The Future of Communicable Disease Control: Toward a New Concept in Public Health Law

LARRY GOSTIN

EACH STATE, THROUGH THE EXERCISE OF ITS police powers, has the constitutional prerogative to intervene in the private sphere when necessary for the preservation of the health, safety, and morals of the community. Pursuant to this constitutional authority, all states and many localities have enacted public health statutes designed to control the spread of communicable diseases. The theory behind public health statutes is that the spread of infectious disease can be impeded by the exercise of state powers such as: case identification—e.g., testing, screening, and physical examination to detect whether a person is infectious; investigation of other persons likely to have contracted the infection—e.g., sexual contact tracing; and, then, by controlling the behavior of those found to be infectious or potentially infectious—e.g., isolation of cases or carriers of disease or quarantine of healthy individuals who have been exposed; or medically intervening in the cycle of disease—e.g., by requiring a class of persons to submit to a preventive vaccine or a curative treatment.

The exercise of compulsory public health powers for the common good of the community involves a potentially massive infringement of individual liberty, autonomy, and privacy. Yet, public health is a highly neglected area of the law. While other civil justifications for interference with liberty and self-determination, such as civil commitment of the mentally ill, have been the subject of cogent legal analysis in the last two decades, restraint for the good of the health of the people has barely caught the attention of the legal profession. Much of that complacency has now been displaced by the introduction in 1981 of a lethal, geometrically spreading disease, for which there is

The Milbank Quarterly, Vol. 83, No. 4, 2005 (pp. 1–17)

Reprinted from The Milbank Quarterly, Vol. 64, Suppl. 1, 1986 (pp. 79–96). Style and usage are unchanged.

no prevention or treatment—acquired immune deficiency syndrome (AIDS).

The classic question for public health jurisprudence, to be addressed in this article, is the extent to which the state may require its citizens to submit to restraint in order to interrupt the spread of communicable diseases. First, I will seek to demonstrate that public health statutes do not reflect modern conceptions in science and law. Second, the major deficiencies in public health law will be described and illuminated. Finally, I will propose a coherent statutory basis for the future of public health law. This effort represents a critically important attempt to develop guidelines for a model public health statute for the control of communicable diseases, for adoption by state and local legislatures.

An Antiquated Conception of Communicable Disease Control Measures

This article grew out of a national legislative survey for the United States Assistant Secretary for Health, which involved a thorough analysis of the public health statutes passed by Congress and in the legislatures of nine major states, New York City, Los Angeles, San Francisco, and Houston. This review covered the entire statutory and regulatory framework involving the control of communicable disease in each jurisdiction. A full analysis of the court cases in the area of communicable diseases was also undertaken. The study also reported the results of a survey of AIDS-specific legislation and proposed legislation, from which responses were elicited from all fifty states and the District of Columbia (Curran, Gostin, and Clark 1986).

The study for the United States Assistant Secretary for Health revealed that current public health statutes across the country reflect an approach to communicable disease fashionable in the earlier part of this century. They do not reflect modern conceptions in both science and law. At the time public health statutes were written, there was still a strong tradition of rather crude confinement of real or suspected cases of disease. This sometimes involved quarantine of an entire geographic area without any clear understanding of the mechanism by which the disease spread or how it could be interrupted (e.g., *Jew Ho v. Williamson* 1900[1]).

[1] *Jew Ho v. Williamson*, 103 F. 10 (N.D. Cal. 1900).

Modern public health interventions are more likely to be founded upon the developing scientific disciplines of virology and epidemiology. Focused public health interventions are preferred today, based upon a more precise understanding of who harbors an infectious agent, the most efficient modes of transmission, and the methods of modifying behaviors or environments necessary for interruption of the spread of a disease. Accordingly, modern conceptions of reducing the spread of disease are predominantly based upon research and education and counseling specifically targeted to groups at risk of spreading, or contracting, the disease.

