# Law, Federalism, the Constitution, and Control of Pandemic Flu

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I. INTRODUCTION

In a given year most communities in this country are unaffected by major disasters – the ones significant enough to be declared by the President. However, with a longer view, the prevalence of catastrophic events is much different. An analysis of disaster declarations over the past fifteen years shows that the vast majority of counties in the entire nation experienced a major disaster declaration at least once in this period.

The kind of disaster risk a community faces usually depends on geographical location. Ohio is not at a high risk for hurricanes but is subject to relatively frequent flooding and tornadoes. New York does not experience many earthquake disasters and is not in the path of “tornado alley” located in the mid-west, but it does experience flooding, ice storms, and the occasional hurricane.

One threat all communities are susceptible to, however, is the spread of contagious disease. Though the probability of a pandemic outbreak on a mass scale is uncertain, influenza pandemics tend to occur every few decades. Public health officials remain convinced that a pandemic flu is on the horizon whether of the widely publicized avian influenza strain or from some as yet unknown strain of the virus. Efforts and funding have poured in for research, planning, and exercising a variety of pandemic scenarios. Most of these resources became available only after the terror attacks on September 11, 2001 and the anthrax mail attacks several months later.

Attention to the need for preparedness for emergencies involving the health of the public has also been stimulated by the aftermath of Hurricane Katrina in 2005. Although hurricanes are not commonly viewed as “health events,” Katrina exposed the direct link between catastrophic damage to structures and community infrastructure and the public health. Take away working electric power, potable public water and working sewage systems, and cover a community with contaminated floodwaters, and disease will not be far away. Additionally, Hurricane Katrina showed

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that even in communities spared of hurricane force winds and flooding, a 
public health emergency can be and was created by a massive influx of 
evacuees dislocated from their homes, communities, jobs, medical care 
systems, and social support networks.

While there are an extraordinarily wide range of legal issues that 
will be faced by attorneys in a public health emergency, these issues can 
be categorized into two basic areas: legal authority and cost shifting. In 
reviewing the first, legal authority, we explore the authority of government 
to act to protect public health – both the extent of authority and restrictions 
the law places on whether actions are legal. Even though their primary 
interest during a pandemic flu outbreak will be saving lives and protecting 
public health, government officials also have an interest in knowing 
whether an action would subject them to the risk of criminal prosecution, 
major criminal penalties or to a career ending investigation. While the 
powers of government to protect public health are broad, there are 
significant constitutional and equitable tensions between individual rights 
and government police power, and also between individual rights and 
broad community interests. The law seeks to distinguish – even in 
emergencies – between government action that protects the public 
generally from demonstrable risks and fairly distributes the costs incurred 
in catastrophic events, and actions taken based on racial or ethnic or 
cultural or socioeconomic biases that tend to ensure the resources go to the 
rich and the powerful. The history of the exercise of government’s power 
to act to control an outbreak of disease is particularly illustrative of these 
tensions.

A second arena in which the lawyer has a significant role is in 
efforts to shift the cost – the loss suffered by the lawyer’s client as a result 
of a disease outbreak or other public health emergency. Every 
catastrophic event necessarily has a major economic impact, such as the 
cost of the personnel required to respond to an event, the cost of repairing 
or replacing facilities and equipment and supplies used in the emergency, 
and the lost income that would have been received had normal medical 
services not been disrupted by the event. Every catastrophic event will 
also impose very real hardship on victims who get sick or are hurt or lose 
wages. One of the key roles of lawyers in disasters is to protect their 
clients from becoming the ones that ultimately pay the economic cost of 
catastrophic events. Lawyers do so by seeking to minimize the risks of 
their client’s liability and by seeking to transfer responsibility for disaster 
costs to someone else, not just through litigation but also by working to 
ensure eligibility for insurance coverage or for federal assistance. These 
efforts to shift the economic burden of a disaster are natural and 
predictable. Further, how much of the burden gets shifted will depend not 
just on standing legal rules of general applicability but also depends on the 
enactment of disaster-specific laws providing special assistance as 
legislators respond to tragedy faced by their constituents.
This article discusses developments in only one type of cost shifting that is critical to planning for pandemic flu response: the rules governing the scope of immunity faced by government contractors tasked with assisting in pandemic flu response efforts. For while the liability system is intended to ensure that compensation is paid to victims by those whose negligence hurt them, it is critical that this system not interfere with government’s efforts to control and limit the total harm suffered by its residents as a result of a public health or other emergency.

A. Government Legal Authority to Protect the Public Health in Emergencies

1. Crisis Phase

Government officials must have and generally do have adequate legal authority to take action to protect their jurisdictions during disasters. Indeed, when a threat to lives, health, or property is imminent and obvious, and prompt action is required to save lives and property, government executives at every level of government, from the President, to federal agencies such as the Secretary of Health and Human Services to state Governors and their state public health officers, to county and local executives, have broad authority to act quickly even if it requires the expenditure of significant moneys and even if it affects individual liberty and property interests. The Robert T. Stafford Disaster Response and Emergency Assistance Act, for example, allows the President to take actions that are “essential to meeting immediate threats to life and property,” including but not limited to search and rescues, and providing shelter, food, medicine and medical care, communication, transportation, public warnings, and more.3 The President is authorized to “use the authority and resources of any federal agency, with or without reimbursement,” in support of state and local government efforts to save lives, protect property, and the public health and safety.4 State governors have similar broad powers to protect the public welfare in emergencies, including ordering evacuations, and even (as in this excerpt from the law in Connecticut) the power to modify or to suspend in whole or in part “any statute, regulation or requirement . . . whenever in his opinion it is in conflict with the efficient and expeditious execution of civil preparedness functions.”5 In a sense, provisions like this are a special grant of power to the executive of the Legislative branch’s treasured powers to appropriate funds and to enact laws.

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4 Stafford Act Sec 403; 42 USC § 5170b.
Governmental response failures during Hurricane Katrina stimulated many investigations of what went wrong, including a review of whether government authority was lacking so that laws should be changed to make sure officials are not caught “flat footed” again. In virtually every instance, however, it turned out that the problem was not a lack of government authority, but rather either a lack of understanding of the authority and to whom it was delegated, or a failure to implement existing legal authority.6

Indeed, I submit that, what is far more important than enacting new laws to provide more legal authority for action during response to a disaster event is developing a common understanding by responders of what that broad authority is, and how it can be exercised. Legal authority to act must be made operational through the development and then exercising of plans, processes, and protocols to apply during emergency events. This is a principal objective of federal efforts to develop and require state and local adoption of a National Incident Management System (“NIMS”), which is discussed further below.

