Health Law Section Newsletter

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Will I Lose My License? Representing Physician Clients before the State Board of Medical Examiners

by Alex J. Keoskey

Any attorney combing through the state departments and agencies section of the *Lawyers Diary* will likely take note of the multi-layered bureaucracy within the New Jersey Department of Law and Public Safety. Tucked deep within the department's Division of Consumer Affairs is the New Jersey Board of Medical Examiners. When representing physicians in actions initiated by the board, it is imperative counsel have a working knowledge of some key areas of the law.

Fundamental to the task of defending board matters is a solid background in health law, medical malpractice and administrative law. Equally crucial is an understanding of the structure, authority and powers of the board and the state attorney general, especially with regard to their powers of investigation and prosecution. Last, but surely not least, one should have a thorough familiarity with the intricate web of mandatory regulatory reporting. These 'tripwire' reporting mechanisms will inevitably affect not only the physician/client's licensure, but his or her ability to maintain hospital privileges, controlled dangerous substance (CDS) prescribing privileges and status as an approved provider for health insurers. They will be described in more detail later in this article.

While recognized as the regulatory authority that establishes qualifications of applicants for medical licenses as well as standards for the practice of medicine in the state, the board has a crucial role not only as a licensing entity but as disciplinarian for all New Jersey physicians. On any given month, a physician, podiatrist or psychiatrist licensed by the board suffers a temporary or permanent loss of his or her license to practice medicine. The allegations against these physicians may range from malpractice or gross negligence to insurance fraud, sexual misconduct, conviction of a crime, or a host of other violations of the laws and regulations governing the practice of medicine.

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Health Law Section Leadership

While providing a full and comprehensive outline of a board action and its consequences is beyond the scope of this article, this brief overview may be helpful in navigating through the procedural thicket.

The Power behind the Board

As an agency of the Division of Consumer Affairs within the Department of Law and Public Safety, almost all of the board's actions against physicians are prosecuted within the Office of Administrative Law (OAL). The prosecutor for these matters is always an assigned deputy attorney general (DAG) from the Professional Board Prosecution Section within the Division of Law (DOL). Most of these DAGs are seasoned veterans with a solid grounding in the intricate web of board regulations and laws.

Equally important is the fact that the board operates not just as an agency of the state's attorney general, but as a client. The attorney general serves not only as prosecutor, but as the board's legal counsel. The counseling task is handled by a different section within the DOL—the Professional Boards Counseling Section. While there may arguably appear to be a conflict in this arrangement, the counseling and prosecuting DAGs maintain a 'wall' of separation regarding active board matters.

The attorney general's authority to prosecute board matters derives from the Uniform Enforcement Act (UEA)[1] and the New Jersey Medical Practice Act (MPA).[2] These two statutes overlap in defining the methods of investigating and conducting disciplinary proceedings involving professional licensees.[3]

The MPA grants comprehensive supervisory powers to the board, including subpoena power to compel attendance at board hearings, and to seek penalties for failure to appear or to give testimony.[4] It also has broad rule-making powers to carry out its legislative objectives,[5] and may suspend or revoke a license based on one or more grounds enumerated under the MPA.[6] In fact, the board may even seek the summary suspension of a physician's medical license by demonstrating the physician's practice of medicine constitutes a 'clear and imminent danger' to the consuming public.[7] Preparing for and defending physicians at these so-called temporary suspension hearings is particularly challenging, given the short time frame defense attorneys are afforded in these emergent actions.

The board employs a full-time medical director "to assist [it] in carrying out its duties pursuant to Title 45."[8] The medical director must be a New Jersey-licensed physician, and his or her duties shall include reviewing complaints and reports of "medical malpractice, impairment, incompetence or unprofessional conduct," and assisting the board "in making disciplinary determinations regarding a licensee."[9] The medical director is a non-voting member of the board.

The board also promulgates regulations found in the New Jersey Administrative Code.[10] Physicians are expected to adhere to the standards outlined by the board and to maintain their knowledge of these regulations, even as they may change or be revised.