Legal and societal conceptions have also altered considerably since the civil rights era of the 1960s. Since the Warren court, greater attention has been devoted to individual rights and the rights of minorities. Lack of rigor in developing statutory criteria and procedures for the exercise of compulsory powers has been successfully challenged in a variety of analogous contexts such as confinement of juvenile offenders (e.g., *In re Gault* 1967[2]) and the mentally ill (e.g., *O'Connor v. Donaldson* 1975[3]; *Lessard v. Schmidt* 1972[4]).

Civil commitment is the only other legal context in which liberty may be deprived without proof of the commission of a criminal offense; confinement for both public health and mental health is based upon the principle that restriction of individual rights is justified by the avoidance of future harm to the wider community. The courts now constitutionally require precise criteria for civil commitment based upon dangerousness, and strict due process procedural safeguards.

These substantive and procedural elements are conspicuously absent from most public health statutes, which have little regard for the price, in terms of restriction of individual rights, exacted by the exercise of compulsory powers. The powers provided in public health statutes are overly restrictive, largely reliant upon outdated concepts of full isolation or quarantine. The laws seldom contain a graded series of less restrictive measures. There are also no clearly stated criteria to guide public health officials in the exercise of their powers. Thus, society, through its legislature, has not enunciated the circumstances under which important public health decisions are to be made. This leaves the delicate balance between public protection and individual rights to the

[2]*In re Gault*, 387 U.S. 1 (1967).
[3]*O'Connor v. Donaldson*, 422 U.S. 463 (1975).
[4]*Lessard v. Schmidt*, 349 F. Supp. 1078 (E.D. Wisc. 1972), *vacated and remanded on other grounds*, 94 S. Ct. 713 (1974).

unfettered, largely unreviewable discretion of public health officials. Moreover, public health statutes often do not provide for the rigorous and impartial decision making required under the due process clause of the Fourteenth Amendment to the United States Constitution. The exercise of restrictive public health powers, therefore, is not hedged with appropriate procedural safeguards protective of individual rights. Considering that public health is one of the very few circumstances where a person's liberty can be restricted without the commission of a criminal offense, it is essential that the criteria and procedures for decision making are clearly understood and fairly applied.

Deficiences in Public Health Legislation and Case Law

There are a number of deficiencies in public health law which render it antiquated and inflexible as a tool for interrupting the spread of communicable disease. These deficiencies are described and illuminated below: basic structural problems caused by artificial boundaries erected between venereal and communicable diseases; the absence of clearly stated criteria, including the requirement of a scientific foundation for the exercise of compulsory powers; the absence of procedures necessary for fair and impartial public health decision making; and the absence of a range of less restrictive powers sufficiently flexible to allow supervision in the community.

Structural Defects in Public Health Statutes: Disease Classification

Most current statutory schemes erect an artificial boundary between venereal diseases and other communicable diseases. Each disease is intended to fit within the straitjacket of one of these two rigid disease classifications. The venereal (or sexually transmitted) disease classification, including syphilis, gonorrhea, and herpes, has an explicit undercurrent of punishment for wrongdoers. Provisions for the control of venereal disease have persistently been targeted at the population of prostitutes, which resulted in isolation of voluminous numbers of cases in the early to middle part of this century (Brandt 1985). Cases contesting deprivation

of liberty against this group, to be discussed below, demonstrate that these powers were often used indiscriminately, without proof that the "prostitute" was even infectious (e.g., *Ex parte Company* 1922[5]); and that prisons with deplorable conditions were used for incarceration, underlying the retributive nature of these laws (*Ex parte Martin* 1948[6]).

Current venereal, or sexually transmitted, disease classifications almost universally authorize strict control measures including isolation, surveillance, sexual contact tracing, physical examination, and treatment, all of a compulsory nature. Indeed, the majority of statutes specifically make the intentional spread of venereal (but not other communicable) diseases a criminal offense. By contrast, communicable diseases are often not subject to as strict a control system. Generally, communicable disease classifications do not authorize the exercise of compulsory powers unless specific regulations are promulgated.

