

**Protecting the Public: A Guide for Physicians, Healthcare  
Providers and Attorneys on Quarantining and Isolating  
Patients With Communicable Diseases**

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The authority to isolate, treat, and quarantine individuals with communicable diseases stands at a crowded intersection of federal law, state law, and constitutional law. A healthcare provider's duty to protect the public while treating his/her patients who suffer from highly communicable, potentially deadly diseases is a difficult subject. At the 30,000 foot level, the issue presents an age-old clash between the governments' interest in protecting the security of the population and the individual's constitutional right to liberty. Both federal and state laws, and their associated regulations, have attempted to balance these two interests. These efforts occasionally result in contradictory outcomes. Although the government is accorded substantial legal authority to protect the public health, ultimately the responsibility to control pandemics falls on physicians and other healthcare providers. Without pre-planning and coordination among local health official, courts, providers and hospitals, any effort to protect the public from highly communicable diseases through the use of quarantines is doomed to failure.

**The Constitutional Issues**

Efforts by the states and the Federal Government to isolate or quarantine<sup>i</sup> individuals suffering from a highly communicable disease implicate two related constitutional rights. The first is the right of due process, which generally prohibits government from depriving individuals of their "liberty" without first providing adequate procedures. Second, in the cases *Cruzan v. Director of Community Health*<sup>ii</sup> and *Washington v. Glucksburg*<sup>iii</sup>, the Supreme Court recognized a fundamental right to "body integrity" which prohibits the imposition of unwanted medical treatments without a compelling reason. As a Constitutional matter, these two doctrines place substantial restrictions on the government's ability to impose quarantines on unwilling patients.

The leading case regarding the treatment of individuals with communicable diseases occurred in 1905 and pertained to the state law forcing immunizations. In *Jacobson v. Massachusetts*<sup>iv</sup>, the state enacted a law which allowed municipalities to order forced vaccination if necessary to protect the health of the community. In the course of a smallpox pandemic, the City of Cambridge enacted an ordinance requiring all individuals to be vaccinated for the disease. The plaintiff refused the vaccination and was criminally prosecuted. The plaintiff argued that the forced vaccination deprived him of his XIVth amendment right to due process and equal protection. In an argument foreshadowing the current position of the vaccination denier movement, the plaintiff asserted that vaccines were both ineffective and medically dangerous. The court rejected this argument, using language that continues to resonate:

There is, of course, a sphere within which the individual may assert the supremacy of his own will, and rightfully dispute the authority of any human government.... But it is equally true that in every well-ordered society charged with the duty of conserving the safety of its members the rights of the individual in respect of his liberty may at times, under the pressure of great dangers, be subjected to such restraint, to be enforced by reasonable regulations, as the safety of the general public may demand.<sup>v</sup>

Despite this broad language, the Court noted that there were limits to the government's authority, stating that any such mandatory immunization laws be "reasonable" "not arbitrary" or "oppressive." Despite its age, *Jacobson* remains good law, and the Second Circuit Court of Appeals cited it most recently in 2015, in a case which upheld New York's mandatory vaccination law for children attending public secondary schools. *Phillips v. City of New York*<sup>vi</sup>

Although the court in *Jacobson* dealt with forced vaccinations, the holding stands for the broader principle that the government is vested with ample authority to protect the public from communicable diseases, which includes the ability in select cases to impose quarantines. The key case that specifically addresses quarantines arose in Florida. In 1951 the Florida Supreme Court in *Moore v. Draper*<sup>vii</sup> upheld a state statute which provided for the compulsory isolation of individuals suffering from tuberculosis. The Court recognized that protecting the health of the general public was the government's "most important" duty and rejected the plaintiff's due process and free exercise arguments.

Although the leading cases recognize the government's broad authority to impose

quarantines, there are two notes of caution.

### **Need For Quarantine**

First, there is a split of authority on the government's burden of establishing the need for quarantine.

