Pandemic Legal Preparedness

A Brief Overview

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Zika. Ebola. Bird flu. SARS. The list of potentially catastrophic diseases that could lead to a pandemic seems to grow daily.[1] The potential legal issues facing healthcare providers, hospitals, state agencies, and local health authorities in treating individuals with highly communicable diseases are legion and generally not well developed. For this reason, the Communicable Diseases and Pandemic Preparedness Ad Hoc Task Force of the State Bar of Michigan spent the last two years studying those legal issues and compiled resources available to help both private and public health organizations prepare for a pandemic outbreak. Although predicting all the legal ramifications arising from a pandemic is impossible, this article highlights three areas in which healthcare lawyers and their clients must be prepared to act quickly in the event of a pandemic.

Involuntary quarantines of individuals with communicable diseases

One of the primary tools used to prevent the spread of communicable diseases is forced or voluntary quarantine. Quarantines date back to at least biblical times.[2] In the United States, the authority to isolate, treat, and quarantine individuals with communicable diseases who refuse treatment stands at a crowded intersection of federal, state, and constitutional law. The legal authority of states to investigate and control disease outbreaks is grounded in the police powers reserved to them

under the Tenth Amendment to the U.S. Constitution. The issues involving an exercise of that authority present an age-old clash between the government's interest in protecting the security of the population and the individual's constitutional right to liberty. Both federal and state laws and their associated regulations have attempted to balance these two interests in occasionally contradictory ways. Although the government is accorded substantial legal authority to protect the public health, the responsibility to treat patients ultimately falls on physicians and other healthcare providers. Thus, the public health and medical communities must work together, and this collaboration must begin before a public health emergency occurs. Without preparedness and coordination, any effort to protect the public from highly communicable diseases through the use of isolation or quarantine is doomed to fail.

The leading case regarding the compelled treatment of individuals with communicable diseases is from 1905. The state in *Jacobson v Massachusetts*[3] enacted a law that allowed a local board of health to force individuals to be vaccinated if necessary to protect the health of the community. During a smallpox pandemic, the plaintiff refused to be vaccinated and was criminally prosecuted. The plaintiff argued that the forced vaccination deprived him of his Fourteenth Amendment right to due process and equal protection. The court rejected this argument, ruling that in "times of great danger," the government may impose mandatory medical treatment where "reasonably" necessary to protect the public's health.

Most recently in *Mayhew v Hickox*,[4] the requirement that quarantines must be reasonable was reinforced. A Maine district court refused to issue an order to quarantine a nurse who had been exposed to the Ebola virus. The nurse did not display any symptoms at the time and denied the type of exposure known to transmit the disease. While states may exercise broad police powers to protect the public's health, such actions must be reasonable and supported by science to survive judicial challenge.

Despite this broad authority, the state of Michigan, by statute, has created a Byzantine legal structure that must be followed when an involuntary isolation or quarantine becomes necessary. Generally, the procedures for isolation or quarantine include the rights to notice, counsel, a hearing, and a rational/reasonable basis. Any compulsory measures must be implemented in a least restrictive manner. Michigan's involuntary detention statute[5] grants a "local health officer" broad authority in the event of an epidemic to issue emergency orders to prohibit the gathering of people, require mass immunizations, and temporarily commit individuals suffering from hazardous communicable diseases. This authority is supplemented by a related provision authorizing the local health officer to issue an "imminent danger order" requiring the individuals to whom it is directed to take "immediate action necessary to avoid, correct, or remove the imminent danger."[6] Violation of any valid order issued by the health department is a misdemeanor.[7]

FAST FACTS

The potential legal issues surrounding communicable diseases are generally not well developed.

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The public health and medical communities must work together to address public health emergencies, and this collaboration must begin at the preparedness stage.

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MIOSHA standards and the "general duty" to provide a workplace free from recognizable hazards that are likely to cause death or serious harm to employees require healthcare institutions to take appropriate steps to protect their employees from pandemic illness.

Outside of an imminent danger order, the procedures to be followed to involuntarily quarantine a carrier turn on (1) whether the local public health authority has declared a "public health emergency" (an undefined term) and (2) the proposed length of the quarantine. If the local public health agency has declared an emergency, Section 5207 of Michigan's Public Health Code authorizes the agency to obtain an expedited and ex parte order from the circuit court to take into custody any "individual whom the court has reasonable cause to believe is a carrier and is a health threat."[8] Assuming the court issues the order, the seized individual may be involuntarily quarantined for up to 72 hours.