The law also often better protects confidentiality relating to diseases classified as venereal or sexually transmitted because they are believed to involve social or moral opprobrium and reputational damage. If a disease is classified as sexually transmitted, there is usually a specific statutory provision proscribing the release of personal information, sometimes even in response to a judicial subpoena (*People ex rel Director of Public Health v. Calvo* 1982[7]; *In re Baker's Mutual Insurance Company of New York* 1950[8]). However, if a disease is classified only as communicable, frequently there is weak statutory protection of confidentiality.

When a new infectious disease is spreading rapidly among the population, a decision must be taken as to where in the rigid statutory scheme it should be classified. This poses particular problems where the mode of transmission of the disease includes, but is not limited to, sexual contact, such as in AIDS or hepatitis B. Placing a disease within a particular generic classification often requires a public health, sometimes a quasi-political, decision involving a time-consuming amendment to the regulations. The decision as to where to classify AIDS, a blood-borne disease which is also transmissible through semen, resulted in confusion and delay in many jurisdictions; in no case is it logical to classify AIDS solely under a single heading. AIDS has, for the most part, been designated as

[5] *Ex parte Company, Ex parte Irvin*, 106 Ohio St. 50, 139 N.E. 204 (1922).
[6] *Ex parte Martin*, 188 P. 2d 287 (Ct. App. Cal. 1948).
[7] *People ex rel Director of Public Health v. Calvo*, 89 Ill.2d 130, 432 N.E.2d 233 (1982).
[8] *In re Baker's Mutual Insurance Company of New York*, 301 N.Y. 21, 92 N.E.2d 49 (1950).

communicable (in Colorado, Florida, Illinois, Massachusetts, New Jersey, and Texas), or as simply a "reportable," "special," or "unusual" disease. In either case, a further specific regulation may be required to exercise compulsory powers.

In part, public health departments have shied from classifying AIDS as a venereal disease or have failed to amend their regulations, because any AIDS activity is subject to intense public scrutiny, and might be construed as an intention actually to exercise those compulsory powers against vulnerable groups. There is no clear public health rationale for providing statutory authority to control the spread of venereal and other listed communicable diseases, while having no statutory authority to control the spread of AIDS. Nor is there a clear rationale for generally affording greater confidentiality protections for venereal diseases than for AIDS. AIDS is but a single illustration of the inflexibility which occurs by the necessity of classifying diseases. It is odd, for example, to suppose that an airborne disease is not necessarily quarantinable without a specific regulatory amendment, while a sexually transmitted disease is always quarantinable.

There is a further adverse consequence of the requirement to classify and list diseases within the public health regulatory structure. Public health statutes across the nation are often confusing and indigestible amalgams, comprising several layers of statutory provisions and administrative rule making. They are often beyond the comprehension of informed members of the public and difficult to construe even for experienced public health officials and lawyers. Simply gaining access to a complete package of regulatory measures and relevant notices is a difficult undertaking. Lack of clarity in law is unsatisfactory, particularly where decisions are to be made affecting the health of the people and rights of individuals.

The Absence of Clearly Stated Criteria for, and Judicial Oversight of, the Exercise of Compulsory Powers

Since public health statutes authorize the restriction of individual liberty, they raise major social and legal issues. The most important issue is to determine the circumstances in which it is justified to exercise compulsory public health powers. It is for society, through its

elected legislature and judiciary, to set clear limitations on the exercise of compulsory powers. Yet, existing public health statutes and the courts have been silent as to the legitimate boundaries of public health power. The absence of clear legislative criteria and judicial oversight has resulted in many cases of public health officials being pressured into unjustifiably restrictive measures, responding to public fears; or, worse, public health measures have sometimes been mere pretenses for the restriction of rights of politically insular or unpopular minority groups. Below, I will demonstrate the absence of any meaningful legal framework for the use of compulsory powers, and the harm that can result.