Prior to 1979, courts imposed a very low threshold for the government to meet its burden; it needed to show only that it had "reasonable belief" that the individual being isolated carried a communicable disease. In *In re Halko*, for example, the California Court of Appeals rejected Plaintiff's habeas petition, brought because local health authorities had isolated him based on his tuberculosis because the plaintiff failed to establish (or even allege) that he was disease free.<sup>viii</sup>

In the early 1970's however, the United States Supreme Court issued a series of rulings that greatly expanded the right of procedural due process. As part of this expansion, in 1979 the Court ruled in *Addington v. Texas*<sup>ix</sup>, that due process required a full adversarial hearing before an individual could be civilly committed based on mental illness. The Court placed the burden on the government to establish that the committed person was a danger to himself/herself or others by "clear and convincing evidence," which is a higher standard of proof than the traditional "preponderance of the evidence standard" used in most civil proceedings.

At least two courts have adopted this elevated procedural due process requirement in the context of forced quarantines. In *Greene v. Edwards*<sup>x</sup>, the West Virginia Supreme Court ordered the state to give an individual who had been quarantined for showing symptoms of active tuberculosis a full adversarial hearing subject to the "clear and convincing" evidence standard reached in *Bradley v. Crowell*<sup>xi</sup>, where the New York Supreme Court ruled that the heightened *Addington* standard applied to the state's efforts to quarantine an individual suffering from tuberculosis.

The federal courts have not specifically ruled on the applicability of the *Addington* standard to communicable diseases. On one hand, the government's interest in preventing the spread of communicable diseases is likely greater than its interest in committing an individual who might be harmful to themselves or a relatively small number of people. Unlike mental illness, communicable diseases spread geometrically and the government has an extraordinarily high interest in stopping the spread of the communicable disease. Requiring the government to prove by "clear and convincing evidence" that everyone it seeks to quarantine during a raging pandemic would make it virtually impossible for the government to take decisive action and protect the public's health.

On the other hand, the “liberty” interests of both persons with mental illness and individuals with communicable diseases are the same. The question of how much process is due a person with a communicable disease remains open.

### **Body Integrity**

Second, the leading cases involving quarantines also predate the recognition of a fundamental right of body integrity. To the extent that quarantine is a form of medical treatment, the United States Supreme Court has suggested on two occasions that unwanted medical treatment can only be imposed for the most compelling of reasons. *Cruzan, supra* and *Glucksberg, supra*.<sup>xii</sup> The court’s imposition of a higher standard is contrary to the cases cited in quarantine section above, which required the government to only act “reasonably.”<sup>xiii</sup> Thus, there is a chance that the courts could ultimately require the government to defend a large scale quarantine order under the much higher strict scrutiny standard, which requires a compelling state interest instead of the historic “reasonableness” standard.

### **Federal Laws Regarding Quarantine**

Congress derives its authority to quarantine people from the Commerce Clause, art. I, § 8 of the United States Constitution. Any statute Congress passes under this clause must tie-in some fashion to interstate commerce. Pursuant to this authority, Congress has enacted a statute designed to “prevent the introduction, transmission, or spread of communicable diseases from foreign countries into the States or possessions, or from one State or possession into any other State or possession.”<sup>xiv</sup>

The statute delegates broad authority to the Surgeon General of the United States to enact such regulations as he or she sees fit to prevent the spread of communicable diseases between the states. This authority includes the power to order the “inspection, fumigation, disinfection, sanitation, pest extermination, and destruction of animals or articles found to be so infected or contaminated as to be sources of dangerous infection.”<sup>xv</sup>

This law specifically gives the Surgeon General the authority to “apprehend” and “detain” individuals with infectious diseases for the “purpose of preventing the introduction, transmission, or spread of... [such] diseases.”<sup>xvi</sup> Further authority is delegated to the President of the United States to issue Executive Orders identifying communicable diseases subject to regulation and to implement any related quarantine order<sup>xvii</sup>. The President’s authority includes the right to seize individuals “reasonably believed to be carrying a designated communicable disease” or if they are

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“likely” to become communicable. However, this authority is not without limit. The government’s right to quarantine occurs only when it establishes that the person is “moving between” two different states or will “probably” be the source of infection for someone else who will be moving from state to state.<sup>xviii</sup> Consistent with the Federal Government’s power over the national boundaries, the President and the Surgeon General are given essentially unlimited authority to exclude from entry to the United States, individuals traveling from foreign countries where a pandemic is occurring.<sup>xix</sup>