2. Pre-Disaster Phase

The broad authority of executives in the crisis response phase of catastrophic events must be distinguished from the “pre-disaster” and “post-disaster” phases. Government executive authority is much more limited when the risk to lives and property is not imminent and obvious, when there is no hurricane or other hazard identified from satellite pictures, or when a pandemic flu has not emerged and there are only worrisome indications of disease in bird populations overseas. Yet it is in this period that the most cost-effective measures to reduce the impact of natural or man-made hazards can be taken. For example, enactment and enforcement of building codes can assure that buildings survive high winds or earthquakes. Land use planning can assure structures are built out of the floodplain or are elevated out of harms way. Executive authority is more limited in the period before a disaster because there is time for all institutions of government, both the executive and the legislative branches, to set priorities, evaluate options for reducing risk and enhancing preparedness, and consider the availability of appropriations to finance mitigation and preparedness. What mitigation measures are appropriate? How much should be spent? Who should spend it? What measures should the government require the private sector to perform and under what legal authority?

These questions are inherently political because they involve the balancing of risks against costs. They involve a determination by the

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legislature specifying the amount of government funds to be spent on disaster mitigation and preparedness, and to whom they will be appropriated. Governments must struggle with these issues to prepare for an outbreak of pandemic flu even if governments are confident that the threat of an outbreak is real. It may be clear that there will be a need for increased hospital beds during a pandemic disease outbreak – but it is certainly not clear how to fund and who should or can fund the cost of building surge capacity, or of maintaining it until the outbreak of pandemic actually arrives. In a system of government which rests on a balance of power between the executive branch and the legislative branch, legislatures will not, without imminent threats to life and property, give up their most treasured prerogatives – the power to make law and the power of the purse – to governors or presidents.

Thus, the difficulty in implementing disaster mitigation options – even though they are far more cost effective than actions taken during actual response – is that by definition, predisaster mitigation occurs when everyone is aware that the catastrophic event may well not arrive this year or even the next year. As a result, in the ever tight fiscal environment, expenditures to mitigate the risk from hazards are frequently deferred.

3. Post-Disaster Phase

Similarly, after a crisis is brought under control and there is no longer an imminent threat to life, property, public health, and safety requiring immediate action, the broad scope of legal response authority dissipates and the scope of authority is reduced as needed to protect other values and individual rights and to resume normal roles.

In the recovery phase of a disaster decisionmakers face once again the reality of limited resources. Who will pay for what happened? Can anyone be held liable for damages? Since we cannot pay to restore all damage or to compensate for all pain and lost income, to whom will assistance be provided? How can governments ensure this disaster does not happen again, by providing funding or regulatory incentives encouraging disaster mitigation?

During all phases of emergency management, i.e., mitigation, preparedness, response, and recovery, governments grapple with an inherent tension in disaster law. On one side of the scale, governments are concerned with providing incentives to encourage physical preparedness (e.g., stronger structures) and financial preparedness (e.g., insurance). On the other side of the scale governments are concerned with providing assistance to those whose lives and property have been devastated by a catastrophic event that they either could not have, or did not, prepare for. For example, Congress, frustrated by repetitive payment of flood disaster assistance, might and did pass a law saying that it will not pay for disaster
assistance unless the grant recipient agrees to be insured.\textsuperscript{7} Or, Congress might, and did, mandate a reduction in assistance paid for damage to the same building caused by the same kind of hazard event a second or third time.\textsuperscript{8} Or, Congress might, and did, not pay disaster assistance for uninsured structures located in the floodplain.\textsuperscript{9} Or, Congress might, and did, pass a law restricting eligibility of illegal aliens for housing assistance.\textsuperscript{10} When legislatures pass these laws, as Congress has, then a government bureaucracy has to keep track of these rules, and also try to implement them in a way that is not suicidal as a political matter in cases of genuine hardship.

B. Constitutional Underpinning of Emergency Response

In the United States Constitution, the sovereign states granted certain powers to the federal government. For purposes of emergency management, the most important of these powers are: interstate commerce, national defense, and power to tax and spend for public welfare.\textsuperscript{11} But the sovereign states retained for themselves the powers that they did not grant to the federal government. The most important of these powers, for purposes of emergency management, is the general police power.

While over the last two centuries the scope of the Federal government’s enumerated powers has grown, fundamentally it is the states that still have the broadest police power and can wield it to protect the public welfare of their citizens – by taking extraordinary actions to save lives, protect property, and protect the public health and safety.

C. Emergency Management Simplified

Emergency management begins with “first responders,” such as the local police, fire and emergency management personnel. Businesses and a lot of volunteer organizations are also among the first to respond to catastrophic events. They respond first because they reside there, are physically closer to the scene, and may even be victims of the disaster.

First responders do not pick the disaster that befalls them. They will be on the scene first to respond not only to tornados, ice storms, earthquakes, and hurricanes, but to chlorine leaks from derailed railway tank cars, bombings at an abortion clinic, or a terrorist’s release of a contagious biological agent.

\textsuperscript{7} 42 U.S.C. § 5154.
\textsuperscript{8} 42 U.S.C. § 5172(b)(2).
\textsuperscript{9} 42 U.S.C. § 5172(d).
\textsuperscript{10} 8 U.S.C. §§ 1611, 1621.
\textsuperscript{11} U.S. Const.art. I, § 8, cl. 1, 3, 12.
If the event is large enough to warrant support, State reinforcements will be next on the scene. In cases where the state is overwhelmed and requests federal assistance, the federal government will send federal resources, but generally it will take at least forty-eight to seventy-two hours after the event for significant reinforcements to arrive.

In effect, emergency management systems mirror the federal structure of the Constitution. Local authorities are first on the scene. As the incident expands local incident commanders require and call for help. State resources help where local authorities are overwhelmed. Federal sources of assistance respond either in assisting state and local governments in response or asserting federal exclusive or concurrent jurisdiction.

1. Who is In Charge? – Federalism and Coordination of Multiple Responding Organizations

What is the operating and management environment in emergency response like? Picture a disaster area now populated with local, state, and federal responders, drawn from multiple agencies at each level of government and from private and non-profit organizations and volunteers. Each response group has its own chain of command. It should be noted that these responding organizations have widely disparate organizational cultures. Police, fire and military organizations do not generally approach problems in the same way that environmental regulators, housing officials, medical professionals and social workers do.