Current public health statutes provide only the most general criteria under which compulsory powers can be exercised, leaving the public health officer with wide discretion. The California Health and Safety Code (s. 202), for example, allows the state to imprison or confine an individual "for the protection of the public peace or health . . . ." The New York Public Law (s. 2100) similarly empowers the health officer to isolate persons when necessary for the protection of the public health.

Such highly discretionary language has remained in public statutes only because it has not been challenged in the courts in recent years. Most of the relevant public health cases were decided around the turn of the century and early 1900s. The very earliest cases considered the exercise of public health powers to be such a compelling state interest that it was immune from *any* judicial review (e.g., *Hurst v. Warner* 1894[9]). The U.S. Supreme Court subsequently made clear that there are, of necessity, limits beyond which the legislature cannot go in exercising its police powers to protect the public health. The problem is that the courts have failed to specify clearly what those limits actually are. The classic statement from the U.S. Supreme Court came in *Jacobson v. Massachusetts* (1905)[10], a case involving compulsory vaccination for smallpox. The Court said the state must refrain from acting in "an arbitrary, unreasonable manner," or "going so far beyond what was reasonably required for the safety of the public." This standard of review is highly submissive. The Court would support any reasonable state regulatory measure which was not wholly irrational, indiscriminate, or enacted in bad faith.

[9] *Hurst v. Warner*, 102 Mich. 238 (1894).
[10] *Jacobson v. Massachusetts*, 197 U.S. 11 (1905).

The current criteria in public health statutes for depriving an individual of liberty would be likely to be held constitutionally invalid if challenged in court today. Mental health statutes prior to the 1970s had language which was highly similar to that still used in public health statutes. They authorized civil commitment if the patient was mentally ill and "in need of treatment or care," or if commitment was necessary to protect the welfare of the individual or the welfare of others. These statutes were struck down as unconstitutionally vague, and not sufficiently related to the state's valid interests in protecting the public from harm (e.g., *Johnson v. Solomon* 1979[11]).

More representative of current constitutional analysis in the public health field is *New York State Association for Retarded Children v. Carey* (1979)[12]. The Second Circuit Federal Court of Appeals determined that mentally retarded children who were carriers of serum hepatitis could not be excluded from attending regular school classes because "the Board was unable to demonstrate that the health hazard . . . was anything more than a remote possibility." This remote possibility did not justify the action taken considering the detrimental effects of isolation to carrier children.

The rigorous form of judicial oversight demonstrated in *Carey* has, thus far, been followed by the courts in AIDS cases (e.g., *District 27 Community School Board v. The Board of Education of the City of New York* 1986[13]) and other modern cases (*Arline v. School Board of Nassau County* 1985,[14] a tuberculosis case pending before the United States Supreme Court).

The absence of clear criteria and judicial oversight has resulted in public health actions which were largely ineffective and highly invidious. Some of the worst abuses against vulnerable groups throughout ancient and modern history have occurred in the name of public health.

Some early public health cases illustrate the harm that can occur from imposing control measures that aren't clearly supported by scientific evidence. In *Kirk v. Wyman* (1909)[15], an elderly woman with anesthetic leprosy was quarantined even though there was "hardly any danger of

[11] *Johnson v. Solomon*, 484 F. Supp. 278 (D. Ind. 1979).
[12] *New York State Association for Retarded Children v. Carey*, 612 F. 2d 644 (2d Cir. 1979).
[13] *District 27 Community School Board v. The Board of Education of the City of New York*, Sup. Ct. N.Y. County of Queens. Index No. 14940/85 (Feb. 11, 1986).
[14] *Arline v. School Board of Nassau County*, 772 F. 2d 759 (11th Cir. 1985), cert granted.
[15] *Kirk v. Wyman*, 65 S. W. 387 (S. Ct. S. C. 1909).

contagion." She had lived in the community for many years, attended church services, taught in school, and mingled in social life without ever communicating the disease. The court thought it "manifest that the board were well within their duty in requiring the victim of it to be isolated" when the "distressing nature of the malady is regarded." The court's preparedness to support the public health department was not diminished by the fact that Mrs. Kirk's disease was not curable and that the quarantine would be indefinite. Nor did the court in *State v. Rackowski* (1913)[16] require any more than "common knowledge" in deciding whether or not a person had scarlet fever.

