scrutiny requires that a law be narrowly tailored to compelling government interests, *e.g.*, *Brown v. Entm't Merchs. Ass'n*, 131 S. Ct. 2729, 2738 (2011), while a rational basis requires only a reasonable relation between the government action and the purpose, *Jackson v. Indiana*, 406 U.S. 715, 738 (1972).

Most of the early quarantine cases discussed above likely would fall under the rubric of substantive due process challenges if they were to be characterized under today's framework. They challenged whether the state's restraint on individual liberty was consistent with the Constitution. As courts long have recognized, the right to be free from restraint is not without limit, and states have broad authority over public health matters. *See, e.g.*, *Jacobson*, 197 U.S. at 25-26. The states must retain power to restrain individuals in certain situations for the good of society. *Id.*

The Supreme Court has not yet considered what level of scrutiny is required to analyze a restraint on physical liberty in the quarantine context. At least one scholar has argued that courts likely would apply a rational basis test in a judicial review of a quarantine for public health protection. Daubert, *supra,* at 1315.

Yet given that the Court has recognized a "fundamental right of interstate movement," *Shapiro v. Thompson*, 394 U.S. 618, 638 (1969), *overruled in part on other grounds by Edelman v. Jordan*, 415 U.S. 651, 670 (1974), the right to leave one's home (or hospital room) surely also is a fundamental right triggering strict scrutiny of laws that infringe that right. Moreover, the severe restriction of liberty caused by a quarantine would further impact individual rights, including loss of income. Thus, it is logical to assume that restricting a person's liberty by quarantine to prevent him or her from being in public entirely would be subject to strict scrutiny.

That is not to say quarantine would be constitutionally invalid. Preventing the spread of an infectious and fatal disease easily could qualify as a compelling government interest. In cases discussing quarantines and other public health measures, the courts have emphasized the important nature of this government interest. *See, e.g.*, *Jacobson*, 197 U.S. at 25-26; *Barmore*, 134 N.E. at 817, 819. The more difficult question is whether a particular quarantine is tailored narrowly enough to the government's interest in preventing the spread of disease.

Two factors courts may find relevant when considering this issue can be drawn from the older cases described above: (i) whether a quarantine was necessary under the circumstances and (ii) whether the conditions of confinement are adequate. *See, e.g.*, *Kirk*, 65 S.E. at 387. Other considerations may include questions of the effectiveness and proportionality of the quarantine, and whether harm to the individual is avoided. *See, e.g.*, Daubert, *supra,* at 1310; Lawrence O. Gostin, *Jacobson v Massachusetts at 100 Years: Police Power and Civil Liberties in Tension*, 95 AM. J. PUB. HEALTH 576 (2005).

Applying these considerations, a review of the specific facts of a quarantine would be necessary to determine whether it is constitutional.

Courts would consider the nature of the disease, including how contagious and dangerous it is. A highly contagious, deadly disease most likely would allow for much greater restrictions under a due process analysis than a mild disease of limited contagion with known and effective treatment options.

Courts also would consider the nature of the quarantine. A general quarantine of the population of an entire city almost certainly would violate due process as not being sufficiently tailored to the harm, but the quarantine of a single individual known to be contagious likely would be upheld. A quarantine within one's home may be upheld as entirely reasonable, but a quarantine within a guarded cell without running water or medical care likely would be found unconstitutional.

2. Procedural Due Process

Procedural due process weighs different interests. Under the balancing test first set forth in *Mathews v. Eldridge*, 424 U.S. 319 (1975), courts are to weigh the individual's interests that are to be affected, the benefit from additional procedure and risk of erroneous deprivation of interests with the procedure used, and the government's interest in providing the lower level of procedural protections. *Id.* at 335.

Procedural due process ordinarily requires an opportunity to be heard after adequate notice, including the right to present evidence and confront adverse witnesses. *Goldberg v. Kelly*, 397 U.S. 254, 267-69 (1970). Generally, procedural due process requires that the notice and hearing take place before the deprivation of rights. *See Zinermon v. Burch*, 494 U.S. 113, 127 (1990).