While the board is the state's watchdog with regard to negligent or wayward doctors, like criminal prosecutors, it relies almost exclusively on tips from the public at large. The board's investigation can only begin when it receives information from an outside source, whether it is the targeted physician's patient, colleague, a hospital supervisor, a county prosecutor, an insurance company investigator, an office employee or even a spouse.

The board has no independent resources to investigate physicians who may be found wanting with regard to quality of care, misconduct, fraud, overprescribing of CDS, patient-physician boundary issues or any number of violations of the MPA, as the board's staff does not include an investigative unit. Instead, the board utilizes the Enforcement Bureau (EB), the investigative agency of the Division of Consumer Affairs, which performs its role under the supervision of the deputy attorneys general assigned to the Professional Board's Prosecution Section. The EB investigators assigned to the board, like the DAGs who counsel and prosecute on behalf of the board, have superior knowledge regarding the practice of medicine in the state, as well as the laws and regulations governing medical practice. Many of these investigators are former healthcare professionals. The reports the EB investigators render on behalf of the board and the AG are detailed, comprehensive and of a high quality.

Board Investigations

As stated previously, the investigative powers of the board are broad in scope and often entail records inspections and interviews with patients and coworkers. They may be based upon contemporaneous investigations by federal agencies such as the Drug Enforcement Administration (DEA) or Food and Drug Administration

(FDA) or medical experts and investigators employed by insurers. The board's investigative powers are outlined within the UEA.[11] Investigated matters come to fruition through a full hearing before the board during its monthly meetings at the Hughes Justice Complex in Trenton (if limited in length and scope), but in most cases through a plenary hearing before an administrative law judge (ALJ) at the OAL.

Pursuant to OAL procedure, the ALJ will draft and file an opinion in the form of an initial decision, which in turn is reviewed by the full board. The board then renders a determination in the form of a final decision, which is appealable through the Appellate Division.[12]

Most physicians seeking legal counsel in relation to a board matter usually receive a notice from the board to appear before the board's Preliminary Evaluation Committee (PEC). The PEC consists of two or three board members who are assigned to hear testimony from the physician after the initial investigation has been launched. It is vitally important that an attorney not only ensure the physician-client is thoroughly prepared before a PEC hearing, but also ensure the client is accompanied to the PEC by competent counsel.

In preparation, an attorney must spend ample time with the client reviewing the medical records or other documents related to the investigation. Unlike other forums, where the attorney can enter objections or dominate the proceeding, the PEC members will not take well to an attorney or physician who interrupts, obstructs or agitates in any manner. Such aggressive representation will not serve the client well. The atmosphere at the PEC conference should be professional, deferential and cooperative. How well, or how poorly, a physician answers questions posed by the DAG and board members present at the PEC conference may well make the difference between the board determining there is no cause for further investigation and recommending an active suspension of the physician's ability to practice.

Other committees of the board serve other functions. The board's Impairment Review Committee deals with physicians struggling with alcohol and drug dependency and/or addiction. The Priority Review Committee (PRC) reviews emergent matters that come onto the board's radar screen.

While this provides a cursory outline of the procedures at the board, there is an underlying concern that must be reckoned with whenever an attorney is negotiating with the board concerning the level of discipline meted out to a physician. More specifically, counsel must take into account whether the final outcome of the negotiation will be a resolution that is made public on either the board's[13] or other government watchdog agencies' websites, the most significant of which is the National Practitioner Data Bank.

The National Practitioner Data Bank

The Healthcare Quality Improvement Act of 1986 (HCQIA)[14] included a provision establishing a National Practitioner Data Bank (NPDB). The vision of HCQIA in authorizing the creation of the NPDB was a clearinghouse for reporting board disciplinary actions against licensed physicians, malpractice payments from settlement or satisfaction of a claim or judgment, exclusions or prohibitions from the Medicare and Medicaid programs and professional review actions involving competency or conduct by professional societies.

An essential tool for hospitals, licensing authorities and other healthcare organizations seeking to hire, credential or grant privileges physicians, the NPDB allows those entities access to doctors' disciplinary records before the entities decide to hire them. Before the NPDB, such entities would have to research a physician's background on their own, taking the physician's word that nothing was being concealed. This usually entailed a telephone call to the physician's prior employers, and perhaps the medical boards of each state where the doctor had previously practiced.

