Legislative Alternatives to the Model State Emergency Health Powers Act (MSEHPA)

LSU Program in Law, Science, and Public Health White Paper #2
April 21, 2003

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Critical Points

- The MSEHPA is Not Necessary
- The MSEHPA Poses Unacceptable Ethical Issues
- The MSEHPA Can Undermine Existing Emergency Preparedness Laws
- The MSEHPA Does Not Address Necessary Public Health Reforms
- Incremental Reform and Planning is the Key to Effective Public Health Law

Introduction

It has often been said that crisis brings out the best and the worst in people. The same is true of legislatures. The events of 9/11 led to welcome bipartisanship in Congress and state houses. Unfortunately, 9/11 is also fueling a "do something" mentality which is encouraging legislatures to pass laws without a clear understanding of their implications for individual liberty or national security. The proposed Model State Emergency Health Powers Act will not improve day to day public health practice or the response to bioterrorism. In fact, it may make such responses more difficult by undermining confidence in public health agencies and by disrupting the complex web of existing state public health and emergency preparedness laws. Legislatures considering this Act should turn their attention to incremental public health law reforms for specific problems faced by their states and to the much more important problem of improving public health and public health law practice.

What is Behind the MSEHPA?

This is a proposed model law, primarily written by academics at the Center for Law and the Public's Health, a federally funded project at Georgetown and Johns Hopkins Universities. It was done as a response to concerns about bioterrorism raised by the events of 9/11. The act is based on the assumption that existing state laws are wholly inadequate to confront a bioterrorism event and should be superseded by a comprehensive act which will override any conflicting state laws. While the Center for Law and the Public's Health is relatively new, the main academics behind it have been

AIDS law activists since the 1980s. From the mid-1980s until 9/11, the primary focus of this research group has been to repeal traditional public health laws and substitute civil rights style laws which significantly reduce the authority of public health officials. Ironically, many of the problems that the MSEHPA claims to remedy stem from the public health law "reforms" passed in the 1980s and 1990s.

Are Old Laws Still Good Laws?

The central argument put forward for the MSEHPA and other model laws such as the Turning Point Model Public Health Law is that public health laws are outdated and would not be upheld in modern courts. The assumption that state public health laws drafted 50, 100, or even more years ago cannot be useful in the modern world is at the core of the Centers for Disease Control funding for public health law research and most of the funding provided by private foundations. This argument started in the AIDS law projects in the 1980s as a way to prevent states from applying traditional public health measures such as named reporting and contact tracing to HIV/AIDS. Professor Gostin, the main drafter of the MSEHPA, led the opposition personally when the Colorado legislature was considering the nations first HIV named reporting law, proposed by Dr. Tomas Vernon, then President of the Association of State and Territorial Health Officers.[1]

In answer to the claim that such laws were outdated and unconstitutional, Professor Richards did a comprehensive review of public health law jurisprudence from the Colonial period to 1989. When the review was published,[2] two things were clear: 1) the courts were not overruling old public health law cases; and 2) the courts were taking old public health doctrine and expanding it rather than backing away from it. In a series of cases the United States Supreme Court applied traditional public health law theory in then new situations such as preventive detention for criminal conduct. The past 14 years have seen the court move much more strongly in this direction. In a prominent example, the Court used the 1905 smallpox vaccination law case[3] as precedent for upholding sexual predator laws.[4] Most recently, the court used preventive jurisprudence to uphold Megan's Law cases that required the community identification of persons convicted of sex-related crimes.[5]

The Homeland Security Act and related post-9/11 legislation embodies the same prevention jurisprudence as does the earliest public health cases. Whether one agrees

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[1] The law did pass. For more information on the genesis of this and the controversy, see Edward P. Richards, Communicable Disease Control in Colorado: The Rational Approach to AIDS, 65 DENV. U. L. REV. 127 (1988).

[2] Edward P. Richards, "The Jurisprudence of Prevention: Society's Right of Self-Defense Against Dangerous Individuals," 16 Hastings Constitutional Law Quarterly 329-392 (1989).

[3] Jacobson v. Commonwealth of Massachusetts, 197 U.S. 11 (1905).

[4] Kansas v. Hendricks, 521 U.S. 346 (1997).

[5] Smith v. Doe __ US ___, 2003 WL 728556 (2003).

with the increasing willingness of the courts to allow significant infringement of individual rights in the name of national security, it is clear that these courts have no problems upholding traditional public health laws.