Given the multiplicity of organizations and responders at a disaster site, it is less helpful to ask, “who is in charge?” than “who is in charge of what?” In our federal system there are multiple levels of government and multiple chains of command. The Federal government is quite clearly in charge of the deployment and command of federal assets and personnel, and can exercise federal legal authorities. The state government is similarly in charge of state assets, personnel, resources, and legal authorities. Further, the owners or managers of private companies own property and have employees and funds that they can direct in support of their own response priorities.

Some observers have concluded that the Federal government should simply “take over.” The reality is that there is very limited constitutional or legal basis for the Federal government to give orders to most of these types of responders to perform particular missions.12 Indeed, in Printz v. United States13 the Supreme Court held that:

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13 Printz v. United States, supra n. 12.
Congress cannot compel the States to enact or enforce a federal regulatory program. Today we hold that Congress cannot circumvent that prohibition by conscripting the State’s officers directly. The Federal government may neither issue directives requiring the States to address particular problems, nor command the States’ officers, or those of their political subdivisions, to administer or enforce a federal regulatory program.\(^{14}\)

There may be a type of terrorist event in which the federal government, acting under its national defense power, “took charge” of an event. Certainly, the federal government, after making the appropriate findings, could deploy the military, federalize the National Guard, establish a secure border around an area, and simply prohibit non-federal responders from entering a geographic area. Note, however, that this strategy results in reducing the total resources available to respond to a humanitarian and economic catastrophe.

The federal government does wield extraordinary influence over the actions of other players in emergency response by reason of its technical expertise and its checkbook (e.g., the federal government reimburses state and local governments for “eligible” emergency expenses, and can and does influence those governments’ actions by advising which expenditures it will pay for). However, the federal government does not employ or supervise the employees of other organizations at a disaster site.

Given the number and the diversity of organizations that respond to a disaster and the lack of a single “commander” of those resources, it is critical that these institutions “speak the same language.” This need is not limited to languages such as English, Spanish, Vietnamese, and so on, although these languages are important and indeed, one of the new statutory requirements enacted by Congress is for the FEMA Administrator to study, in consultation with state and local governments, “what population groups there are with limited English proficiency which must be taken into account in planning for an emergency or major disaster.”\(^ {15}\) Speaking the same language in emergency response also means developing a common vocabulary used to describe resources. The resources required to respond to an event will more likely arrive and can be deployed more effectively if requesting jurisdictions know how to describe what they need, know where those resources can be found, and have arrangements in place so that they can be requested and delivered.

\(^{14}\) *Id.* at 935.

quickly. In addition, any legal issues that will predictably slow response must be identified and addressed ahead of time so that they do not delay response.

One of President George W. Bush’s initiatives after the 9/11 terrorist attacks sought to achieve this goal. Homeland Security Presidential Directives (“HSPD”) Numbers 5 and 8 required the Department of Homeland Security (“DHS”) to create a National Incident Management System, or “NIMS,” that would apply to all types of events. It then required federal agencies to comply with NIMS, and urged state and local governments to follow or run the risk of losing federal funds. At the outset, NIMS was created by executive fiat and, frankly, did not work very well during Hurricane Katrina. Implementation was still in its infancy and many federal, state and local decision makers did not even know what it was. Surprisingly, NIMS' failure during Hurricane Katrina did not lead to its downfall, but rather to renewed calls for NIMS training and to legislation codifying key elements of NIMS into the Homeland Security Act. For example, the Act now requires that the FEMA Administrator enter into a Memorandum of Understanding with State, local and tribal governments and “organizations that represent emergency first responders, [which now includes the private sector to] collaborate on developing standards for deployment capabilities, including credentialing of personnel and typing of resources likely needed to respond to natural disasters, acts of terrorism, and other man-made disasters.” Thus, given the complex emergency operating environment, the President issued executive orders to create an effective management system for emergencies. In order to make that management system work, Congress and the President enacted laws and required negotiation and execution of agreements.

Note that this discussion of the emergency operating environment has turned naturally into a discussion of legal matters: Congress’ enactment of laws requiring greater coordination among the governments and private and non-profit organizations that must work together in disasters. This discussion has also highlighted the importance of negotiating agreements – memoranda of understanding and mutual aid agreements – which carry with them some thorny legal issues of liability,


indemnity, reimbursement, and so on. However, we cannot leave a discussion of legal authority in emergencies – particularly where the focus has been on an emergency caused by disease outbreak – before looking specifically at the powers available to government that apply specifically to disease. These public emergency health measures are critical to protection of the community from a disease outbreak. The measures also highlight the constitutional tension between the government’s police power to protect the public and the individual rights of those who make up that public.

2. Public Health Emergency Powers

Protection of the public health from communicable disease is one of the critical responsibilities of government. Mandatory disease control measures have a very long history, beginning in this country from the very early days of the colonization of the Americas. Our success over the last century in controlling contagious diseases has meant that we have had relatively little recent experience in the large-scale application of mandatory disease control. But authorities can wield a wide range of public health powers to quell and lessen the severity of disease outbreaks. They include disease surveillance and reporting requirements, mandatory treatment and inoculation, impounding unsafe or diseased property, and the power we will explore more fully here: quarantine and isolation. As we will see, the history of quarantine is a history characterized by broad deference given to health authorities, mixed with a real risk of abuse and prejudice whenever the threat and the measures needed to control disease are not clearly understood.

3. Quarantine and Isolation: Definitions

Quarantine and isolation are distinct concepts. A patient is placed in isolation after he or she is diagnosed with a communicable disease. The objective is to reduce the likelihood that the patient’s disease will be communicated to other patients. From a legal standpoint, patients in isolation share a key characteristic: they have actually been diagnosed as having a communicable disease and therefore demonstrably pose a threat to the health of those who might come in contact with them. The fact that they are already infected also means that they may be more amenable to having their movements restricted: they frequently are already bedridden, they know that specialized health care will be more readily available in places like hospitals, and they can usually be persuaded that they should try not to infect others.²⁰

²⁰Note that tuberculosis (“TB”) patients, even after diagnosis, are not always willing to comply with isolation orders. In May 2007, Andrew Speaker, diagnosed with a dangerous drug-resistant strain of TB violated TB regimen requirements in making two transatlantic trips. Upon re-entry into the United States, Speaker became the first TB patient since 1963 to be put under isolation by the U.S. government. See WASHINGTON
By contrast, the word quarantine is used to describe people who have not been diagnosed with any communicable disease and do not show symptoms, but are determined, or perhaps just suspected by authorities, to have been exposed to a communicable disease. Thus, persons subject to a quarantine order are not and will not feel sick.21 They may not even believe they have been exposed, and many still have responsibility to provide for, feed, or care for their families.