The worst cases of misuse of public health power are when they appear to be associated with a form of discrimination against vulnerable groups. In the early to middle part of this century literally tens of thousands of prostitutes were "quarantined" as real or suspected carriers of venereal disease (Brandt 1985). In *Ex parte Company* (1922) the court actually upheld a quarantine regulation which included a provision that "all known prostitutes and persons associated with them shall be considered as reasonably suspected of having a venereal disease." The court did not appear unduly concerned to discover whether or not Martha Company actually had venereal disease. Even as late as 1944 a court accepted the logic that "suspected" prostitutes were "natural subjects and carriers of venereal disease," making it "logical and natural that suspicion be cast upon them" (*People v. Strautz* 1944[17]).

One of the most invidious public health measures was struck down by the Federal District Court in *Jew Ho v. Williamson* (1900). Public health officials had quarantined an entire district of San Francisco containing a population of more than 15,000 persons, ostensibly to contain an epidemic of bubonic plague, which is most easily communicated in situations of overcrowding and unsanitary conditions. The court said that the public health measure actually posed a danger to the health of the community: "It must necessarily follow that, if a large territory is quarantined, intercommunications of the people within that territory will rather tend to spread the disease than to restrict it." More important, the quarantine was made to operate exclusively against the Chinese community, demonstrating an "evil eye and an unequal hand."

[16] *State v. Rackowski*, 86 A. 606 (S. Ct. Conn. 1913).
[17] *People v. Strautz*, 386 Ill. 360, 54 N. E. 2d 441 (1944).

The Absence of Procedures Necessary for Fair and Impartial Decision Making

A scheme for the control of communicable disease, in addition to specifying standards under which the individual may be restrained, must identify the decision makers and describe a process for gathering information and making a fair and correct decision. Most state statutes delegate wide discretion to public health officials. There has been no careful thought given by most state legislatures as to procedural safeguards designed both to achieve a more accurate fact-finding process, and greater equity and fairness to the individual whose liberty is to be restrained.

Again, these statutory provisions are only in place because they have yet to be challenged in the courts. Mental health statutes before the 1970s also failed to require rigorous due process procedures. Several courts found that these statutes violated the due process clause of the Fourteenth Amendment. The most notable of these cases, *Lessard v. Schmidt* (1972), required notice and an opportunity to be heard before a neutral judge, with a right to counsel. The U.S. Supreme Court in *Addington v. Texas* (1979)[18] later found that a standard of proof by clear and convincing evidence was constitutionally required in civil commitment cases.

Modern courts would certainly require procedural due process standards prior to, or immediately after, the exercise of personal control measures to protect the public health. In determining the kinds of procedures required by the Fourteenth Amendment, the courts balance the interests of the state with those of the individual (*Mathews v. Eldridge* 1976[19]). The state's interest in protecting the public from serious harm is compelling. The interest of the individual grows with the level of coerciveness of the public health measure to be applied. Where a control measure infringes on liberty, as in the case of quarantine, the courts would be likely to require very strict procedural due process safeguards because of the deep invasion of personal rights; the risk of erroneous fact finding; and the importance of avoiding confinement of nondangerous persons.

[18] *Addington v. Texas*, 441 U.S. 418 (1979).
[19] *Mathews v. Eldridge*, 424 U.S. 319 (1976).

The Absence of Graded Series of Less Restrictive Measures

Most current public health laws provide a set of personal control measures limited to compulsory examination, vaccination, or treatment, and isolation or quarantine. They seldom have a graded series of more flexible, less restrictive measures. The effective options for public health officials are to introduce voluntary programs or severe restrictions on personal liberty. The temptation is either to exercise no statutory power or to reach for provisions which are too restrictive of individual liberty to be acceptable in a modern democratic society. In effect, public health laws provide a stick that is too big to wield.