The Role of the Courts

The Model State Emergency Health Powers Act ignores a key fact: judges will not stand in the way of emergency actions taken to protect the public from a clear and present danger, and if they do, the state appeals court will over turn their rulings in a matter of hours. From the Colonial period until today, the history of judicial restraint on emergency powers is one of blind obedience to civil and military authority, not one of necessary actions thwarted by overly particular jurists. It is inconceivable that the courts would stand in the way of actions to control a major public health threat such as a smallpox outbreak, even if the state was clearly stepping beyond its statutory powers. Even the Japanese interment during World War II, which is universally recognized as unjustified from a historical perspective, was upheld as a valid public health and safety action.[6] This case has never been overruled and is still precedent, because the court recognizes that hindsight is always keener than foresight when judging preventive actions. This reality makes the Model State Emergency Health Powers Act unnecessary in a true emergency and unjustifiably broad as a response to non-emergency situations.

This deference to state power to protect the public health and safety is well-grounded constitutionally.[7] The Constitution gives the primary power to protect public health and safety - the police power - to the states. The intent was clear because communicable disease control and Draconian public health actions were important issues in the colonies. The constitutional convention was almost disrupted by a yellow fever epidemic.[8] Thus it is clear that the states have the power.

Secondly, public health law is a part of the legal field known as administrative law. Administrative law principles recognize the balance between individual and societal rights that is at the heart of public health law. Whether it is the balancing of process versus accuracy in Matthews v. Eldridge,[9] or the right to private information for public purposes in Whalen v. Roe,[10] the United States Supreme Court is very clear that individual liberties must be weighed against the public good: "...while the Constitution protects against invasions of individual rights, it is not a suicide pact.[11]" This is reflected

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[6] Korematsu v. United States, 323 U.S. 214 (1944).

[7] Edward P. Richards and Katharine C. Rathbun, "The Role of the Police Power in 21st Century Public Health," Journal of Sexually Transmitted Diseases, 1999;26(6):350-7.

[8] Powell JH. Bring out your dead: the great plague of yellow fever in Philadelphia in 1793. Philadelphia: University of Pennsylvania Press; 1949.

[9] 424 U.S. 319, 335 (1976).

[10] 429 US 589 (1977).

[11] Kennedy v. Mendoza-Martinez, 372 U.S. 144 (1963).

in the state and federal public health and safety cases back to the colonial period. The case law makes it clear that the role of the court is very limited in public health determinations and that the court is not to act as an arbiter of best public health practices.[12]

Administrative law is based on the principle that agencies need flexibility in the enforcement of laws.[13] This is especially true in public health where a central function of public health agencies is to deal with the unexpected. Agencies have no flexibility if their enabling statute does not give them sufficient power. However, given the broad discretion the courts accord to public health agencies, the traditional vague and general public health statutes are nearly always construed as providing whatever powers are necessary for the agency's actions in meeting emergencies. In almost all cases where state agencies responding to threats are found to have insufficient power it is because the legislature has either over specified the agencies duties and responsibilities or taken the power away from the agency by specific legislation. Such specifications limit the agency powers and often force the agency to do things that do not make good public health sense. We saw this in the 1980s and early 1990s when many states "reformed" their public health laws in response to individual liberties activists and did take necessary powers away from their public health agencies. Ironically, it is some of these laws, passed with the support given by governmental public health research money, that pose the greatest problems for routine disease control and for dealing with potential bioterrorism incidents.

The Problem with Model Public Health Law Acts

Public health agencies should operate under broad general grants of authority, with legislative budgetary processes and executive branch direction establishing their priorities. These general powers can be fleshed out with administrative regulations, with every state having a notice and comment process analogous to the Federal Register/Code of Federal Regulation. In general, highly detailed model laws, such as the Turning Point Model Public Health Law, and the Model State Emergency Health Powers Act, limit necessary agency flexibility and constrain agencies in ways that are detrimental to the public health. These model acts, and the others that have been proposed based on federal government funded public health law projects, represent very specific attacks on public health powers through raising the administrative cost of public health enforcement through increasing due process requirements well beyond those imposed by the state and federal constitutions.

Model acts are very important in areas that involve national and international commerce. Thus the Uniform Commercial Code and other model acts have been essential to the development of our national economy. Model acts are not a good approach when the

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[12] City of New York v New St. Mark's Baths, 130 Misc. 2d 911, 497 N.Y.S.2d 979 (1986), affirmed, New York v. New St. Mark's Baths, 168 A.D.2d 311, 562 N.Y.S.2d 642 (N.Y. App. Div. 1st Dep't 1990).