The detained individual must be given a full adversarial hearing within 72 hours. At the conclusion of this second preliminary hearing, the court may continue the confinement order for an additional five days if it finds based on a "preponderance of the evidence" that the individual would pose a threat to others if released.[9]

If a health emergency has not been declared, or upon expiration of the eight-day period allowed for temporarily quarantining individuals in "emergency situations," an individual who presents a potential threat to human health has a much broader right to due process. The procedures to commit such individuals are set forth in Michigan's Hazardous Communicable Diseases Act.[10] Before seeking a quarantine order, the act requires the state or local public health authorities to issue a written warning to the contagious individual, outlining the specific steps he or she must take to avoid further legal action.[11] If the individual refuses to take the required actions, including voluntary isolation, the health officer may petition the local circuit court for an order compelling compliance with the warning.[12]

Before ordering quarantine under this provision, the court must first consider the recommendation of a "commitment review panel."[13] This panel is appointed by the court and composed of three physicians: two must be experienced in communicable diseases and approved by the Department of Health and Human Services and the third is to be selected by the individual. After the panel has given its recommendation and based on clear and convincing evidence, the court can order an involuntary quarantine for up to six months.[14]

Fortunately for practitioners, Kent County has prepared a bench book for the 17th Circuit Court containing model pleadings that comply with the requirements of the Public Health Code for involuntary commitments. The book spells out the legal authorities and procedures and provides resources for judges and practitioners in evaluating a petition for an emergency public health order. It's available on the task force's website.[15] The task force encourages healthcare attorneys to work with local circuit court judges to prepare in advance for the inevitable pandemic.

Protecting healthcare workers from pandemic disease

In any battle against pandemic disease, Michigan's healthcare workers will be on the front lines.

Michigan's Occupational Safety and Health Act imposes a duty on employers to "[f]urnish to each employee, employment and a place of employment that is free from recognized hazards that are causing, or are likely to cause, death or serious physical harm to the employee."[16] This "general duty" mirrors the requirement contained in the federal Occupational Safety and Health Act. Employers must take steps to abate recognized hazards even if no applicable standard exists. The Michigan Occupational Safety and Health Administration (MIOSHA) and the federal Occupational Safety and Health Administration (OSHA) often look to generally accepted industry standards to determine if a known hazard exists. In the case of pandemic illness, the potential hazards have been well identified by the healthcare community. OSHA has confirmed that the failure of a healthcare institution to take appropriate steps to protect its employees from pandemic illness might result in a general duty clause violation.[17]

While neither OSHA nor MIOSHA has promulgated a specific pandemic illness standard, several generally applicable standards, including MIOSHA's Bloodborne Infectious Diseases, Personal Protective Equipment, and Respiratory Protection standards, can be used to address pandemic illness. These standards all require employers to audit their workplaces regularly to identify particular hazards and develop methods of protecting their employees. For instance, the Personal Protective Equipment standard requires all employers to perform a hazard assessment to identify and provide appropriate personal protective equipment for employees and periodically review, update, and evaluate the program's effectiveness. Similarly, the Bloodborne Infectious Diseases standard requires employers to evaluate routine and reasonably anticipated tasks to determine whether there is actual or reasonably anticipated employee exposure to blood or other potentially infectious material and establish a written exposure control plan to eliminate or minimize employee exposure to bloodborne pathogens.

This type of advance planning will be critical in dealing with any outbreak of pandemic illness because there simply will not be time to develop practices and procedures once an outbreak occurs. The duty to protect employees extends beyond direct caregivers to employees in other departments such as maintenance, sanitation, food preparation, transportation, and mortuary who may come in contact with infectious materials.

The Personal Protective Equipment standard requires all employers to perform a hazard assessment to identify and provide appropriate personal protective equipment for employees.

There are many resources available to assist Michigan hospitals and medical centers in developing their pandemic preparedness plans. OSHA has developed websites dedicated to pandemic flu[18] and Ebola.[19] Many of these links are also available on the task force's web page.[20]

Technological considerations

As with every other aspect of life, technology has had and will continue to have a growing impact on the response to public health emergencies. The law has already responded to technological change in some ways, and additional change can be anticipated in the future.

One place where technology might make a difference is in protecting lawyers, judges, and witnesses involved in the commitment hearings previously discussed. When in-person hearings may be contraindicated due to the condition of the individual or to prevent further spread of the disease, technology may provide an effective alternative. Although there are no specific provisions in the law or court rules to address a public health situation, there are provisions for use of "communication equipment" in motion practice.[21] The definition of "communication equipment" is broad and accommodates both audio and visual equipment. The use of audio-visual capabilities and a multi-party bridge would permit participation of all interested parties and their counsel, without sacrificing the rights of the affected individuals.

The mere issuance of an isolation or quarantine order does not, of course, end the public health system's interaction with the individual. Isolated patients require medical care and other forms of support, and quarantined individuals need to be monitored for symptoms of disease. Traditionally, these tasks have been accomplished through regular visits from public health and medical professionals. However, with the development of remote monitoring devices ranging from wellness devices to "Internet of things" (IoT) devices such as connected televisions and refrigerators, the process of monitoring affected individuals in the midst of a pandemic will change. Through monitoring of movement, the IoT television will be able to provide information regarding activity level; the refrigerator will be able to record both food and fluid intake and report the need for more groceries. Specific-purpose monitoring devices will be able to measure and transmit temperature, blood pressure, heart rhythms, and other biometric data that will permit public health and medical personnel to closely monitor the individual without exposing them to communicable diseases.