The Centers for Disease Control (“CDC”), the agency charged with promulgating regulations governing communicable diseases, has promulgated a surprisingly small number of regulations addressing this serious issue.<sup>xx</sup> The rules generally fall in two categories. First, a number of the rules apply at all times and impact individuals directly. The CDC for example, has promulgated a rule which makes it illegal for an individual with a communicable disease to travel from one state to another without a written permit from the chief health officer of the destination state.<sup>xxi</sup> Individuals suffering from cholera, the plague, smallpox, typhus or yellow fever or who have been exposed to those diseases and are potential carriers are forbidden from traveling between states absent a permit from the Surgeon General. Such individuals are also forbidden from boarding trains, planes and/or buses which are traveling interstate.<sup>xxii</sup>

Other rules become effective only if certain precedent conditions are met. The rules suggest that, with the exception of protecting national borders, the primary responsibility for limiting the spread of diseases inside the country’s borders lies with the states.<sup>xxiii</sup> Upon a presidential proclamation of the existence of a pandemic, the CDC is authorized to compel vaccinations and create clinics as necessary to do so.<sup>xxiv</sup> Most of the regulations, however, deal with the government’s authority to regulate and even close ports to prevent the introduction of communicable diseases.<sup>xxv</sup>

A presidential Executive order establishes the list of diseases the CDC is authorized to quarantine. Federal quarantine and isolation are currently authorized for the following diseases:

- Cholera
- Diphtheria
- Infectious tuberculosis
- Plague
- Smallpox

- Yellow fever
- Viral hemorrhagic fevers
- Severe acute respiratory syndromes
- Flu that can cause a pandemic<sup>xxvi</sup>

The federal government has largely left to the states the authority to deal with pandemics. The federal government has exercised its authority to address pandemics by closing international borders to prevent infected individuals from entering the country. However, the full scope of federal power to isolate or quarantine infected individuals has never been fully exercised or challenged. The last time the Federal Government exercised its authority to compel quarantine within the states occurred during 1918-1919 during the Spanish Flu pandemic.<sup>xxvii</sup>

### **State Laws Regarding Quarantine**

As noted above, the states have retained the primary power and duty to impose and enforce quarantines. Indeed, in the first Supreme Court case to interpret Congress's power to regulate interstate commerce, *Gibbons v. Ogden*<sup>xxviii</sup>, the Court noted that the states retained the power to adopt quarantine laws, and "health laws of every description." Since that time, Congress's power to regulate commerce, including the power to impose general health laws, has expanded dramatically. Nonetheless, the Federal Government has largely chosen to allow the states to take primary responsibility for protecting against the outbreak of communicable diseases.

### **Michigan's Laws**

Michigan's Involuntary Detention Statute<sup>xxix</sup> grants "local health officers" broad authority in the event of an epidemic to issue emergency orders to (1) prohibit the gathering of people, (2) require mass immunizations, and (3) temporarily commit individuals suffering from a hazardous communicable disease. A related provision supplements a local health officer's authority to issue an "imminent danger order" requiring the individuals to whom it is directed to take "immediate action necessary to avoid, correct, or remove the imminent danger."<sup>xxx</sup> Violation of any valid order issued by the health department is a misdemeanor.<sup>xxxi</sup>

Although the "imminent danger order" provision, at first glance, would seem to be directed at remedying nuisances, its language is broad enough to encompass isolation and quarantine. Among other things, the imminent danger order may "specify action to be taken or prohibit the



presence of individuals in locations or under conditions where the imminent danger exists.”<sup>xxxii</sup> The definition of “imminent danger” encompasses diseases: “Imminent danger means a condition or practice which could reasonably be expected to cause death, disease, or serious physical harm immediately or before the imminence of the danger can be eliminated through enforcement procedures otherwise provided.”<sup>xxxiii</sup> When viewed in *toto* these provisions appear to give health departments ample authority to order at least home quarantine of individuals who present an “imminent danger” to the public health.