4. Purpose of Quarantine: Increasing “Social Distance”

The reason that quarantine measures are adopted is that it takes some time after exposure to a communicable disease before any symptoms of disease appear. Also, in many instances the person becomes a carrier of the disease and can spread it to others before symptoms appear. As a result, the state has a real interest in separating the exposed from the rest of the population until the state can be establish, by the presence or absence of symptoms at the end of the disease incubation period, whether the person has contracted the disease. What public health officials aim to do with a quarantine order is to reduce the “social distance” between potentially infected persons and uninfected persons.

Quarantine can be implemented in a number of different ways, from physically seizing exposed persons and placing them in a detention facility, to directing that exposed persons stay in their own home until the incubation period has ended. Further, traditional quarantine is only one of many different measures that can be adopted to reduce the transmission of disease. A number of other measures can increase “social distance” and reduce the risk of transmission of disease. For example, government can order that schools and day care centers be closed, essentially directing that teachers and children take “snow days” for an extended period. Officials can order the cancellation of large public gatherings. They can encourage workers to stay at home or telecommute. In addition, governments can reduce transmission by informing the public on how to screen for symptoms or by distributing aids such as surgical masks, barrier precautions, and hand hygiene. How effective each measure will be in increasing “social distance” depends radically on the characteristics of the disease itself, its incubation period, method of communicability, treatment options, communicability of disease by patients who show no symptoms, and so on. These public health measures also directly restrict the individual freedoms protected by the Constitution because quarantine directly restricts individual liberty, as does mandatory treatment and

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21 Excerpt from CDC’s division of Global Migration and Quarantine website, http://www.cdc.gov/ncidod/sars/isolationquarantine.htm (last visited April 7, 2008).

inoculation. As such, and not surprisingly, some public health emergency orders have led to litigation.

D. Balancing Collective and Individual Rights: Jacobson v. Massachusetts

The seminal case explaining the scope of government authority to impose mandatory public health measures is *Jacobson v. Massachusetts*. In 1902, Henning Jacobson, a minister, refused to be vaccinated after the City of Cambridge passed an ordinance finding “smallpox prevalent in the city and continues to increase” and directed vaccination of all inhabitants of city except children who present a certificate signed by physician that they are unfit subjects of vaccination. State law authorized city boards to require and enforce vaccination and specified a fine of five dollars for anyone who refused to comply. Jacobson refused to be vaccinated because he viewed vaccination as unsafe and ungodly. He appealed his fine all the way to the US Supreme Court.

The Court responded with a stirring decision supporting the right of communities to use their police powers to protect the public welfare. In the words of Mr. Justice Harlan:

> Real liberty for all could not exist if each individual can use his own, whether in respect of his person or property, regardless of the injury that may be done to others. . . . Upon the principle of self defense, of paramount necessity, a community has the right to protect itself against an epidemic of disease which threatens the safety of its members.

However, this collective right of self-defense was not absolute. Justice Harlan qualified the scope of the police power to restrict liberty for public health as follows:

> Police power of state must be held to embrace, at least, such reasonable regulations established directly by legislative enactment as will protect the public health and safety. . . . subject, of course, that . . . no rule . . . or regulation . . . shall contravene the Constitution of the

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24 *Id.*

25 *Id.* at 653.

United States, or with any right which that instrument gives or secures.\textsuperscript{27}

The most significant rights that a public health order cannot contravene are the rights provided by the Fifth and Fourteenth Amendments to the Constitution, which prohibit federal and state governments, respectively, from taking an individual’s liberty or property without “due process.”\textsuperscript{28} A good example of what “due process” means in the context of public health emergency orders can be found in the two-year saga of \textit{Best v. Bellevue Hospital}.\textsuperscript{29} This case involved the isolation of Mr. Best, who had been diagnosed with tuberculosis (“TB”).\textsuperscript{30} However, Mr. Best refused to complete his TB drug regimen and could have developed a drug-resistant strain of TB, so the Health Department issued an order detaining him and requiring completion of his treatment.\textsuperscript{31} Mr. Best filed suit against the Health Department and hospitals, and the courts reviewed whether Mr. Best was dangerous to himself and the community and whether the State gave Mr. Best an adequate hearing. In the end, the Health Department prevailed, but only after four hearings, which resulted in over seven administrative, state, and federal judicial orders over the course of two years. During this two-year saga, the federal court declared that in order to detain a patient under the health code, New York had to comply with both procedural due process (the right to notice; the right to counsel; the right to hearing upon request), and substantive due process (“the right to a particularized assessment of an individual's danger to self or others”).\textsuperscript{32}

1. Procedural Due Process

On procedural due process, the Court described the factors considered in determining constitutionality of detention procedures as follows:

First, the private interest that will be affected by the official action; second, the risk of an erroneous deprivation of such interest through the procedures used, and the probable value, if any, of additional or substitute procedural

\textsuperscript{27} Id. (emphasis added).

\textsuperscript{28} U.S. Const. amend. V: “No person shall be . . . deprived of life, liberty, or property, without due process of law.” U.S. Const. amend. XIV: “nor shall any State deprive any person of life, liberty, or property without due process of law . . . .”


\textsuperscript{30} Id.

\textsuperscript{31} Id.

safeguards; and finally, the Government's interest, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirement would entail.\textsuperscript{33}

The Court found that the procedures followed by the New York City Health Department had indeed been constitutionally adequate. Mr. Best had been given notice of the order and of the basis for the detention; he had been provided counsel; and he had clearly had an opportunity – indeed, a number of opportunities - to challenge the Health Department’s order.

2. A Digression: Procedural Due Process and the Challenge of Mass Incidents

The resources dedicated to giving a single individual, diagnosed with a communicable and extremely dangerous disease, his multiple days in court are sobering as we consider how procedural due process would work in a large-scale disease outbreak such as the case of pandemic flu. How would Health Departments provide procedural due process when mandatory health orders are issued against thousands or tens of thousands of people? It is difficult to find an answer in case law, since courts in the United States do not have recent mass quarantine experience. It is clear that in the event of a mass incident, requirements for individual hearings will likely be relaxed.