This technology, however, poses security and privacy risks. Unlike medical devices, general health and wellness applications are not created with patient privacy in mind. Similarly, IoT devices are designed to gather data for use in product development and marketing. Typically, these vendors have privacy policies that are far more focused on the data the vendor is allowed to collect and use and far less focused on ensuring that the consumer's privacy is protected. Public health departments will need to be prepared to deal with the significant influx of data that would result. An additional benefit of such data could be improvement in the mapping of the spread of disease and the true course of (particularly emerging) infectious diseases.

There is also the potential difficulty related to authentication—ensuring that the data being collected is attributed to the correct person in the household. Unless the isolated or quarantined individual is the only person in the dwelling, it could be difficult to ensure that every data point relates only to the isolated or quarantined individual. The inclusion of invalid data points could lead to inaccurate conclusions. Thus, for this technology to reach its full potential, improvements in authentication of data source will be necessary.

Technology can also help minimize the transmission of disease and accommodate employees who have been exposed or need to work from home to care for family members. For employers, the question may arise whether an employee may be prevented from working due to exposure to a communicable disease, particularly when the employee is not symptomatic. Under various nondiscrimination laws, an employer may not take action against an employee on the basis of prejudice or unfounded fear. However, when there is legitimate concern that the employee poses a significant health or safety risk, the employer may limit the ability of the employee to work to prevent posing an unacceptable risk to coworkers and customers. Employers should evaluate their policies before a public health emergency occurs to ensure the policies support remote work options when appropriate.

Finally, consideration should be given to preparations necessary to maintain the confidentiality and security of data and technology during an epidemic or pandemic. One can anticipate that cybercriminals will seek to take advantage of the disruption caused by epidemic or pandemic disease to exploit technical vulnerabilities, and that information security staff will be affected by the disease and unable to carry out their responsibilities. Therefore, in the course of emergency preparedness, plans should be established to maintain security

despite the possibility of increased attacks, limited security staff, and increased remote use by employees.

The previous discussion illuminates just some of the potential legal issues facing healthcare providers, hospitals, and state and local health authorities in treating individuals with highly communicable diseases. In addition to constitutional, legal, manpower, and technology considerations, health lawyers should be prepared to advise and assist their clients in preemptively developing sound policies and practices to quickly respond in the event of a pandemic. ■

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ENDNOTES

1. According to the World Health Organization, a *pandemic* is the worldwide spread of a new disease. An *epidemic* is the occurrence of a disease or other health-related condition in an area, clearly in excess of normal expectancy. World Health Organization, *Definitions* <http://www.who.int/hac/about/definitions/en/>. According to the Centers for Disease Control and Prevention, *quarantine* is the separation and restriction of movement of healthy people who have been exposed to contagious disease to see if they become sick, and *isolation* is the separation of sick people from healthy to prevent the further transmission of contagious diseases. Centers for Disease Control and Prevention, *Quarantine and Isolation* <https://www.cdc.gov/quarantine>. All websites cited in this article were accessed January 6, 2017.
2. 1, Lev. 13.46.
3. *Jacobson v Massachusetts*; 197 US 11; 25 S Ct 358; 49 L Ed 649 (1905).
4. Unpublished opinion of the Fort Kent District Court in Maine, entered October 31, 2014 (Docket No. CV-2014-36) <http://courts.maine.gov/news_reference/high_profile/hickox/order_pending_hearing.pdf>.
5. MCL 333.2453.
6. MCL 333.2451(1).
7. MCL 333.2261.
8. MCL 333.5207(1).
9. MCL 333.5207(5).
10. MCL 333.5201 *et seq.*
11. MCL 333.5203.
12. MCL 333.5205.
13. MCL 333.5205(8).
14. MCL 333.5205(13).
15. SBM, *Communicable Diseases and Pandemic Preparedness Ad Hoc Task Force* <http://connect.michbar.org/healthcare/taskforce/pandemic>.
16. MCL 408.1011(a).
17. *Pandemic Influenza Preparedness and Response Guidance for Healthcare Workers and Healthcare Employers*, Occupational Safety and Health Administration, OSHA 3328-05R (2009).
18. OSHA, *Pandemic Influenza* <https://www.osha.gov/SLTC/pandemicinfluenza/>.
19. OSHA, *Ebola* <https://www.osha.gov/SLTC/ebola/>.
20. SBM, *Communicable Diseases and Pandemic Preparedness Ad Hoc Task Force* <http://connect.michbar.org/healthcare/taskforce/pandemic>.
21. MCR 2.402.