The analogy to civil commitment is again useful. Compulsory mental health strategies have long been limited to involuntary hospital admission. Increasingly, care and supervision in the community are seen as viable, less restrictive alternatives to civil commitment. Community-based mental health programs can often accomplish the goals of treatment and public protection as well as, or more effectively than, total confinement in an institution. When mental health joined the judicial revolution of the civil rights movement, a number of courts declared a doctrine of the least restrictive alternative (e.g., *Lake v. Cameron*, 1966[20]; *Lessard v. Schmidt* 1972). Since that time, there has been increasing support for voluntary measures or legal controls within a community setting (Lamb and Mills 1986). Guardianship and conservatorship are two legal mechanisms now used that require the mentally ill person to receive care, treatment, and some degree of control in the community, without the necessity of full deprivation of liberty.

The principle of the least restrictive alternative can also be of foremost importance in the exercise of public health powers. A major goal of public health is to foster voluntary cooperation through testing, notification of contacts, and alteration of high-risk behavior. The use of a drastic involuntary measure may deter vulnerable individuals from cooperating with public health officials or attending public health programs such as clinics for the treatment of sexually transmitted diseases or the treatment of drug or alcohol abuse.

[20] *Lake v. Cameron*, 364 F. 2d 657 (D.C. Cir. 1966).

Public health officials can easily misunderstand the principle of the least restrictive alternative. Public health is based upon the assumption that it is preferable to provide the maximum protection against the spread of infectious disease. If there is a risk of error, it is best that it be on the side of a more restrictive, and thus more cautious, approach. As a matter of risk management it is understandable that if the almost certain result of contracting a disease such as AIDS is death, aggressive use of public health powers at an early stage may be justified. The principle of the least restrictive alternative is not necessarily inconsistent with this view. It does not require a less effective measure merely because it is less intrusive. It requires a less intrusive measure only if it is equally, or more, effective. The legal principle thus represents good public policy. Adoption of equally effective, less restrictive alternatives will be appreciated by vulnerable groups, and will encourage voluntary compliance with public health advice.

The principle of the least restrictive alternative, however, cannot resolve all dilemmas in public health policy. It is, after all, in the nature of public health policy that it is made under some conditions of uncertainty; and it is not usually possible to measure accurately the efficacy of two public health approaches. It is, therefore, seldom a question of choosing the less restrictive of two *equally effective* measures. Nevertheless, the principle requires the decision maker to achieve his or her public health goals, wherever possible, with the least drastic means. Public health statutes ought to make this an explicit requirement and provide a set of less restrictive options to choose from.

Toward the Development of Model Guidelines for Contemporary Public Health Statistics

In the previous section, I have tried to demonstrate that public health legislation is based upon antiquated conceptions relating to the control of communicable diseases, and that there are a number of marked deficiencies in the statutes. This has resulted in the highly inappropriate use of control measures and a lack of clarity as to the parameters for the exercise of public health powers. In this final section I will make a number of proposals which may help guide the future reform of public health statutes.

A Unified Legislative Structure

A modern public health statute should remove the rigid distinctions between venereal and communicable diseases and should enact strong, uniform confidentiality protections. There are a whole variety of important factors in deciding whether a compulsory control measure is appropriate in any individual case: the mechanism of transmission, the period of communicability, the availability of a prevention or treatment, and the seriousness and prevalence of a disease. Today, there is no particular relevance in the distinction between venereal and communicable disease; the existence of the two classifications in modern statutes causes delay, confusion, and arbitrary consequences for liberty and confidentiality. (See below for further proposals for specific confidentiality protections.)

Clear Statutory Criteria

The statement of clear statutory criteria is important because they place boundaries on the discretion of public health officials; they put individuals on clear notice as to the circumstances which may give rise to loss of liberty; and they allow society, through its legislative process, to place the fulcrum to achieve a careful balance between individual autonomy and the health of the public. Clear statutory criteria could produce more consistent decision making and help avoid decisions based upon unsubstantiated fears or prejudice.