Certainly, quarantine measures can be enforced before an opportunity for a hearing is provided. We can make analogies to mass arrests during riots and protest demonstrations.\textsuperscript{34} Several years ago, in an effort to clarify mass quarantine procedures, New York City officials amended Sec. 11.55 of the New York Health Code\textsuperscript{35} to specify how long individuals could be detained without a hearing and to provide for procedures to apply in large scale quarantine events.\textsuperscript{36}

The most important recommendation for communities as they prepare for a potential pandemic flu, is to have their legal departments review applicable statutes and ordinances in their jurisdiction and develop

\textsuperscript{33} Best v. Bellevue Hosp., supra n. 29.

\textsuperscript{34} Jennifer Steinhauer, Final Tally Awaits Police and Protester, N.Y. TIMES, Sept. 8, 2004, http://www.nytimes.com/2004/09/08/nyregion/08detain.html?_r=2&oref=slogin&oref=sl ogin (last visited April 07, 2008). During the 2004 National Republican Convention nearly 2,000 protesters were arrested and detained for more than 24 hours.

\textsuperscript{35} New York City, N.Y., Tit 24, Health Code, § § 11.5.

plans for implementing a large scale quarantine. These plans must involve not just the work required of the health department, such as developing forms for quarantine orders and sample affidavits. These plans must also consider the other actors who are part of providing procedural due process. How will notice of the order be served, and by whom? How will counsel be recruited and contacted? What measures will be employed to protect safety of hearing officers and participants (“in person” vs. electronic or telephonic hearings)? How will hearings be provided to the non-English speaking population?

3. Substantive Due Process

Courts must also determine whether a public health order violates a person’s substantive due process rights; in other words, whether there is a rational and reasonable basis for the order. This analysis is in essence a balancing of the collective right of self defense enunciated in *Jacobson* against individual rights to liberty and property. As in the case of procedural due process, there are relatively few recent cases defining the Constitutional requirements for restricting individual liberty during public health emergencies.

We can be confident that in these cases, courts will give great deference to the judgment of public health officers, as noted in dissent by Judge Hydrick of South Carolina’s Supreme Court in 1909:

> In dealing with such matters, a wide range of discretion must be allowed the local authorities, and they should not be interfered with, unless it is clearly made to appear that they have abused that discretion to the probable injury to health or life.\(^\text{38}\)

If public health officials set out in their order the nature of the threat posed by communicable disease and how important control of that disease is to the collective “right of self-defense,” courts will certainly give the benefit of the doubt to their expert judgment.

4. A Second Digression: Substantive Due Process, Fear and Prejudice

Indeed, the discretion normally provided to public health officials to control communicable disease is so broad, and our understanding of exactly how a disease is transmitted so uncertain, that public health officers and courts alike may find that their view of what is necessary to

\(^{37}\) Model State Public Health Emergency Powers Act, NCSL, Larry Gostin, 2001 – which states, “Isolation and quarantine must be by the least restrictive means necessary to prevent the spread of . . . disease to others . . . .”

protect the community is heavily colored by the fears and prejudices of the majoriti.
One example of a case based on bad science and social prejudice was Virginia’s adoption of an order requiring compulsory sterilization of women who were declared too stupid to have children. Justice Oliver Wendell Holmes, in one of his lesser moments as a justice, upheld the order, saying, “The principle that sustains compulsory vaccination is broad enough to cover cutting the Fallopian tubes. Jacobson v. Massachusetts.\(^{39}\) Three generations of imbeciles are enough.”\(^{40}\) The Jacobson balancing test has also been used to justify internment of Japanese American citizens during World War II, and was cited by Justice Thomas in his concurring opinion defending the Bush Administration’s enemy combatant doctrine.\(^{41}\)

Prejudice can also deter officials from taking action that might in fact be appropriate to protect the public health. In Kirk v. Wyman, for example, the majority overturned a Board of Health quarantine order based largely on race/class stereotypes. According to the majority, an elderly “lady of culture and refinement,” who had contracted anesthetic leprosy while serving as missionary in Brazil, could not be detained by the Board of Health in the city’s pesthouse that had previously been used to detain negroes with smallpox.\(^{42}\) The majority simply found it unfathomable for an upper-class and (presumably white) lady to be so treated.\(^{43}\)

How do we ensure that another Buck v. Bell does not emerge in measures taken to protect against pandemic from a poorly understood virus? The answer lies less in law and more in how public health officials and emergency and political officials carry out their responsibilities, base their decisions on credible science, coordinate with each other, and communicate with the public rather than on the requirements of our Constitution – but let’s get back to some further implications of substantive due process.

5. Substantive Due Process and Social Distancing Measures

As in any balancing test, how much of a threat to the community must exist, and how the threat is based on science rather than supposition, will depend on the situation as it comes before the court. A court will be quite aware that pandemic flu poses a real threat. However, two principles that have support in the case law may significantly affect how social


\(^{40}\) Buck v. Bell, 197 U.S. at 25.


\(^{43}\) Id.
distancing measures can be implemented. First, to the extent that
individuals and families are deprived of the ability to meet their basic
needs (e.g., food, shelter, medical care) by movement restrictions imposed
by the state, the state creates for itself an obligation to provide for those
basic needs. While I have not seen a quarantine case so stating, cases
finding that prison conditions are so bad as to be unconstitutional, such as
overcrowding, inadequate access to medical care, may help indicate the
scope of these requirements.\textsuperscript{44}

Second, despite the great deference given to public health officials,
officials cannot justify their orders simply by stating that the order will
prevent the transmission of the disease. They must also show that they
could not have controlled the spread of the disease with different public
health measures that did not have such a significant impact on individual
liberty. The United States Constitution provides that states cannot deprive
persons of their “life, liberty, or property without due process.”\textsuperscript{45} In the
\textit{Best v. Bellevue} case mentioned earlier, this language was interpreted to
mean that if the public health objective can be achieved by measures short
of physically locking up those subject to an order - if there are less
“restrictive alternatives” to detention – then the formal quarantine order
may well be an unreasonable restraint and violate the constitution. Some
states have even adopted statutes that include the least restrictive means
necessary test, following the examples set by the Model State Emergency
Health Powers Act.\textsuperscript{46}

Recall the range of social distancing measures available to public
health officials mentioned earlier in this paper:

- “Snow days” for teachers and children: Closing of schools and
day care centers.
- Cancellation of large public gatherings
- Work quarantine (exposed nurses must not come home, but can
continue to work, with adequate personal protection)
- Encourage telecommuting
- Public communication: how to screen for symptoms
- Distributing or requiring use in public of surgical masks,
barrier precautions, and hand sanitizers

\textsuperscript{44} \textit{Wellman v. Faulkner}, 715 F.2d 269 (C.A.Ind. 1983) (holding that medical
care at prison was inadequate by constitutional standards and that the prison was
unconstitutionally overcrowded).