Outside of an imminent danger order, the procedures to be followed in the commitment setting turn on: (1) whether the local public health authority has declared a “public health emergency” (an undefined term); and/or (2) the proposed length of the quarantine. If the local public health agency has declared an emergency the Public Health Act<sup>xxxiv</sup> authorizes the public health authority to obtain an expedited and ex-parte order from the circuit court to take into custody any individual whom the court has reasonable cause to believe is a carrier and is a health threat to the local public health.”<sup>xxxv</sup>

The government must file a complaint seeking an involuntary quarantine and an affidavit in support of the request to quarantine for any ex-parte relief. Assuming the court enters an ex parte order of confinement, the seized individual may be involuntarily admitted to an “emergency care or treatment facility” for purposes of diagnosis, treatment, and if authorized by the court, quarantine for up to 72 hours.<sup>xxxvi</sup>

The law requires that the court provide a full adversarial hearing to the detained individual within 72 hours, exclusive of weekends and holidays.<sup>xxxvii</sup> At the conclusion of this second preliminary hearing, the court may continue the confinement order for an additional five days, if it finds based on a “preponderance of the evidence” that the individual would pose a threat to others if released.<sup>xxxviii</sup>

Where local health officer a health emergency, or upon expiration of the eight-day period allowed for temporarily quarantining individuals in “emergency situations,” an individual who presents a potential threat to human health has a much broader right to due process. See, Hazardous Communicable Disease Act (HCDA)<sup>xxxix</sup>

The procedures to commit a person with a health threat to others, on a longer term basis, are set forth in the HCDA<sup>xl</sup>, HCDA applies to any individual who presents a “health threat to others” and who has refused “to conduct himself or herself in such a manner as to not place others

at risk of exposure.”<sup>xxli</sup> Before seeking a quarantine order, the Act requires the public health department to issue the contagious individual a written warning that outlines the specific steps he or she must take to avoid further legal action.<sup>xlii</sup> If the individual refuses to abide by the written warning, including voluntary isolation, the health officer may petition the local circuit court for an order compelling compliance with the warning.<sup>xliii</sup> Although the hearing must be held within 14 days of the filing of the health officer’s petition, the statute requires that the individual being sued be given at least three days’ notice.<sup>xliv</sup>

From the point when the Petition is filed, the procedural requirements turn on the type of the relief sought.<sup>xlv</sup> To the extent the health officer wants to compel the individual to undergo counseling, education, outpatient treatment, testing, or “cease and desist conduct that constitutes a health threat to others,” the court may order immediate relief.<sup>xlvi</sup> Involuntary quarantine orders, however, require an additional step. Before committing the individual to an “appropriate facility” for treatment and isolation, the court must first “consider the recommendation of a commitment review panel appointed by the court...to review the need for commitment of the individual to a health facility.”<sup>xlvi</sup> This panel is composed of three physicians, two of whom must be experienced in communicable diseases. The individual who is under scrutiny selects the third panelist. Before making its recommendation, the panel is supposed to meet, review the record, interview the individual and consider alternatives to involuntary commitment.<sup>xlviii</sup> Any order requiring commitment is limited to six months, and is subject to an expedited appeal.<sup>xlix</sup>

The HCDA does not set forth the burden of proof, other than to say that the government can obtain relief if it can establish that (1) the written warning was ignored, and (2) the person constitutes a health threat to others.<sup>1</sup> It is notable that the provision governing interim commitment orders provides for “reasonable cause” (for the first three days) and “preponderance of the evidence” (for days four through eight). However, the HCDA is silent on the burden of proof in the long term commitment provision. The case law developed in the mental health context suggests that the court will require the government to meet a “clear and convincing evidence” burden of proof.