In this section I will support the following proposal: Future public health statutes should specify that personal control measures must be based upon a finding that the person is in an infectious state, and is reasonably likely to transmit the infectious agent, causing a serious risk to the public health.

Public Health Necessity. The constitutional foundation for the exercise of compulsory powers is a public health necessity. "Public health necessity" should be made a specific component of modern public health statutes. To establish a public health necessity, the state should demonstrate, by clear and convincing scientific, epidemiologic, and/or medical evidence that: (1) there is urgent need to interrupt the spread of an epidemic; (2) in the particular case the person is shown to be infectious by a thorough medical examination; (3) there is a reasonably high probability that the infection will be communicated; and (4) the control measure is likely to be effective in eliminating or reducing the risk of contagion.

Public health statutes should be specifically designed to prevent a significant deprivation of individual rights based upon purely speculative assumptions. The justification for a public health action that fundamentally interferes with individual rights must be a currently established scientific assessment of reasonably high probability of serious harm.

The Avoidance of Serious Harm. Public health powers are exercised under the theory that they are needed to prevent an avoidable harm. An important public health question is how serious and probable that harm must be in order to justify deprivation of the rights of an individual.

In exercising a compulsory power, the state is not purporting to act in the interests of the individual and does not require a showing that the intervention is justified by personal incompetency, self-protection, or the need for care or treatment. Since the predominant rationale for public health intervention is to prevent harm to the public, the seriousness and probability of that harm should be the major parameters for decision making. The absence of any intention to serve the interests of the individual suggests that the threshold for public health action should be a reasonably high probability of serious harm.

A decision to take compulsory public health action in any individual case should be based upon a careful balance between the degree of intrusion on individual rights and the probability and gravity of the harm to be avoided. As the public health measure becomes more intrusive in its restriction of rights and duration, the gravity and probability of harm must be greater in order to justify the action. Ultimately, the right of the state to take measures which avoid a probable and grave harm must be respected, even at the cost of individual civil liberties.

Procedural Safeguards. The importance of procedural safeguards prior to, or shortly after, the exercise of compulsory public health powers has already been emphasized. Procedural due process is not merely protective of the individual. It is also a means of ensuring high-quality decision making where there is a structured opportunity to present full information to a dispassionate decision maker.

The West Virginia Supreme Court, in *Greene v. Edwards* (1980)[21], has held that the procedural due process safeguards required in civil commitment of the mentally ill are applicable in cases of involuntary civil confinement of infectious persons. This includes the right to written

[21] *Greene v. Edwards*, 265 S.E. 2d (W. Va. 1980).

notice, to counsel, and to present evidence and cross examine; a clear and convincing standard of proof; and a verbatim transcript for appeal. But the state need not go so far as providing the procedural safeguards of a criminal trial (*Morales v. Turman*, 1977[22]).

The foregoing procedural requirements should be built into public health statutes. Thus, prior to, or in cases of urgent necessity immediately after, the imposition of personal control measures an impartial decision maker should hear the case. This function could properly come within the jurisdiction of the courts. Alternatively, an independent administrative tribunal, including professional as well as lay members, could be specially constituted pursuant to the public health statute. The potential subject of control measures should have the right to be represented by counsel. Interference with liberty must be fully justified; the individual should have representation to promote critical examination of the grounds and evidence upon which decisions are to be made.

A Range of Less Restrictive Powers: Community Health Orders. Public health statutes across the country often do not provide for a graded series of less restrictive powers. Below, there is a proposal for a community health order which should be utilized only where there is a clear and imminent danger to public health, meeting the criteria set out earlier. A comprehensive public health program should be able to utilize a variety of less restrictive powers, broader in scope than are currently contained in most public health statutes. The use of less restrictive community-based powers could allow for some continued association with family, community, and work environments; public health officials would seek to accomplish their goals without significant disruption of community life. By allowing infected persons to participate in social activities, the law would encourage his or her voluntary cooperation, while drawing clear limits in proscribing particular unsafe behaviors or exposures.