\textsuperscript{45} U.S. Const. amend. XIV.

\textsuperscript{46} Model State Public Health Emergency Powers Act, NCSL (2001), which
suggests, “Isolation and Quarantine must be by the least restrictive means necessary to
prevent the spread of . . . disease to others . . . .” California, New Hampshire, and
Connecticut are among some of the states which have adopted Isolation and Quarantine
measures that reflect the least restrictive means test. Cal Health & Safety Code 120130,
Each of these measures is much less intrusive to individual liberty than detention. Additionally, depending on the characteristics of the disease, some of these measures may be as effective, or more effective, than mandatory detention in a quarantine facility. If so, a court could well find a quarantine detention order to be unconstitutional. More likely – given the reluctance of a judge to second-guess public health officials in an emergency - a court may require public health officials to explain, in the affidavit accompanying a quarantine order, why the more physically intrusive option was selected.

E. Lessons from Canada: SARS Quarantine Enforcement

There are important lessons that can be drawn from recent quarantines in other countries. Thus, while the United States escaped the brunt of the SARS crisis with only a few cases, SARS created a major public health crisis in Toronto, where over 30,000 individuals were quarantined, largely by a “mandatory requirement that those exposed stay home or, in the case of those providing medical care to SARS patients, remain at work with protective masks – a “work quarantine.”

Note the extraordinary legal success of the effort:

- Only twenty-seven formal quarantine orders were served
- Only ONE formal appeal was filed, and even this appeal was later voluntarily withdrawn after explanation

The success of the Toronto quarantine was largely attributable to its public communications. Frankly, communications are the key to all emergency management. Toronto established hotlines staffed by 80 nurses who received 300,000 calls. Balancing the need to disseminate information against the risk that bringing people together could help spread disease, Toronto officials conducted a number of community meetings across the city to explain what SARS was, how it could spread, what people could do to reduce the risk of contagion and to identify

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47 The list of non-quarantine, social-distancing measures have all been used in recent public health events. Some solve other problems as well. For example, work quarantine allows some health care workers to continue to work at the hospital or health care setting where they were exposed as long as they feel well and use extensive precautions re: personal hygiene, masks, gowns, etc. Factors Influencing Compliance with Quarantine in Toronto During the 2003 SARS Outbreak. Clete DiGiovanni. Vol. 2, Number 4, 2004, at 265. Biosecurity and Bioterrorism: Biodefense Strategy, Practice and Science. Mary Ann Liebert, Inc. Severe Acute Respiratory Syndrome (“SARS”) CDC. Toronto, http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5223a4.htm, Canada. 2003.


49 Id.
symptoms. Information was posted on websites in fourteen different languages, reflecting the very diverse population of the city.\textsuperscript{50}

Even with substantial voluntary compliance, however, there are factors that undercut compliance, such as lost wages or income, groceries and essential services, and boredom, which may hinder an individual’s ability or desire to abide by quarantine mandates. Wages, groceries and essential services are what individuals and families require to sustain themselves. The lesson of SARS may be that while Constitutional due process may require the state to provide food and essential services when implementing strict quarantine, no massive quarantine effort will work, as a practical matter, without accommodation of these basic needs.

\textbf{II. Special Challenge of Pandemic}

The basic model of emergency management is that people and resources from outside the affected area flood into the disaster area to provide assistance. Help arrives from the places where the disaster is not; this is why a broad network of mutual aid agreements that facilitate intergovernmental aid is such a critical part of the National Incident Management System. However, this model will be strained in a pandemic event; in a true pandemic, the emergency conditions caused by communicable disease are experienced everywhere. While there may be some variation in case rates, few communities will be comfortable with sending to other communities their own response resources. And there will likely be hiccups in the ability of the federal government to deploy its military and other personnel, who may also be affected by disease, in response operations. Thus, pandemics pose a special challenge in that they do not quite fit the model of emergency response.

A critical part of public health emergency preparedness for a pandemic – as with any other emergency – is figuring out how to make sure that the people with the skills you will need are willing to serve you in your time of need. Necessarily, governments and “first responders,” including medical care facilities, will be searching for ways to supplement their overloaded staff in pandemic events as they must in more geographically defined emergencies.

\textbf{A. Accessing Emergency Personnel: Mutual Aid}

Mutual aid is founded in the same humanitarian instinct that motivates volunteers. Mutual aid at the most basic level is simply one community or entity volunteering, when it is able, to help a community in need. Mutual aid began as nothing more than communities helping each other – frequently without any compensation, written agreements or even the pestering presence of lawyers – and informal mutual aid is still prudent for relatively minor operational deployments. During the War of 1812,
towns on United States-Canada border helped each other put fires out even though they were “at war.” Over time, as communities experienced and began preparing for more extensive mutual aid deployments, the legal issues could not be ignored. Who is authorized to send resources into another jurisdiction for mutual aid? How would they do it? Which government would be responsible for injuries caused by mutual aid workers, or suffered by mutual aid workers: the government which employed the workers and deployed them to help another community or the community needing the work that they would provide?

For skilled professions subject to state licensing requirements, such as engineers, doctors, and nurses, the governments had to specify how licensing would be handled where mutual aid personnel crossed over state lines. Finally, mutual aid agreements became more formal when the federal government determined that it could not reimburse the cost of mutual aid responders unless there was an expectation of payment for those costs that was documented by a written agreement.

B. Interstate Mutual Aid: EMAC

The Emergency Management Assistance Compact (“EMAC”) is the most important of the interstate mutual aid agreements, and the importance of EMAC deployments has been growing rapidly. In the immediate aftermath of Hurricanes Katrina and Rita, for example, 65,000 responders were from other states and deployed to Louisiana, Mississippi, and Alabama, and of these responders, 3,500 were medical personnel. EMAC has a special legal status – it is an agreement approved by Congress and adopted by statute in all of the states. Liability concerns do not weigh down state personnel deployed under EMAC because they are treated as employees of the responding state and the requesting state agrees to indemnify the responding state for liability incurred on an EMAC deployment. Professional licensing and credentialing are addressed in EMAC: a professional licensed in the responding state and deployed under EMAC is deemed licensed by the requesting state for the work.