In some cases, where there is a "necessity of quick action by the State" or it is impractical to provide "any meaningful predeprivation process," a prior hearing may not be necessary and "some meaningful means by which to assess the propriety of the State's action at some time after the initial taking" can be sufficient. *Parratt v. Taylor*, 451 U.S. 527, 539 (1981), *overruled by Daniels v. Williams*, 474 U.S. 327 (1986); *see also Fed. Deposit Ins. Corp. v. Mallen*, 486 U.S. 230, 240

(1988) ("An important government interest, accompanied by a substantial assurance that the deprivation is not baseless or unwarranted, may in limited cases demanding prompt action justify postponing the opportunity to be heard until after the initial deprivation."). In other cases, a public hearing involving someone with a dangerous communicable disease in and of itself may cause a public health risk of the further spread of the disease at the hearing.

In one relatively recent public health case, *Greene v. Edwards*, 263 S.E.2d 661 (W. Va. 1980), a court analyzed the procedural due process rights of an individual quarantined for tuberculous. The court analogized quarantine to the confinement of mentally ill individuals and concluded that the same procedural protections are required before an individual can be confined due to that disease. *Id.* at 663. The court also concluded that the statute providing for confinement of tuberculosis patients did not afford procedural due process because it did not adequately provide for legal counsel for the patients, the right to confront and present witnesses or confinement based only upon clear and convincing evidence. *Id.* at 662.

Historically, habeas corpus has been the procedural vehicle used by quarantined people to challenge both constitutional violations and the propriety of quarantine under statute or regulation, as is true of many of the cases discussed above. *See also* Christopher Ogolla, *Non-Criminal Habeas Corpus for Quarantine and Isolation Detainees: Serving the Private Right or Violating Public Policy?*, 14 DEPAUL J. HEALTH CARE L. 135, 141-42 (2011). At a minimum, this procedural venue is available to confined individuals.

Individuals subject to quarantine or isolation likely also must receive some procedural protections from the state before or during confinement to challenge the propriety of the quarantine. Many state laws, including MSEHPA, recognize this need for such procedures, although the range of procedural protections varies widely.

The level of procedural protections that must be provided as a constitutional matter to individuals in a quarantine situation is a difficult question to answer; it likely will vary based upon the nature of the particular public health threat being addressed by the quarantine. While it is clear that notice and an opportunity to be heard must be provided at some point, the precise nature of the required hearing is greatly dependent on the facts. The evidentiary standard to be applied, whether an attorney must be appointed for the individual being quarantined and the ability of that individual to present and contest evidence all must be considered. *See Greene*, 263 S.E.2d at 662.

Some scholars, including an author of MSEHPA, argue that due process requires individuals be given notice, the right to counsel, a "full and impartial hearing" with proof of a health threat by clear and convincing evidence, and the right to appeal. Gostin, *et al., The Law and the Public's Health, supra,* at 122. But it may be difficult for state authorities faced with a new or relatively unknown disease to gather clear and convincing scientific evidence about the nature of and threat caused by that disease, as well as possible ways to stop it.

Assuming notice and an opportunity to be heard must be provided, the opportunity to be heard may not necessarily mean an in-person hearing, given the nature of the disease causing the quarantine. With modern video conferencing technology, the lack of an in-person hearing would have significantly lessor impact on an individuals' rights today than it would have a few decades ago.

In situations where a rapid public health response is necessary and the risk of contagion is high, the *Mathews* balancing factors likely would allow for the procedure to contest the propriety of the quarantine to occur after it is implemented. However, given the extreme deprivation of liberty caused by a quarantine, the hearing should follow quickly after the confinement begins.

## V. AMERICA'S EBOLA RESPONSE

Despite the nearly continuous news coverage and the high level of panic during the recent Ebola scare in the U.S., relatively few Americans ever came in contact with the Ebola virus. And, to date, all of the very few people who have contracted the disease in the U.S. have survived it.

Texas' response to the Ebola outbreak, as well as the quarantine of a Maine nurse, Kaci Hickox, who had returned to the United States from West Africa during the Ebola outbreak there, provide case studies for considering the constitutionality of public health responses to significant public health threats today.