Discipline or restrictions against a physician's practice can also be meted out by hospitals and other healthcare entities, which may restrict a doctor's ability to practice by withholding certain privileges directly related to that doctor's specialty. The fact that a relatively simple hospital peer review matter may get reported to the NPDB is not widely known by physicians. However, if a physician's hospital privileges are limited, suspended or revoked for a period of more than 30 days, the hospital must report it to the board and the NPDB. This is an important consideration when representing physicians facing a disciplinary proceeding within a hospital setting.

Insurance companies not only routinely refer alleged insurance fraud matters involving physicians to the board, but under the New Jersey Insurance Fraud Prevention Act[15] the insurer must report insurance fraud actions to the Department of Banking and Insurance

(DOBI), which may then assigned a deputy attorney general to file a civil complaint in superior court. Such actions are also reported to the board.

It may be necessary to defend a client facing two concurrent actions by the state attorney general for the same or similar allegations—a civil action in superior court by a DAG assigned to DOBI, and an OAL matter brought by a DAG assigned to the board. It is also not unusual to have board actions accompanied by criminal prosecutions filed in U.S. District Court by assistant U.S. attorneys on behalf of the FDA, DEA or other federal agencies. Needless to say, the legal bills can became quite expensive for such a physician-client.

Controlling Expectations

In that spirit, as with any other legal matter handled for any client, the most pragmatic approach an attorney can have for resolving board matters is to dampen down their client's expectations regarding what can and cannot be accomplished. Physicians generally have little acumen concerning the law, especially litigation. It is simply not a component of their training or education. A physician-client must be made to understand that his or her attorney does not control the process and cannot predict the outcome. An honest cost-benefit assessment must be made and communicated to the client, taking into account the great risks inherent in uncertain outcomes at the OAL and the board, including the effect a NPDB report would have on the physician's ability to maintain provider status for health insurance and managed care entities.

Table pounding and forceful arguments will glean little if the board is convinced the physician was in the wrong. Compromise and willingness to negotiate is key to resolution. Unlike civil matters, in which two parties negotiate from equal bargaining positions before a neutral judge, the deck is stacked in favor of the DAG by virtue of the fact that the board is, in a sense, both judge and prosecutor. The best result comes about when neither party gets exactly what they are seeking. As Robert Louis Stevenson said: "compromise is the best and cheapest lawyer."

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Endnotes

1. N.J.S.A. 45:1-1 *et seq.*
2. N.J.S.A. 45:9-1 to -27.
3. *Miller v. Passaic Valley Water Comm'n.*, 259 N.J. Super. 1, 12, 611 A.2d 128 (App. Div.), *certif. denied,* 130 N.J. 601, 617 A.2d 1222 (1992).
4. N.J.S.A. 45:9-2.
5. *Ibid.*
6. N.J.S.A. 45:9-16.
7. N.J.S.A. 45:1-22.
8. N.J.S.A. 45:9-19.6.
9. *Ibid.*
10. N.J.A.C. 13:35-6.5.
11. N.J.S.A. 45:9-27.
12. N.J.A.C. 1:1 *et. seq.*
13. The link is identified by the Division of Consumer Affairs as "New Jersey Health Care Profile."
14. 42 U.S.C. 11101.
15. N.J.S.A. 17:33A-1 *et. seq.*

Risks and Requirements for Employer Wellness Programs

by Miriam Straus

Workplace wellness programs have become increasingly popular, as employers aim to encourage healthy habits and lower health insurance costs. However, wellness programs may implicate several federal laws, including the Health Insurance Portability and Accountability Act (HIPAA), the Americans with Disabilities Act (ADA), and the Genetic Information Nondiscrimination Act (GINA). Employers who offer wellness programs should be aware that even common features may subject them to ADA or GINA liability.

This article discusses the requirements for wellness programs under HIPAA's nondiscrimination requirements, a recent Equal Employment Opportunity Commission (EEOC) action that alleges ADA and GINA violations in a wellness program, and state laws that may apply to such programs.