[13] Chevron U. S. A. Inc. v. Natural Resources Defense Council, Inc., 467 U. S. 837, 842-843 (1984).

problems are local and do not involve fungible economic goods or commerce. If these areas need uniform legislation, it is most appropriately done by Congress. Constitutionally, public health is the most state and locality specific area of law. It is part of a complex matrix of state laws that differ greatly from state to state. Changing bits of these laws can have profound unintended consequences.

Understanding these laws requires a careful analysis of an entire state's regulatory and political system - the same statute can have profoundly different meanings in Louisiana, Oregon, and New York. Yet the CDC and other government sources have repeatedly funded superficial surveys of state laws, as if they could be averaged to come up with a "best" law. These surveys provide no legitimate information about the function of law and have been misused to support political positions such as the often repeated claim that state public health departments do not have enough power to respond to emergencies.

The use of administrative regulations and guidelines, which are subject to public comment and review, is more democratic and leads to better regulations than detailed statutes because they can be better tailored to the specific needs of the state. Most importantly, administrative regulations can be modified as agencies gain more knowledge about public health threats. Detailed statutory schemes have two dangerous flaws. First, they are difficult to change, especially once the legislature loses it interest in bioterrorism. Second, it is impossible to predict the collateral effects of enacting a hastily drafted statute and all the expected amendments that will creep in during the legislative process. The likely result is a law that weakens public health practice and muddles state authority, but will be very difficult to change.

This administrative law approach, with agencies fleshing out broad statutory authority with regulations is why 100 year old laws can work, just as a 200+ year old Constitution still works. The key to this process is that the courts defer to administrative decisionmakers when they are operating under broad grants of authority. This process is derided by some academics as being too vague and no longer constitutionally adequate, but it has been strongly endorsed by the United States Supreme Court and all state supreme courts. Thus a traditional state law establishing a health department might say little more than that the department was empowered to protect the public health. As long as the actions taken by the health agency are rationally related to protecting the public health they will be upheld by the courts. Since public health agencies are subject to political controls, they are unlikely to greatly overstep the bounds of acceptable regulation.

Conflicts with Existing Laws

The most serious flaw in the Model State Emergency Health Powers Act is that it ignores the diversity of state government structures and state constitutional law. It also assumes that the states have no emergency preparedness laws or procedures. When the Nebraska legislature was considering this law, the state emergency preparedness director pointed out that Nebraska, as with all other states, had passed detailed emergency preparedness laws in the mid-1990s as part of a federal mandate. These laws give the states both the

necessary powers and the organization to carry them out, but in a legally responsible way. Rather than overriding existing state laws, the emergency preparedness laws attempt to co-exist with them. This is critical because public health law, more than any other area of law, is a creature of individual state history, state constitutional provisions, court precedent, and the state's physical and political environment. It is seldom codified in a single place, but usually is spread through many different parts of the state law and constitution.

The Model State Emergency Health Powers Act cuts across all these interlocking laws and traditions and will have unpredictable consequences, including generating state and federal constitutional law problems which may ultimately disrupt public health law practice. It is especially troubling that the Act attempts to specify where the ultimate state authority should lie for specific public safety concerns, which will encourage conflicts in authority, rather than clarify it. The MSEHPA also abolishes the long term checks and balances developed by state courts and political institutions that serve to keep public health agencies from abusing their broad powers. This led Professor George Annas, a leading authority on medical law and ethics and the legal editor of the New England Journal of Medicine, to write:

> "All sorts of proposals were floated in the wake of the September 11 attacks — some potentially useful, such as irradiation of mail at the facilities that had been targeted, and some potentially dangerous, such as the use of secret military tribunals and measures that would erode lawyer–client confidentiality, undermine our constitutional values, and make us less able to criticize authoritarian countries for similar behavior. I think the Model State Emergency Health Powers Act is one of the dangerous proposals."[14]

What is the Real Problem with the Public Health System?

The fundamental problem with our response to bioterrorism is not inadequate legal authority. It is that health departments do not have adequate political and economic support. One consequence of this lack of public support is that many health department positions, from directors to the front-line inspectors, are staffed by individuals who are not properly trained and do not have adequate experience in public health practice. This was documented in the IOM report, The Future of Public Health, in 1988 and all indications are that the skills of public health departments have not improved since that report. The inability to respond to a bioterrorism threat is just an extreme example of the general inability to respond to public health threats ranging from food borne illness to emerging infectious diseases and the growing threat that antimicrobial resistance will reverse much of our progress in conquering infectious diseases.