### A. The Dallas, Texas Quarantines

After Mr. Duncan was diagnosed with Ebola, Texas officials undertook a rapid public health response to try to prevent the spread of the disease. As discussed in great detail in a recent (and quite interesting) article describing the Ebola response in Dallas, the CDC required that one person be designated as in charge, and the person designated was a local judge with minimal public health background. Bryan Burrough, *Trial by Ebola*, VANITY FAIR, Feb. 2015, at 88, 93. Dallas officials ended up directing nearly all of Texas' Ebola response. According to one count, 177 individuals in the Dallas area were quarantined in some manner while they were monitored for Ebola symptoms. *Id.* at 140.

Mr. Duncan's fiancée and the three other people who resided with her in the apartment where Mr. Duncan fell ill were quarantined in that apartment pursuant to a control order under Texas law, Tex. Health & Safety Code Ann. § 81.083. *Id.* at 93. Although some reports suggested they had suffered significant exposure to Mr. Duncan's bodily fluids, this later was determined not to be the case. To get them out of the apartment containing items potentially contaminated by Mr. Duncan, officials moved them to a house two days after they were put under quarantine. *Id.* at 139. Their apartment then was decontaminated by a cleaning crew, with the majority of its contents, including the television and video counsel, destroyed. *Id.* at 96.

Under Texas law, the family had the ability to invoke a fairly rigorous procedural process to address the quarantine, if they wished to do so. Although the control order was issued without notice or prior procedure, *see id.* at 93, the family was entitled to a hearing requiring proof by clear and convincing evidence, appointed counsel and other procedural protections. *See* Tex. Health & Safety Code Ann. §§ 81.151–.212. These available procedures likely satisfy minimal due process requirements.

Substantively, the quarantine of Mr. Duncan's family likely was constitutional. Scientific evidence shows a high risk of contagion for individuals who come into contact with the bodily fluids of someone showing Ebola symptoms. Mr. Duncan had been diagnosed with, and later died from, Ebola. It is clear his family had been exposed to his bodily fluids, even if they had avoided direct contact. As a result, they were quarantined for the 21-day Ebola incubation period. Although initially quarantined within the apartment containing the potentially infectious items used by Mr. Duncan, the family was moved out of the apartment into a house two days after the control order was issued, where they stayed for the remainder of the 21-day evaluation period. *See* Burrough, *supra,* at 139. None of Mr. Duncan's family contracted Ebola.

The quarantine of a homeless man, Michael Lively, in the Dallas area during the recent Ebola scare presents a different case.

Immediately after Mr. Duncan was transported to the hospital by ambulance, Mr. Lively rode in the same ambulance. *Id.* at 140. After Mr. Duncan's Ebola infection was discovered, officials realized that Mr. Lively had been in the same ambulance as Mr. Duncan and became concerned that he had been exposed to the Ebola virus. But by that time, Mr. Lively no longer was under medical care and his whereabouts were unknown.

Mr. Lively then became the subject of an intense manhunt. After being located once, he walked off after waiting hours to be evaluated, spurring police to join the search. After he was located again, he was quarantined against his will, using a control order like that issued for Mr. Duncan's family, even though he too did not show any Ebola symptoms. *Id.* Because he did not have a home, the man first was held in a hotel room, but later was moved to an empty hospital wing. *Id.* Mr. Lively did not contract the disease and was released at the end of the 21-day Ebola incubation period.

Although the quarantine conditions imposed on Mr. Lively were much more restrictive than those imposed upon Mr. Duncan's family, the lack of reasonable alternatives caused by the fact that Mr. Lively was homeless, and therefore could not be quarantined in his home, make it likely his quarantine was constitutional.

A key obstacle to a conclusion that the Texas Ebola quarantines were constitutional, as is true for any Ebola quarantine, is that the scientific evidence makes clear that Ebola can be contracted only from a symptomatic individual. Thus, individuals without any Ebola symptoms, like Mr. Duncan's family and Mr. Lively, almost certainly were not contagious when and while they were quarantined. This fact significantly reduces the necessity for a quarantine of non-symptomatic individuals who have been exposed to the Ebola virus.

