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 when contending with patients who suffer from highly communicable, potentially deadly diseases is likewise not subject to any easy answer. At the 30,000 foot level, the issue presents an age-old clash between societies—and therefore 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 in occasionally contradictory ways. 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, 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 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*, 497 U.S. 261 (1990) and *Washington v. Glucksburg*, 521 U.S. 707 (1997), 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 is from 1905 and actually involved forced immunizations. The state in *Jacobson v. Massachusetts*, 197 U.S. 11 (1905), 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

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1 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](http://www.cdc.gov/quarantine/QuarantineIsolation.html). Except where noted, the terms are used interchangeably.
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. Id. at 29.

Despite this broad language, the Court went on to note 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, having been cited most recently in a 2015 Second Circuit Court Opinion which upheld the state of New York’s mandatory vaccination law for children attending public secondary schools. Phillips v. City of New York, 2015 WL 74112 (2d Cir. Jan 7, 2015).

Although dealing with forced vaccinations, Jacobson stands for the broader principle that the government is vested with ample authority to protect the public from communicable diseases, including the ability in select cases to impose quarantines. The leading case specifically involving quarantines comes from the state of Florida, where in 1951 the Florida Supreme Court upheld a state statute which provided for the compulsory isolation of individuals suffering from tuberculosis. Moore v. Draper, 57 So. 2d 648 (Fla. 1952). The Court, recognizing that protecting the health of the general public was the government’s “most important” duty, rejected the plaintiff’s due process and free exercise arguments.

Although the leading cases recognize broad authority to impose quarantines, two notes of caution must be sounded. 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, requiring the government to show only that it had “reasonable belief” that the individual being isolated carried a communicable disease. In In re Halko, for example, a California court of appeals rejected a habeas petition filed by an individual suffering from tuberculosis who had been isolated for two years by local health authorities because the plaintiff failed to establish (or even allege) that he was disease free. 54 Cal. Rptr. 661 (Ct. App. 2nd 1966).

In the early 1970’s however, the Supreme Court handed down a series of rulings that greatly expanded the right of procedural due process. As part of this revolution, in 1979 the Court ruled in Addington v. Texas, 441 U.S. 418 (1970) 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 or others by “clear and convincing evidence”, a standard higher than the traditional “preponderance of the evidence standard” that attaches to 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*, 164 W. Va. 364 (1980), 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. As similar decision was reached in *Bradley v. Crowell*, 181 Misc. 2d 529 (Sup. Ct. Suffolk Cty. 1999), where the New York Supreme Court ruled that the heightened *Addington* standard applied to efforts by the state to quarantine an individual also suffering from tuberculosis.

The federal courts have not specifically ruled on this issue. 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 disease before it spreads. 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. On the other hand, the “liberty” interests of both mentally ill individuals and individuals with communicable diseases are the same. The question of how much process is due a person with a communicable disease remains open.

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 Supreme Court has suggested on two occasions that unwanted medical treatment can only be imposed for the most compelling of reasons. This is contrary to the cases cited above, which required the government to only act “reasonably.” 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, instead of the historic “reasonableness” standard.

**Federal Laws Regarding Quarantine**

Congress derives its authority to quarantine from the commerce clause, art. I, § 8, meaning that any statute it passes in this area 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.” 42 U.S.C. § 264(a). The statute delegates broad authority to the Surgeon General 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.” *Id.*

A different section of the 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.” Further authority is delegated to the President to issue Executive orders identifying communicable diseases subject to regulation and implement any related quarantine order. 42 U.S.C. § 264(d). This authority includes the right to seize individuals “reasonably believed to be carrying a designated communicable disease” or if they are “likely” to become communicable. This power comes with an important caveat: To quarantine, the government must establish 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. 42 U.S.C. § 264(d). Consistent with the Federal Government’s power over the national boundaries, the President and the Surgeon General are given essentially unlimited authority to exclude individuals from foreign countries where a pandemic is occurring. 42 U.S.C. § 265.