The major legal problem is the dearth of skilled public health law practitioners and an informed judiciary, not that existing public health laws provide inadequate authority.

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[14] George Annas, Bioterrorism, Public Health, and Civil Liberties, 346 N Engl J Med 1337 (2002).

There are instances where state laws do need to be strengthened. In most cases, even these states had adequate authority in 1960 to manage any public health threat. They lost the authority in the 1980s and 1990s as legislatures responded to pressure by civil libertarians to limit the state's right to collect information about communicable diseases and to impose personal restrictions without lengthy and costly legal proceedings which shift decisionmaking from public health professionals to judges. Most state public health laws and constitutions provide enough power to deal with bioterrorism and other public health threats, if the existing laws are used appropriately by skilled practitioners who have the trust of their communities.

What Should Be Done?

Each state should develop a plan to coordinate emergency services personnel, the National Guard, and public health departments to respond to major public health threats. These may be due to bioterrorism or more mundane threats such as chlorination failure in a municipal water treatment system or the arrival of an international traveler with a serious communicable disease. Most states have already made significant progress with such plans as they apply to other emergencies and natural disasters. What is missing from most of these plans is an honest appraisal of the resources necessary to carry out large scale actions. The smallpox vaccine program provides a good example of the problem.

Even the relatively small scale roll out of the smallpox vaccine for health care workers has overtaxed many health departments, and the failure to anticipate practical problems such as compensation for injuries has caused health care workers to refuse vaccination. The CDC's proposed plans for managing a smallpox outbreak, which most states are adopting, are very simplistic and ignore problems such as controlling access to health care facilities, the impracticability of having large numbers of persons come to central vaccination sites rather than having health care workers go into the community, and the provision of food and medical services to persons who are asked to quarantine themselves at home. Trying to enforce these unsound plans with a Draconian law is impossible and may lead to large scale civil disobedience. It is much more important to develop realistic contingency plans that the public will accept than to adopt the MSEHPA in the hopes that bad public health planning can be enforced at the point of a gun.

If there are things the state believes that it cannot do under its existing laws, it should seek advice from lawyers who are expert in dealing with state agency laws, rather than personal liberties law experts. The best source would be administrative law practitioners in top business law firms who could assess whether the state really needs to revise its laws and how it can do so in the least disruptive way. Whenever possible, this should be done through administrative regulation and executive orders, which provide more flexible responses than statutes.

Each state should start a longer range process to study the structure and staffing of public health departments to assure adequate expertise and training of all key personnel and, as

much as possible, to replace political appointees with skilled public health professionals, especially physicians who are certified public health specialists.

Each state should begin the process of studying its public health laws by working with public health practitioners to find areas where there is inadequate authority or conflicting mandates. These statutory problems should be remedied as simply as possible before states attempt wholesale revision of their public health codes. Since one of the major impediments to effective public health law practice is the absence of any public health law practice guides, the state should prepare a clear guide to public health law practice in the state. This will help the city, county, and state attorneys who assist in the front line work of public health enforcement. The LSU Law Center will be developing templates to help states with these projects.

Each state should also address the lack of professional opportunity in public health law practice. Finding expert legal support for public health poses a special problem because most lawyers who provide public health legal services work for city, county, or state legal departments, not the public health departments. These lawyers do not identify themselves as public health lawyers and do not belong to public health professional associations such as the American Public Health Association (APHA). There are no professional organizations for public health lawyers and few opportunities for the private practice of public health law. City, county, and state legal departments do not provide career paths for public health lawyers. Public health legal work often goes to the most junior lawyer in the office, who will then pass it to the next lawyer as soon as possible. The result is that there are very few career public health attorneys and few legal departments with any personnel skilled in public health law.

Conclusions

There is no need for any state to enact the Model State Emergency Health Powers Act. It is critical to avoid overreaction and the passing of ill-conceived legislation during a time of crisis. States should determine what changes in their own laws will allow them to carry out their state emergency management plans, and make only those changes. In most states, these changes will be minor or will not be necessary at all. States should evaluate their legal support for their public health agencies and develop public health law career tracks that will attract and retain the best possible legal talent in public health law practice.