Requirements under HIPAA Nondiscrimination Provisions

Generally, HIPAA prohibits group health plans and group insurance carriers from discriminating against individual participants and beneficiaries in eligibility, benefits, or premiums based on a health factor. However, there is an exception for premium discounts or rebates, or modifications to otherwise-applicable cost sharing in return for adherence to programs of health promotion and disease prevention (wellness programs). The Affordable Care Act (ACA) increased the maximum reward allowed for health-contingent wellness programs under HIPAA's nondiscrimination provisions.

On June 3, 2013, the Department of Labor published a final rule on wellness programs in the *Federal Register*.[1] The final rule addresses the requirements to meet the exception to the HIPAA nondiscrimination provisions. However, it specifically disclaims any impact on other federal or state laws that may apply to wellness programs.

Consistent with previous regulations, the final rule divides wellness programs into two categories: participatory wellness programs and health-contingent wellness programs. For both types of programs the definition of "reward" includes: 1) obtaining a reward, such as a discount or a rebate of a premium or contribution, a waiver of all or part of a cost-sharing mechanism, an additional benefit, or any financial or other incentive; and 2) avoiding a penalty, such as the absence of a surcharge or other financial or nonfinancial disincentive.

Participatory Wellness Programs

Participatory wellness programs either do not provide a reward or do not include any conditions for obtaining a reward that are based on satisfying a standard related to a health factor. Examples of participatory wellness programs include: 1) a program that reimburses employees for all or part of the cost of membership in a fitness center; 2) a diagnostic testing program that provides a reward for participation but does not base any part of the reward on outcomes; and 3) a program that provides a reward to employees for attending a monthly, no-cost health education seminar.

Participatory wellness programs are permissible under the HIPAA nondiscrimination rules as long as they are available to all similarly situated individuals, regardless of health status. The final rule does not limit the reward allowed for participatory wellness programs.

Health-Contingent Wellness Programs

Health-contingent wellness programs require an individual to satisfy a standard related to a health factor in order to obtain a reward (or require an individual to undertake more than a similarly situated individual based on a health factor in order to obtain the same reward). This category is further divided into activity-only wellness programs and outcome-based wellness programs.

Activity-only wellness programs require individuals to perform or complete an activity related to a health factor to obtain a reward. Examples of activity-only wellness programs include walking, diet, or exercise programs.

Outcome-based wellness programs require an individual to attain or maintain a specific health outcome, such as not smoking or achieving certain results on a biometric screening, in order to obtain a reward. An example of an outcome-based wellness program is a program that: 1) tests individuals for specified medical conditions or risk factors, such as high cholesterol, high blood pressure, abnormal body mass index (BMI), or high glucose level; and 2) provides a reward to employees who are within a normal or healthy range, while requiring employees who are outside the normal or healthy range to take additional steps to obtain the same reward.

The requirements for health-contingent wellness programs are more stringent than those for participatory wellness programs. Under the final rule, health-contingent wellness programs (both activity-only and outcome-based) must meet the following five requirements in order to qualify for the HIPAA nondiscrimination exception:

1. Individuals must have the opportunity to qualify for the reward at least once per year.
2. Generally, the total reward offered to an individual under health-contingent wellness programs with respect to a plan cannot exceed 30 percent of the total cost of coverage under the plan, including both the employer and employee contributions toward the cost of coverage. For health-contingent wellness programs designed to reduce or prevent tobacco use, the reward may be increased to 50 percent of the total cost of coverage.
3. Health-contingent wellness programs must be reasonably designed to promote health or prevent disease. This determination is based on all of the relevant facts and circumstances.
4. The full reward under health-contingent wellness programs must be available to all similarly situated individuals. Employers are required to provide a reasonable alternative standard or a waiver of the otherwise applicable standard for obtaining the reward (reasonable alternative) in certain circumstances. For activity-only wellness programs, a reasonable alternative must be available to any individual for whom: 1) it is unreasonably difficult, due to a medical condition, to meet the otherwise applicable standard; or 2) it is medically inadvisable to attempt to satisfy the otherwise applicable standard. For outcome-based wellness programs, a reasonable alternative must be available to *any* individual who does not meet the initial standard based on a measurement, test, or screening.
5. Plans and plan issuers must disclose the availability of a reasonable alternative in all plan materials describing the terms of the health-contingent wellness program.