Exercising this authority, the CDC has promulgated a surprisingly small number of regulations governing the fight against communicable diseases. 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. 40 C.F.R. § 70.3. 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. Id. at § 70.5.

Other rules become effective only if certain precedent conditions are met. The rules suggest that outside of protecting national borders, the primary responsibility for limiting the spread of diseases within the country lies with the states. See 42 C.F.R. § 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”). 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. Id. at § 70.9. Most of the regulations, however, deal with the government’s authority to regulate and even close ports to prevent the introduction of communicable diseases. Id. at § 71.

The list of diseases the CDC is authorized to quarantine is established by Executive order. 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
With the exception of closing international borders to prevent infected individuals from entering the country, the full scope of federal power to isolate or quarantine infected individuals has never been exercised or challenged because the federal government has largely left to the states the authority to deal with pandemics. The last time the Federal Government exercised its authority to compel quarantine within the states was the Spanish Flu pandemic in 1918-1919.\(^2\)

**State Laws Regarding Quarantine**

For historic reasons, the primary power and duty to impose and enforce quarantines has resided with the states. Indeed, in the first Supreme Court case to interpret Congress’ power to regulate interstate commerce, *Gibbons v. Ogden*, 22 U.S. 1 (1824), the Court noted that the power to adopt quarantine laws, and “health laws of every description” was retained by the states. Since that time, Congress’ 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 Involuntary Detention Statute, Mich. Comp. Laws § 333.2453, 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. This authority is supplemented by a related provision that authorizes the local health officer to issue an “imminent danger order” requiring the individuals to whom it is directed to take “immediate action necessary to avoid, correct, or remove the imminent danger.” Violation of any valid order issued by the health department is a misdemeanor. Mich. Comp. Laws § 333.2261.

Although the imminent danger 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.” Mich. Comp. Laws § 333.2451(1). 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.” Mich. Comp. Laws § 333.2451(3)(a). Putting this all together, these provisions would 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 turns 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, Section 5207 of the Public Health Act authorizes it 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.” Mich. Comp. Laws § 333.5207(1). The procedure is essentially that

\(^2\) [http://www.cdc.gov/quarantine/aboutlawsregulationsquarantineisolation.html](http://www.cdc.gov/quarantine/aboutlawsregulationsquarantineisolation.html)
for any ex-parte relief, requiring the government to file a complaint and an affidavit in support of the request to quarantine. Assuming the order is issued, 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.

The detained individual must be then given a full adversarial hearing with 72 hours, exclusive of weekends and holidays. 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. Id. at § 5207(5).

Where a health emergency has not been declared, or upon expiration of the eight-day period allowed for temporarily quarantining individuals in “emergency situations”, an individual who presents a potential threat to human health has a much broader right to due process. The procedures to commit such individuals are set forth in Michigan’s “Hazardous Communicable Disease Act”, Mich. Comp. Laws § 333.5207. The Communicable Disease Act 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.” Mich. Comp. Laws § 333.5201(1)(b). Before seeking a quarantine order, the Act requires the public health department to issue the contagious individual a written warning outlining the specific steps he or she must take to avoid further legal action. Mich. Comp. Laws § 333.5203. If the individual refuses to take the required actions, including voluntary isolation, the health officer may petition the local circuit court for an order compelling compliance with the warning. Mich. Comp. Laws § 333.5205. Although the hearing must be held within 14 days of the filing of the petition, the Statute requires that the individual being sued be given at least three days’ notice.3

From this point, the procedural requirements turn on the nature of the relief sought. 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. 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.” Mich. Comp. Laws § 333.5205(8). This panel is composed of three physicians, two of whom must be experienced in communicable diseases. The third panelist is to be selected by the individual. Before making its recommendation, the panel is supposed to meet, review the record, interview the individual and consider alternatives to involuntary commitment. Id. at § 5205(8)(a-c). Any order requiring commitment is limited to six months, and is subject to expedited appeal. Id. at § 5205(13).