As demonstrated during Hurricane Katrina, EMAC functioned quite effectively as a vehicle for bringing resources from one state to help another state. In fact, EMAC works so well that it is now grappling with efforts to expand coverage. All those liability protections under EMAC apply only to state personnel deployed under EMAC. Questions are now

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53 For example, at the NEMA Mid-Year Conference, the NEMA Legal Counsel Committee met to discuss, among other things, the inclusion of private sector and volunteer organizations into EMAC, Feb. 11, 2007.
being raised as to whether additional personnel can somehow be transformed into state personnel and enjoy the same liability protections applied to EMAC. Can local government employees who want to serve in a response be somehow converted into state employees for purposes of EMAC? Can private sector contractors from a state be converted into a state asset and be deployed under EMAC and receive the same liability protections? Can doctors, nurses, and pharmacists, normally independent contractors or employees of private or non-profit businesses, be converted into state personnel and receive the liability protections and the state licensing that applies to those under EMAC?

C. Accessing Emergency Personnel: Volunteers

Volunteers and volunteer organizations will also provide critical response resources in a public health emergency as they do after virtually every catastrophic event. The way that volunteers and donated goods pour into a disaster area is an extraordinary and inspiring testament to our humanitarian instincts. Some arrive spontaneously, perhaps without any special skills but with a true motivation to do what they can to help people in need. Others are activated and trained by voluntary organizations, such as the American Red Cross, which are familiar with the disaster environment and their roles in a catastrophic event. And there are also trained but unaffiliated professionals, perhaps with the specialized medical skills people really need, who are willing and even eager to volunteer.

D. Planning for Volunteers

These voluntary resources can really help emergency response but only with proper planning. If a jurisdiction has not prepared for the influx of volunteers and donated materials by preparing and exercising a donations management plan as a part of its general emergency management plan, volunteers and donations can create transportation and logistical bottlenecks, additional public health and safety risks, potential liability, and media and public relations disasters of their own. Use of volunteers is even more critical in public health emergencies because of the specialized professional expertise required to control the spread of illness and to protect the public’s health. Yet using volunteers to provide specialized medical and pharmacological means that public health officials – operating through that Incident Command System – must have an effective system for verifying the professional credentials of medical volunteers.54

Over the last several years the federal government has made a great deal of progress in developing systems such as the “Emergency

54 Jean Cox, Managing Donated Resources Following Catastrophic Events, in E. Abbott and O. Hetzel, A LEGAL GUIDE TO HOMELAND SECURITY AND EMERGENCY MANAGEMENT FOR STATE AND LOCAL GOVERNMENTS (ABA Press 2005).
System for the Advance Registration of Voluntary Health Professionals” (“ESAR-VHP”) project of the Health Resources and Services Administration. ESAR-VHP is encouraging each state to create its own database of medical professionals who have said they will want to volunteer in a public health emergency. Professionals are to be typed in a way that will allow officials to identify the particular medical qualifications of each volunteer and to have these qualifications verified so that the professionals really do have the capabilities claimed.

However, just as it was necessary to address liability issues in mutual aid agreements, liability issues must also be addressed when planning for use of volunteers. Indeed, protecting volunteers from liability was one of the key issues identified in a recent survey of public health officials. Their concern was that fear of liability would interfere with the willingness of non-profit organizations, schools, churches, and even companies to plan how they would assist in a pandemic response.

Many have questioned whether liability concerns are an important part of what motivates volunteers. Disaster sites after every disaster are flooded with volunteers, even in dangerous sites such as the World Trade Center while the fires still burned. But medical professionals face greater liability risks than most other disaster professionals, as is apparent from the size of liability premiums paid by engineers and bulldozer and crane operators with the size of medical malpractice insurance premiums.

Liability concerns of medical professionals has led to enactment, in virtually all states, of “Good Samaritan” laws that immunize emergency treatment provided in emergencies such as an automobile accident. But relying on Good Samaritan legislation to reduce liability during a public health emergency will not suffice for large-scale volunteer efforts. Good Samaritan statutes were crafted more on the model of a single physician stopping at the scene of a road-side accident, whose service is not solicited by the government or medical facility. They only apply to gratuitous volunteers, providing no protection, or at best, uncertain protection to a doctor who is given living expenses while serving in a disaster area for a non-profit organization, or for a physician who is being paid by his group practice while working in a disaster field hospital.

Nor can medical professionals rely on medical malpractice coverage to protect them from liability when providing medical care during public health emergencies. Malpractice insurance policies are generally limited to the specific practice location and do not “follow” a physician down the road into another state where triage has been established to provide care in a chaotic disaster environment. Further,

there will be patients who do not receive the same quality of care in a disaster environment as they would have received under normal conditions – and some may die or suffer permanent adverse health effects as a result.

In short, while there are many defenses to malpractice claims, potential liability exists. The potential liability is so significant, in fact, that the Disaster Response Committee of the Board of the American Red Cross has instructed the Red Cross’ Response and Recovery Division not to deploy volunteers during a Pandemic Flu event absent adequate liability protections. Given these concerns, much of the draft “Legal and Regulatory Issues Report” for ESAR-VHP, released two years ago, was dedicated to an analysis of the risk of liability faced by medical professionals.\(^\text{56}\)

One important legislative initiative now underway to deal with this problem is the development, by the National Conference of Uniform Law Commissioners, of a “Uniform Emergency Volunteer Health Practitioner’s Act.”\(^\text{57}\) A Model Statute governing registration and licensing of volunteer health professionals was adopted by the Commission in 2006, and proposed provisions covering liability and workman’s compensation issues were added in 2007. Indeed, debate on liability was so great that the Commission approved alternate versions of this section. Alternate A would provide protection both to volunteer health professionals and also to organizations – such as the American Red Cross – that deploy volunteers, as long as the volunteers have registered in one of the volunteer registration systems, such as ESAR-VHP, and practice within the general scope of their medical license. Alternate B tracks the current inadequate coverage provided by most current Good Samaritan statutes and the Federal Volunteer Protection Act;\(^\text{58}\) it provides no protection for volunteer organizations.\(^\text{59}\) Now each state must decide – as the Uniform Act is introduced in legislatures across the country – which Alternate to enact into law.