### **Remedies Less Than Commitment**

The expanded procedural rights only apply when the government seeks to commit an individual to an “appropriate facility,” such as a hospital. The procedure for imposing home detention, or detention in someone else’s home or a non-contact order would likely fall within the

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court's power to order the infected individual to "cease and desist conduct that constitutes a health threat to others." By definition, an individual with a communicable disease who is out in public interacting with others is engaged in "conduct that constitutes a health threat to others." Alternatively, the statute appears to also allow for an order of home detention, etc., without the need to go through the commitment review panel process.<sup>li</sup> As discussed above, a quarantine order requires the recommendation of the commitment review panel.<sup>lii</sup> Section 6(g) of the HCDA, however, allows the court to issue an order requiring the infected individual to "live part-time or full-time in a supervised setting for the period and under the conditions set by the circuit court," *without* having to go through the commitment review panel process.<sup>liii</sup> This language suggests that home commitment or the like can be ordered for an indeterminate period of time pursuant to the circuit court's conditions.<sup>liv</sup>

To summarize, the government's authority to compel isolation or quarantine where a health emergency has been declared is limited to three days before a formal adversarial hearing must be given. This period can be extended an additional five days if the government can establish by a preponderance of the evidence that a health risk remains. If no emergency exists, or if the eight-day period for which a person can be detained under an emergency order has passed, a quarantine order must be reviewed and approved by both a court and a commitment review panel.

Michigan law recognizes the constitutional liberty interests at stake and provides ample due process to individuals with communicable diseases whose conduct places others at risk. The law can be criticized, however, for failing to recognize the reality of addressing public safety in the wake of pandemics. The transmission of communicable diseases must be weighed against the delay that can occur in providing due process to an infected person. An infected individual who has ongoing contact with the public during the delay between the petition being filed and the hearing in a non-emergency setting can quickly spread the disease to the point that it is impossible to control its spread. In the event of an emergency where the government needs to quarantine large numbers of people, it will likely not have the resources necessary to impose an extended quarantine.

### **Preplanning and the Role of Health Providers in Preventing Pandemics**

A healthcare provider's role in treating individuals who might present a risk of spreading communicable diseases must be considered in the larger context of emergency preparedness. The Public Health Code,<sup>lv</sup> and the Emergency Management Act<sup>lvi</sup>, vest state and local governments

with ample authority to design and implement emergency disaster plans. In coordination with state plans, the Federal government has the authority to suspend certain healthcare laws, such as Emergency Medical Treatment and Active Labor Act<sup>lvii</sup> and Health Insurance Portability and Accountability Act<sup>lviii</sup>, during the course of a declared emergency. Collectively, these laws and acts grant local government the plenary authority to close schools, order evacuations, compel medical treatment and “direct all other actions which are necessary and appropriate under the circumstances.”<sup>lix</sup>

### ***Pre-planning***

The starting point for practitioners and facilities is pre-planning. Large healthcare facilities will likely play a substantial role in any county’s disaster plan. Pre-coordination and establishment of the health department, physician groups, and hospitals’ roles in the event of a full-blown pandemic will go a long way towards protecting the public health.

In 2006, the CDC issued grants to local communities to develop comprehensive disaster management plans. For example, Kent County, Michigan received one of the CDC grants and developed an extremely comprehensive set of policies, procedures and guidelines for use by the health department and local healthcare facilities.<sup>lx</sup> All healthcare providers would benefit from reviewing the Kent County’s procedures and working with their local healthcare agencies to develop similar protocols.

### ***Reporting***

Setting aside the disaster scenario, a healthcare facility or provider’s role in preventing the spread of communicable diseases, from a legal perspective, begins with reporting. Physicians and clinical laboratories are required to report the incidence of a communicable disease to the county health department within 24 hours of discovery.<sup>lxi</sup>

There are currently over 67 diseases (not including variants) subject to mandatory reporting, including viral hemorrhagic fevers, dengue virus and “novel” influenza viruses.<sup>lxii</sup> The report must contain detailed information regarding the patient, the nature of the disease, the number of cases, and the like. A diagnostic specimen is required to be submitted for certain particularly virulent diseases, such as anthrax and antibiotic resistant strains of staph. Diseases not on the list may also be reported, if the healthcare provider believes that the disease poses a risk to the public. Based on the rules, providers should err on the side of caution, and report whenever the provider “suspects” the presence of a designated condition, potentially before final verification is obtained.