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3 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 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.
The statute 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. Mich. Comp. Laws § 333.5205(6). Given 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), the silence in the long term commitment provision and case law in the mental health context suggests that the “clear and convincing evidence” standard would likely be applied.

These expanded procedural rights only apply when the government seeks commitment to an “appropriate facility”, such as a hospital. The procedure for imposing home detention, or the like, would likely fall within the 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, or the like, without the need to go through the commitment review panel process. As discussed above, a quarantine order requires the recommendation of the commitment review panel. Id. at § 5205(8)(a-c). Section 6(g) of the statute, 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. Id. at § 5205(6)(g). This language suggests that home commitment or the like can be ordered for an indeterminate period of time “under the conditions set forth by the circuit court.” Id.

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 who choose place others at risk with their conduct. The law can be criticized, however, for failing to recognize the reality of pandemics. Communicable diseases have little time for due process and an infected individual out in public during the delay between the petition being filed and the hearing in a non-emergency setting can quickly spread such a disease to the point that attempts to control it are made impossible. In the event of an emergency where large numbers of people need to be quarantined, the government 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
Michigan Public Health Code, Mich. Comp. Laws § 333.1101, et seq., and the Emergency Management Act, Mich. Comp. Laws § 30.401 et seq., 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 EMTALA and HIPAA, 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.” Mich. Comp. Laws § 30.405 (1)(j).

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 what role will be played by the health department, physician groups, and hospitals 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. Kent County, Michigan received one of the grants and developed an extremely comprehensive set of policies, procedures and guidelines for use by the health department and local healthcare facilities, which can be found at http://www.cdc.gov/phpr/healthcare/essentialhc.htm. All healthcare providers would benefit from reviewing these procedures and working with their local healthcare agencies to develop similar protocols.

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. Mich. Comp. Laws § 333.51111; Mich. Admin. Code § 325.173(1). There are currently over 67 diseases (not including variants) subject to mandatory reporting, including viral hemorrhagic fevers, dengue virus and “novel” influenza viruses. 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. The rules err on the side of caution, requiring reporting whenever the provider “suspects” the presence of a designated condition, potentially before final verification is obtained. Mich. Admin. Code § 325.173(6). Hospitals and other healthcare facilities are authorized, but not required, to report communicable diseases. In both instances, the report is not subject to HIPAA.

With this background in mind, a healthcare facility or practitioner facing an individual who is carrying a communicable diseases but refuses treatment, including quarantine, is in a difficult position. The constitution, state law and tort law generally protect individuals from having to undergo unwanted medical treatments. Forced quarantine by a private entity is 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 communicable disease, a healthcare facilities’ “infection control committee” is required to develop policies and procedures to ensure appropriate reporting by physicians who treat individuals at their facilities or use their laboratory services. Mich. Admin. Code § 325.173(7). For that reason, the rules specifically authorize facility administrators and “infection control professionals” to report separately from a treating physician. Mich. Admin. Code § 325.173(8)(a).

Every healthcare facility is different, meaning that any policy regarding communicable diseases developed by its infection control committee 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 insuring 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 encourage multiple reporting of the same event.

The key here is to insure 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 this fact 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, 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.

Along the same lines, local health departments should consider working in advance with the circuit courts in their jurisdiction 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 and the like. A list of physician’s qualified and willing to serve on commitment review panels should also be prepared.

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 to quarantine. Standard forms should be prepared in advance to insure 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”, discharge instructions regarding contact with others, travel, and the like should be prepared and confirmed by the patient.

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.” Mich. Admin. Code § 325.175. 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 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 facility’s legal obligation in the event of an epidemic largely ends once the provider 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. Mich. Admin. Code § 325.174. The rule provides for expedited access to medical records, requiring practitioners and facilities to “promptly” provide the department with any requested medical records. *Id.* 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 diseases. In practical terms, this means:

1) Be willing to provide the department with affidavits or 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.