The public health department should be empowered to issue a community health order, giving it flexibility in fashioning a remedy to a public health risk. The community health order might require the person: to report all changes of address to the public health department; to attend at appropriate places and times for the purposes of education, counseling, testing, or medical examination or treatment; or to be admitted to a hospital, detoxification center, or a clinic for treatment

[22] *Morales v. Turman*, 562 F. 2d 993 (5th Cir. 1977).

of drug dependency or sexually transmitted disease on an out-patient or day-patient basis. A community health order would enable public health officials to supervise and control the infected person who poses a danger to the public without full deprivation of liberty.

The intention behind a community health order is not to widen the net of persons potentially subject to control measures, but only to provide public health officials with less intrusive, more flexible powers with which to accomplish their objectives. Community-based powers involve restriction of freedoms and autonomy, and can adversely affect a person's reputation. They should be used only after complying with the same strict procedural and substantive safeguards as previously discussed. Thus, the person should be entitled to a full and fair hearing by a court or tribunal. The court or tribunal must find, by clear and convincing evidence, that the person is infectious and likely to endanger seriously the public health. The order should be for a specified duration based upon a careful assessment of the time the health risk is likely to continue. There should be a maximum period specified in the order, with periods of renewal only after further review by the court or tribunal.

Confidentiality. Many public health powers, by their very nature, reach into the confidential domain of the physician/patient relationship. The diagnosis that a person has a communicable disease, or carries an infectious agent, may trigger a statutory or regulatory obligation on the part of the physician to report the patient's name to the public health department. The public health department will keep that person's name on a register and may use the information for tracing sexual contacts or for introducing some compulsory power.

A person's health status is a private matter, and communicable diseases such as gonorrhea, leprosy, and AIDS are particularly stigmatizing. Disclosure of such information can lead to social opprobrium and to loss of employment, housing, or insurance. Accordingly, the very basis for cooperation with public health and therapeutic objectives depends upon the trust the person has in the confidentiality of information about health.

A modern public health confidentiality statute should apply uniformly to all disease classifications. The following statutory provisions are recommended: a specific requirement that the person's informed consent is required before the release of any personal information or records relating to known or suspected cases; a specific exemption which protects

the confidentiality of all such information from being disclosed in response to a subpoena or court order; and an exemption that protects all state and local health officers, private health care professionals, or other holders of information from courtroom examination.

Conclusion

Public health statutes for the control of communicable disease have hardly received serious examination in this century. They have been built up—layer by layer—in response to new epidemics of disease. Numerous examples of ineffective, highly invidious measures have been attempted under the auspices of these statutes.

The Harvard School of Public Health national legislative survey for the U.S. Assistant Secretary for Health points to the need for major review of the objectives, criteria, powers, and procedures of public health statutes (Curran, Gostin, and Clark 1986). This article can only serve as a starting point, mapping out the major deficiencies in the legislation. The next phase in the process of reform should be a task force of national caliber comprised of persons experienced in public health law, virology, epidemiology, and other relevant disciplines to formulate guidelines and a model statute for consideration and adoption at the state and local level.

Legal reforms in mental health during the 1970s resulted in sweeping changes in every state statute within the space of a decade. Reform of that magnitude is long overdue in the public health field, but will require thoughtful and systematic consideration over the next years to achieve that goal.

References

Brandt, A.M. 1985. *No Magic Bullet: A Social History of Venereal Disease*. New York: Oxford University Press.

Curran, W.J., L. Gostin, and M. Clark. 1986. *Acquired Immunodeficiency Syndrome: Legal, Regulatory and Policy Analysis*. Washington: U.S. Public Health Service.

Lamb, H.R., and M.J. Mills. 1986. Needed Changes in Law and Procedure for the Chronic Mentally Ill. *Hospital and Community Psychiatry* 37(5):475–80.