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<sup>lxiii</sup>Hospitals and other healthcare facilities are authorized, but not required, to report communicable diseases to the county health department and, the report is not subject to HIPAA.

With this background in mind, a healthcare facility or practitioner attempting to treat an individual who is carrying a communicable disease, who refuses treatment, including quarantine, creates a quandary for the provider. The Constitution, state law and tort law generally protect individuals from having to undergo unwanted medical treatments. A private entity that forces a quarantine, engages in a tort which can expose the healthcare facility to litigation and damages. Given the recent concerns regarding the outbreak of virulent, highly communicable diseases, healthcare providers should be prepared in advance to handle patients who carry such diseases. Such advanced planning has three facets: policies, voluntary compliance and coordination with local public health authorities.

### ***Policies and Procedures***

Although the onus is on practitioners and laboratories to report a communicable disease, a healthcare facility's "infection control committee" is required to develop policies and procedures to ensure that physicians appropriately report individuals treated at their facilities or use their laboratory services.<sup>lxiv</sup> For that reason, the rules specifically authorize facility administrators and "infection control professionals" to report to public authorities separately from a treating physician.<sup>lxv</sup>

Every healthcare facility is different. Any policy the infection control committee develops regarding communicable diseases must be tailored to reflect the nature of the entity, the population it serves, and available resources. At a minimum, an effective policy should include:

#### ***1) The List of Diseases Subject to the Policy.***

Both the federal and state lists, described above, provide a good starting point. For physicians and labs, the policy should, at a minimum, cover all of the diseases covered by the state's mandatory reporting requirements.

#### ***2) Reporting Lines and Procedures.***

When a highly communicable disease is diagnosed, the policy should set forth who should be notified within the facility and who is responsible for reporting to the appropriate state and/or federal authorities. This works at two levels. The first is ensuring that the diagnosing physician, or lab director, has timely and properly reported. The second is whether the facility should overlap the physician/lab with a separate report. The applicable state rules in Michigan encourage multiple

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reporting of the same event.

The key here is to ensure timely notification. The rules specifically require reporting within 24 hours, but as a safety measure, facilities should consider expedited procedures, particularly in situations where a person carrying a communicable disease is refusing treatment. A policy that requires multiple layers of approvals and reviews would be ineffective to stem a potentially serious outbreak. For physicians, the duty to report is mandatory. Facilities however, should not rely on the physician's mandatory reporting requirement, to minimize their own role in preventing the spread of infectious diseases.

Notification under the policy can serve two purposes. For patients who are willing to accept treatment, including quarantine, a provider's prompt notification will give the county health department additional time to minimize the possibility of a serious outbreak. For highly contagious ailments, a few hours can make a real difference. The importance of prompt notification takes on even greater importance in the rare situation where a highly contagious individual refuses treatment and/or quarantine. As discussed in detail above, state law and, to a lesser extent, federal law, vests government with ample authority to compel treatment or impose quarantine. Prompt notification, while the patient is still in the facility or being treated, will allow the local health department to begin the procedures necessary to impose an unconsented quarantine on the ailing person.

Similarly, local health departments should consider working in advance with the circuit courts in their jurisdictions to set up procedures to expedite the process for obtaining mandatory quarantine orders. This jointly developed plan should include training judges on the applicable law and preparing pre-printed legal forms, such as "fill in the blanks" complaints, motions, affidavits, etc. The local health departments should create a list of physicians who are qualified and willing to serve on commitment review panels.

### ***Voluntary Cooperation***

In the vast majority of cases, a person suffering from a highly communicable disease will be cooperative. In this situation, the policy should be straightforward: If appropriate, quarantine the patient and begin treatment. Standard informed consent rules would obviously apply, including obtaining written permission from the patient to quarantine. Standard forms should be prepared in advance to ensure that the patient understands the nature of the quarantine and authorizes that specific form of treatment. Similarly, if the decision is made to impose a "home quarantine," the provider should prepare discharge instructions regarding contact with others, travel, etc. and the

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patient should confirm the instructions.