ADA and GINA Implications

The recent EEOC challenge against Honeywell International, Inc. illustrates some of the potential liabilities for wellness programs. On Oct. 27, 2014, the EEOC filed a petition for a temporary restraining order and preliminary injunction (TRO petition) against Honeywell, alleging the company's wellness program violates the ADA and GINA. The *Honeywell* action is significant because it indicates the EEOC may view some common wellness program features as unlawful.

Honeywell's wellness program includes biometric testing by a third-party vendor, including a blood sample. According to the TRO petition, the penalties for nonparticipation in the biometric testing are as follows: 1) employees will lose their health savings account (HSA) contributions from Honeywell, which may be as much as $1,500; 2) employees will incur a $500 surcharge to their 2015 medical plan costs; 3) employees will be charged a $1,000 tobacco surcharge, even if they choose to forego the biometric testing for reasons other than smoking; and 4) employees with a spouse on their plan will be charged an additional $1,000 tobacco surcharge if their spouse does not submit to the testing, even if the spouse declines for reasons other than smoking.

"Honeywell's plan incentives are in strict compliance with both HIPAA and the ACA's guidelines, which were designed by Congress to encourage healthier lifestyles while helping to control healthcare costs," the company said in a press release. "No Honeywell employee has ever been denied healthcare coverage or disciplined in any way as a result of their voluntary decision not to participate in our wellness programs." Further, the press release noted the biometric results are kept confidential and not shared with Honeywell.

The *Honeywell* case illustrates the question of voluntariness in medical testing under the ADA. Generally,

the ADA prohibits medical examinations that are not job related or consistent with business necessity.[2] However, employers may offer voluntary testing as part of an employee health program.[3] In the TRO petition, the EEOC alleged Honeywell's biometric testing is not voluntary because the company imposes a penalty on employees who do not participate. However, the EEOC has not clarified under the ADA how large a financial incentive must be in order to constitute a 'penalty' for employees who do not participate. However, the EEOC has not clarified how large a financial incentive must be in order to constitute a penalty under the ADA for employees who do not participate.

Honeywell also raises questions about what information GINA protects. Honeywell argued the biometric test does not constitute a 'genetic test' under GINA, which is defined as an "analysis of human DNA, RNA, chromosomes, proteins, or metabolites, that detects genotypes, mutations, or chromosomal changes."[4] However, the EEOC also alleged Honeywell's biometric testing violates GINA by offering an inducement to obtain medical information about employees' spouses, including information that can show hypertension and diabetes. Under GINA, genetic information includes information about the manifestation of disease or disorder in family members of the individual,[5] and a family member includes a person who is a dependent of that individual as a result of marriage.[6]

On Nov. 6, 2014, U.S. District Court for the District of Minnesota denied the TRO petition.[7] The court did not rule on the merits of the case because it found no threat of irreparable harm, and that the balance of harms weighed in favor of Honeywell. However, the court noted "great uncertainty" about how the ACA, the ADA and GINA interact.

"Recent lawsuits filed by the EEOC highlight the tension between the ACA and ADA and signal the necessity for clarity in the law so that corporations are able to design lawful wellness programs and also to ensure that employees are aware of their rights under the law," the court stated.

The EEOC has announced the agency intends to issue proposed rules on the ADA and GINA that relate to wellness plans in Feb. 2015. The ADA regulations will promote consistency between the ADA and HIPAA, and the GINA regulations will clarify that employers who offer wellness programs may adopt a certain type of inducement without violating GINA, the EEOC stated.[8]

State Law Considerations

Wellness programs may also implicate state laws. For example, New Jersey prohibits employers from taking any adverse action against an employee with respect to the compensation, terms, conditions or other privileges of employment because the employee smokes or uses tobacco products, unless the employer has a rational basis for doing so that is reasonably related to the employment.[9] Thus, while the HIPAA nondiscrimination provisions allow a wellness program to impose a surcharge on employees who do not quit smoking, such a program may not be permissible in New Jersey. Employers who offer wellness programs should consider the implication of state laws in each state where they offer wellness programs.