E. Liability concerns and immunity: World Trade Center Disaster Litigation

Liability issues are important to emergency managers in supplementing public health emergency response personnel; this issue is critical to the vast amount of emergency work that is performed by private

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56\textit{Id.}


59 42 U.S.C. § 14503(c).
entities, who contract with the government to provide emergency services. Late in 2006, a decision emerged during pre-trial skirmishing in the ongoing World Trade Center Disaster Site Litigation.\footnote{In re World Trade Center Disaster Site Litigation, 456 F. Supp.2d 520 (S.D.N.Y. 2006), aff’d in part and dismissed in part, 521 F.3d 189 (2nd Cir. 2008).} In that case, more than 10,000 workers descended on the collapsed World Trade Center: first in a desperate search for survivors, and then to assist in the recovery of remains and debris. The atmosphere around the World Trade Center site was filled with dust, smoke, fumes, and other airborne contaminants. Of the 10,000 workers, 70 percent reported that they suffered from increased respiratory problems since September 11, 2001. More than 3,000 volunteers brought suit against a range of defendants, including: the City of New York (which had retained control of the work as incident commander), Contractors to the City, and Subcontractors.\footnote{Id. at 523. See, Robert Herbert, et. al., The World Trade Center Disaster and Health of Workers: Five Year Assessment of a Unique Medical Screening Program Environmental Health Perspectives, Vol. 114, No. 12, at 1853-58 (2006), http://www.ehponline.org/members/2006/9592/9592.pdf (last visited April 7, 2008).} These various defendants moved for summary judgment on the pleadings based on the immunity from suit provided in various state and federal statutes and the common law. They argued that:

- New York State Defense Emergency Act provides “immunity for actions taken in good faith carrying out, complying with, or attempting to comply with any law or order requiring . . . a unified response and relating to civil defense,”\footnote{N. Y. State Defense Emergency Act § 9193.}
- The New York State Natural and Man-Made Disaster Preparedness Law,\footnote{N.Y. State and Local Natural and Man-Made Disaster Preparedness Law, § 25, subd. 5.} and the Federal Stafford Act,\footnote{42 U.S.C. 5148.} both provide immunity from any discretionary action, or failure to act, by the government agencies responding in emergencies that have been declared under the law.

The defendants also claimed immunity under the common law’s doctrine of immunity for inherently governmental functions and asserted that emergency response under the state’s police power. Finally, the governments’ various contractors claimed immunity under the doctrine, relatively well established under federal law, that a contractor performing work directed by the government is not liable for its performance.

In a thorough and well-reasoned opinion, Judge Hellerstein of the Southern District of New York agreed that these statutes did provide...
immunity for at least some of the actions taken by the defendants, but he
denied the requests for summary judgment of all of the governmental and
government contractor defendants. Judge Hellerstein held that there was
no immunity for emergencies that were not essential to address true exigent situations where there was no time to follow normal protocols and procedures in this case involving requirements for workers to wear breathing apparatus. The existence of an emergency declared by the Governor and by the President was not enough since those declarations can remain effective for months at a time. He then concluded that the line between true emergent conditions to which immunity attaches and a situation where a government can be held liable for not following normal procedures was too fact intensive to be decided on the pleadings.

Just as significant, the Court refused to extend immunity to contractors and subcontractors performing emergency work for the government agencies. Judge Hellerstein found, and the Second Circuit affirmed on appeal, that this “derivative immunity” for government contractors is available only where the government:

- Approves reasonably precise specifications
- Supervises and controls the implementation of those specifications, and
- The contractor warned the agency about any dangers known to it but not to the agency.

“Derivative immunity flows only where there is a ‘significant conflict’ between the state law and a federal policy or interest.”

“If the government merely accepted, without substantive review or enforcement authority, decisions made by an entity [a contractor] that entity would not be entitled to derivative discretionary function immunity.”

What does this mean for public health emergencies? Any response to a significant public health emergency will necessarily require involvement of the private sector; the private sector includes most physicians, anesthesiologists, medical laboratories and medical supply companies, pharmacists, some hospitals, and ambulance companies. Some companies will offer their services voluntarily, for free, as a public service to the community and perhaps simply because they want to speed their employees return to work. Other companies will act as contractors. Lets assume that all of these private entities will be working in coordination with the Incident Command established under NIMS and that

65 Id.
66 Id. at 197.
67 Id.
68 Id.
they are even directed to distribute drugs to their employees or to provide care at newly establish field clinics. Governments are unlikely, in the midst of a catastrophic event, to give such “precise specifications” to contractors serving in response that they can satisfy the test that Judge Weinstein laid out as establishing derivative immunity. This is particularly the case for medical professionals, since their work necessarily will involve the application of professional judgment in diagnosing injury or disease from symptoms presented, and in prescribing a course of treatment. Figuring out the starting point and ending point of the actual “emergent conditions” where immunity attaches will also be something that contractors or governments can not do in advance.

One impact of this case is certain: any contractor contemplating providing service for governments in emergency conditions must take special care to negotiate broad indemnity provisions in their contracts so that the government will be responsible should their actions lead to liability. In short, we are still figuring out how our liability system will apply to the people who respond to catastrophic events. We must recognize that in any catastrophic event, there will be vast numbers of residents and businesses that suffer devastating illnesses, injuries, and losses. Many federal and state statutes provide immunity and other protections, so that for most of these residents and businesses, the liability system will not be available to compensate for those losses. The problem we face is that the holes in those immunities may be big enough to deter the people we need to respond to emergency events. And the damage awards available to those few who successfully skirt immunity defenses will dwarf the limited assistance available to all of the other victims of the disaster event.

III. Conclusion

The threat of pandemic flu is real and will strain our public health emergency response systems. It is critical that legal requirements and restrictions be incorporated into response planning. Response will require the coordination of multiple and disparate agencies of federal, state, and local governments working together with private business, non-profit organizations, and volunteers of every stripe. Public health emergency powers can only be exercised effectively if officials know the scope of and restrictions on those powers and have planned how to provide procedural and substantive due process. This coordination will work only with advance attention to the agreements specifying how assistance will be dispatched, how communications will occur, and who will be responsible for “details” such as the cost of response, handling payroll, liability, and workman’s compensation. Lawyers and the law are critical to response to pandemic flu and must be included in development of emergency plans, and in the testing of those plans through training and exercising.