Physicians are required under the administrative rules to “arrange for appropriate barrier precautions, treatment, or isolation if needed to prevent the spread of infection to other household members, patients, or the community.”<sup>lxvi</sup> This obligation should be noted in the policies and the prescribed precautions and treatments prescribed to a particular contagious patient should be documented in the medical record.

When facing a hostile patient, an ounce of commonsense is worth a pound of legal principles. After promptly notifying the local health department, a physician or facility confronting a hostile, contagious patient should obviously first try to convince the patient to protect his/her friends and family by voluntarily agreeing to take the steps necessary to prevent communication of the disease, including quarantine. A “carrot” approach (“you will place the people you love at risk if you leave”) and stick (“if you leave, we will be forced to take legal action”) might be appropriate. Along the same lines, the physician or facility should also inform the individual that federal law forbids him or her from using public transportation or leaving the state without permission. Subtlety delaying the discharge of the patient (“we are still waiting for one more test....”) to give the local health department time to act might also be appropriate.

### ***Coordination with Local Health Departments***

A facility’s legal obligation in the event of an epidemic turns in part on whether the governor and other state officials have triggered the emergency disaster plan(s) discussed above. In that event, hospitals are required to cooperate with local health officials and otherwise play whatever role is imposed on them by the government. Failure to comply with a valid order of the local health department is a misdemeanor.

Absent declaration of an emergency, a physician’s or a facility’s *legal* obligation in the event of an epidemic largely ends once the provider or facility gives the required notice and arranges for appropriate barrier precautions. The statute gives the local health department authority to investigate the report of a communicable disease, and if appropriate, impose quarantines using the procedures described above.<sup>lxvii</sup> The rule provides for expedited access to medical records, requiring practitioners and facilities to “promptly” provide the department with any requested medical records.<sup>lxviii</sup> Once again, HIPAA does not apply to such requests.

Although not specifically required by the rules, practitioners and facilities should be prepared to fully cooperate with local health departments in fighting the spread of communicable

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diseases. In practical terms, this means:

- 1) Be willing to provide the department with affidavits or provide the testimony of experts necessary to impose an involuntary quarantine.
- 2) Sharing internal resources, such as medical expertise, testing facilities, expanded hours of service and the like, as necessary to prevent the spread of the disease.
- 3) Providing advice on appropriate treatments, barrier precautions and immunizations.
- 4) Provide training for both internal staff and department officials on symptomology, treatment and safety protocols.

Although this cooperation does not necessarily have to be formally memorialized in a policy, understaffed health departments, practically speaking, do not have the resources to fight a major pandemic. A cooperative effort has both the short term benefit of improving public health and the long term benefit of forging stronger relationships with the government.

### **Conclusion**

Nowhere is the adage “an ounce of prevention is worth a pound of cure” more apt than in the world of pandemics. Waiting to prepare contingency plans until a recalcitrant patient refuses treatment is a formula for disaster. Physicians, healthcare facilities, circuit courts and local health departments all play an important role in protecting the public health. Pre-coordination and the development of standard policies are critical to meeting those obligations.



## Endnotes

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<sup>i</sup> The term “isolation” refers to the segregation of individuals who already have a communicable disease. “Quarantine” refers to segregation of individuals who have been exposed to a communicable disease, but are currently asymptomatic. See <http://www.cdc.gov/quarantine/QuarantineIsolation.html>. Except where noted, the terms are used interchangeably

<sup>ii</sup> 497 US 261 (1990)

<sup>iii</sup> 521 US 707 (1997)

<sup>iv</sup> 197 US 11 (1905)

<sup>v</sup> *Id.* at 29

<sup>vi</sup> 2015 WL 74112 (2d Cir Jan 7, 2015)

<sup>vii</sup> 57 So 2d 648 (1952)

<sup>viii</sup> 54 Cal Rptr 661 (1966)

<sup>ix</sup> 441 U.S. 418 (1970)

<sup>x</sup> 164 W VA 364 (1980)

<sup>xi</sup> 181 Misc 2d 529 (1999)

<sup>xii</sup> 497 US 261 (1990); 521 US 707 (1997)

<sup>xiii</sup> *Id.*

<sup>xiv</sup> 42 USC 264(a)