On the other hand, because Ebola symptoms can appear without an individual recognizing them immediately, the state still may argue that a quarantine is appropriate after any Ebola exposure. While this tension makes the constitutionality of Ebola quarantines questionable under a substantive due process analysis, the courts' traditional deference to the states on issues relating to a public health emergency make it likely that they pass constitutional muster.

### B. The Quarantine of Kaci Hickox (New Jersey and Maine)

The other highly publicized Ebola quarantine subject is Kaci Hickox, a nurse who had returned from West Africa after a tour of service there with Doctors Without Borders, where she had been near Ebola patients. Although she was not the only American medical professional who had gone to and returned from the epicenter of the current Ebola crisis in West Africa, she was the first to face formal quarantine upon her return home.

On October 24, 2014, Governors Chris Christie of New Jersey and Andrew Cuomo of New York instituted a stringent quarantine policy for their states. *See* Connor Adams Sheets, *Kaci Hickox's Ebola Quarantine Raises Legal Questions Surrounding Response by Chris Christie, Andrew Cuomo*, INT'L BUS. TIMES, Oct. 27, 2014, http://www.ibtimes.com/kaci-hickoxs-ebola-

quarantine-raises-legal-questions-surrounding-response-chris-christie-1714276.

This policy was enacted in response to both Mr. Duncan's Ebola diagnosis and the case of a U.S. aid worker who had contracted Ebola while treating Ebola patients in Guinea. After contracting the disease, but before becoming symptomatic, he returned home to New York, where he traveled on the subway and went to a bowling alley and a restaurant during the 48 hours before he was diagnosed with Ebola on October 23, 2014. *Id.*

The New York – New Jersey policy required mandatory 21-day quarantine of all people traveling into U.S. by way of New York or New Jersey if they have been in contact with Ebola patients. If a traveler lived in another state, he or she would be confined in a medical facility rather than be allowed to travel home, even if he or she was not experiencing any Ebola symptoms. *See* Marilynn Marchione and Mike Stobbe, *NY, NJ Order Ebola Quarantine for Doctors, Others*, ASSOCIATED PRESS, Oct. 24, 2014, http://bigstory.ap.org/article/c13701f9382b47e18971e685cc7fac6e/after-1st-ebola-case-nyc-3-others-quarantined.

On the day this policy began, Ms. Hickox arrived at Newark Liberty International Airport in New Jersey on a flight from Sierra Leone. Officials took Ms. Hickox into custody and quarantined her in a tent outside a New Jersey hospital for four days, despite the fact that she exhibited no Ebola symptoms. *See* Kaci Hickox, *Her Story: UTA Grad Isolated at New Jersey Hospital in Ebola Quarantine*, DALLAS MORNING NEWS, Oct. 29, 2014, http://www.dallasnews.com/ebola/headlines20141025-uta-grad-isolated-at-new-jersey-hospital-as-part-of-ebola-quarantine.ece.

New Jersey's actions in quarantining Ms. Hickox are constitutionally questionable. As with Mr. Duncan's family, New Jersey could argue that some quarantine of Ms. Hickox was necessary. Although she was asymptomatic and therefore not contagious, it was undisputed that she had been exposed to the Ebola virus in West Africa and could have contracted the disease.

However, the conditions of her confinement in New Jersey were much less favorable than those used with Mr. Duncan's family in Texas. Moreover, New Jersey had other options available to it to address its public health concern, like home quarantine and active monitoring. Because of her lack of contagion, the extremely restrictive conditions imposed upon Ms. Hickox likely were not constitutional.

The New Jersey quarantine also may have been procedurally deficient. Although New Jersey adopted MSEHPA, *see* N.J. Stat. Ann. §§ 26:13-1 to 26:13-30, it does not appear these provisions were the basis for the state's actions. *See* N.J. Exec. Order No. 164, Oct. 22, 2014, http://nj.gov/infobank/circular/eocc164.pdf.

After four days had passed (and after her vocal and well-publicized objections to her quarantine and her retention of a civil rights attorney), New Jersey allowed Ms. Hickox to travel to her home state of Maine to wait out the remainder of the 21-day Ebola incubation period in her boyfriend's home in Fort Kent, Maine. *See* Sheets, *supra.* Maine's Governor, Paul LePage, tried to maintain a quarantine over Ms. Hickox in Maine for the remainder of the Ebola incubation period, but she challenged his attempt.