<sup>xv</sup> *Id.*

<sup>xvi</sup> *Id.*

<sup>xvii</sup> 42 USC 264(d)

<sup>xviii</sup> 42 USC 264(d)

<sup>xix</sup> 42 USC 265

<sup>xx</sup> 40 CFR 70.3, *et seq.*

<sup>xxi</sup> 40 CFR 70.3

<sup>xxii</sup> *Id.* at 70.5

<sup>xxiii</sup> See 42 CFR 70.2 (granting the director of the CDC authority to take reasonably necessary measures if he concludes that “the measures taken by health authorities of any state or...are insufficient to prevent the spread of any of the communicable diseases.”)

<sup>xxiv</sup> *Id.* at 70.9

<sup>xxv</sup> *Id.* at 71

<sup>xxvi</sup> EO 13295, April 4, 2003, 68 FR 17255; as amended by EO 13375, April 1, 2005, 70 FR 17299. This Executive Order was further amended on July 31, 2014 at 79 FR 45671.

<sup>xxvii</sup> <http://www.cdc.gov/quarantine/aboutlawsregulationsquarantineisolation.html>

<sup>xxviii</sup> 22 US 1 (1824)

<sup>xxix</sup> MCL 333.2453

<sup>xxx</sup> *Id.*

<sup>xxxi</sup> MCL 333.2261.

<sup>xxxii</sup> MCL 333.2451(1)

<sup>xxxiii</sup> MCL 333.2451(3)(a)

<sup>xxxiv</sup> MCL 333.5207

<sup>xxxv</sup> MCL 333.5207(1).

<sup>xxxvi</sup> *Id.*

<sup>xxxvii</sup> *Id.*

<sup>xxxviii</sup> *Id.* at 5207(5)

<sup>xxxix</sup> Section MCL 333.5201, *et seq.*

<sup>xl</sup> MCL 333.5207

<sup>xli</sup> MCL 333.5201(1)(b)

<sup>xlii</sup> MCL 333.5203

<sup>xliii</sup> MCL 333.5205

<sup>xliv</sup> If the person is already in custody pursuant to declared health emergency, the gap between the eight-day maximum temporary quarantine and the requirement that the hearing for the long term quarantine order be held within 14 days

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presents a challenge. In cases where serious danger is present, courts should be prepared to hold these hearings before the eight-day quarantine period has expired. In practical terms, this means that a person who has gone through the second, temporary quarantine hearing should be immediately notified that another hearing will be held within five days

<sup>xlvi</sup> MCL 333.5205

<sup>xlvi</sup> MCL 333.5205(6)

<sup>xlvi</sup> MCL 333.5205(8)

<sup>xlvi</sup> *Id.* at 5205(8)(a-c)

<sup>xlvi</sup> *Id.* at 5205(13)

<sup>i</sup> MCL 333.5205(6)

<sup>ii</sup> MCL 333.5205(6)(f)

<sup>iii</sup> *Id.* at 5205(8)(a-c)

<sup>iii</sup> *Id.* at 5205(6)(g)

<sup>iv</sup> *Id.*

<sup>iv</sup> MCL 333.1101, *et seq.*

<sup>vi</sup> MCL 30.401, *et seq.*

<sup>vii</sup> 42 USC 1395dd

<sup>viii</sup> 42 U.S. Code § 1320d–6

<sup>ix</sup> MCL 30.405 (1)(j)

<sup>ix</sup> <http://www.cdc.gov/phpr/healthcare/essentialhc.htm>.

<sup>xi</sup> MCL 333.51111; R 325.173(1)

<sup>xii</sup> The list is available at [http://www.michigan.gov/documents/Reportable\\_Disease\\_Chart\\_2005\\_122678\\_7.pdf](http://www.michigan.gov/documents/Reportable_Disease_Chart_2005_122678_7.pdf).

<sup>xiii</sup> R 325.173(6).

<sup>xiv</sup> R 325.173(7).

<sup>xv</sup> R 325.173(8)(a).

<sup>xvi</sup> R 325.175.

<sup>xvii</sup> R 325.174.

<sup>xviii</sup> *Id.*