Under Maine's public health procedures, Me. Rev. Stat., tit. 22, §§ 807-819, the state health department had to file a petition to obtain an order for quarantine. It did so, and requested that Ms. Hickox's activities be restricted before the final petition could be heard and decided. *See* Order Pending Hearing, Mayhew v. Hickox, No. CV-2014-36 (Me. Dist. Ct. Oct. 31, 2014), *available at* http://courts.maine.gov/news_reference/high_profile/hickox/order_pending_hearing.pdf.

Ms. Hickox used the procedures available to her and challenged Maine's petition through her attorney. During her challenge, the court applied the state requirement that a health order be necessary, by clear and convincing evidence, and concluded that Ms. Hickox could be subjected to "Direct Active Monitoring," meaning she had to check her own health, including her temperature, twice daily. The court ordered that she notify authorities if she developed any Ebola symptoms, but declined to require any further restrictions on Ms. Hickox. *Id.* at 2-3. The 21-day monitoring period passed without Ms. Hickox becoming sick.

Given these limited restrictions on Ms. Hickox's liberty, her Maine quarantine likely complied with substantive due process.

## VI. CONCLUSION

The initial reaction of government officials facing a public health crisis, such as the introduction of a deadly contagious disease like Ebola, is to do everything possible to keep the disease from spreading. With the benefit of hindsight, it appears that, despite a few missteps, the U.S. successfully prevented the spread of the Ebola virus during the recent outbreak.

While a prompt and effective public health response is vital to protecting the population, the protections afforded the public by the Constitution also must be considered. After all, it is when the individual rights of some may be at odds with the interests of the majority that our constitutional protections can be most important. With the benefit of hindsight, it also appears, again with a few missteps along the way, that

most government officials were cognizant, at least on some level, of the constitutional implications of their actions in combatting the Ebola outbreak.

The response by federal and state officials to the sudden appearance of Ebola in the U.S. late last year presents a useful case study for analyzing the interplay between science, law and politics during a modern public health crisis.

While the varying approaches used by Texas, New Jersey and Maine in addressing the outbreak can serve as a guide for the handling of future public health threats, such threats can move quickly, and much more quickly than legislatures and courts can act.

The Ebola outbreak in West Africa continues today, with more than 10,000 deaths caused by the disease there. The public health battle to contain this Ebola outbreak continues, with U.S. health care workers working in West Africa to combat the disease and then returning home. As such, it is incumbent upon both state and federal government, public health officials and medical researchers to continue to develop regulations, protocols and treatments protecting the public in event of a public health crisis while at the same time recognizing and maintaining individual rights.

As shown by the U.S. public health response to Ebola, balancing these two interests can be difficult. Emerging health threats often are not fully understood, and public fear and political pressure may complicate the public health response significantly. Nonetheless, use of existing legal precedent may guide public health officials, if used wisely and well, as they address future public health threats.

Despite substantial press and public fear, and with some politicians calling for extreme measures such as stopping all air travel between West Africa and the U.S. or quarantining everyone who might possibly have been exposed to the Ebola virus, most government officials considered the science relating to Ebola and tempered their states' public health responses accordingly. Almost all of those individuals quarantined were left in their homes for the 21-day Ebola incubation period. Ms. Hickox was able to use available statutory procedures to challenge her quarantine.

As a result, even with a limited amount of modern jurisprudence on public health matters such as quarantine, both the states and the public fared relatively well during the recent Ebola outbreak. For the most part, sound judgment was used by people in positions of power and where government officials went too far, as in the case of the New Jersey quarantine, the government's actions soon were corrected.

There is little doubt the U.S. will continue to face the threat of a large-scale epidemic in the future. It is unclear whether courts will have the opportunity to address the competing interests that arise during a public health crisis before the next one occurs. But policymakers can and should assess existing legal frameworks governing public health in order to create well-reasoned policies and plans allowing them to react quickly and appropriately to any new public health threat while protecting individual rights and liberties. The recent Ebola outbreak provides ample information for them to consider while doing so.