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Endnotes

1. Incentives for Nondiscriminatory Wellness Programs in Group Health Plans, 78 Fed. Reg. 106 (June 3, 2013) (codified at 26 C.F.R. pt. 54).
2. 42 U.S.C. § 12112(d)(4)(A).
3. 42 U.S.C. § 12112(d)(4)(B).
4. *EEOC v. Honeywell Int'l, Inc.*, 2014 U.S. Dist. LEXIS 157945, *13 (D. Minn. 2014) (*citing* 29 U.S.C. § 1191b(d)(7)).
5. 29 C.F.R. § 1635.3(c)(iii).
6. 29 C.F.R. § 1635.3(a)(1).
7. 2014 U.S. Dist. LEXIS 157945.
8. EEOC, Amendments to Regulations Under the Americans with Disabilities Act, RIN 3046-AB01; EEOC, Amendments to Regulations Under the Genetic Information Nondiscrimination Act of 2008, RIN 3046-AB02.
9. N.J. Stat. § 34:6B-1.

Commentary:
Ebola, Kaci Hickox, Quarantine Triangle Ignites a Robust Constitutional Debate

by Decanda M. Faulk

In years past, deadly outbreaks such as SARS and avian influenza highlight the fact that crippling infectious disease pandemics are still a very real concern of governments, public health officials and the community at large. When people potentially exposed to and carrying deadly contagions choose to place their individual interests over the concerns of the general public, the government, guided by its public health authorities, is compelled to act. The clash between the individual and the society's interests is not hypothetical. In fact, in 2007 Andrew Speaker, who was diagnosed with a rare and potentially deadly strain of drug-resistant tuberculosis, made a conscious decision to disregard local, state, and federal advice of public health officials and leave his home in Atlanta, Georgia, to fly internationally for a couple of weeks before returning to the United States.

More recently, the role of government in protecting public health has collided with individual rights. This collision has led to controversy over state police powers and the authority of a state to exercise its powers by imposing a mandatory quarantine to protect the public health against the deadly Ebola virus disease (formerly known as Ebola hemorrhagic fever). The recent Ebola outbreak that originated in West Africa and spread internationally very quickly, led to provocative efforts to contain and prevent further spread of the disease. The Ebola outbreak has sparked a renewed debate on whether imposing a mandatory quarantine on people exposed to Ebola, either through their work or contact with a person or people who have been exposed to Ebola, is necessary and proper as a means to protect the public health from a pandemic. The quarantine actions in certain states, specifically New Jersey and Maine, ignited a robust constitutional debate over the legality of mandatory quarantining. This issue could ultimately reach the United States Supreme Court, which will have to decide whether current quarantine laws violate individual civil liberties.

Definition of Ebola[1]

Ebola is a severe illness marked by hemorrhage (severe bleeding), organ failure and, in many cases, death. First recognized in 1997, the virus gets its name from a river in the Democratic Republic of the Congo (formerly Zaire) in Africa. Until the most recent outbreak, Ebola had appeared sporadically.

There are four types of the Ebola virus, three of which cause illness in humans. The exact origin, locations, and natural habitat of this virus remain unknown, but researchers believe it is normally maintained in an animal host that is native to the African continent. The virus lives in animal hosts, and humans can contract it from infected animals. After the initial transmission, the virus can spread from person to person through direct contact with body fluids. No drug has been approved to treat Ebola, and people diagnosed with the virus receive supportive care and treatment for complications. While scientists are coming closer to developing vaccines for this deadly disease, currently no vaccine is proven to prevent Ebola.

Controversial New Jersey Quarantine Order

On Oct. 22, 2014, New Jersey Governor Chris Christie signed Executive Order No. 164 to address the alarming threat of Ebola. As part of the governor's efforts to combat the deadly virus, he imposed a mandatory 21-day quarantine of people, including healthcare providers, who were deemed at risk of contracting Ebola. A Doctors Without Borders nurse, Kaci Hickox, became entangled in the Ebola controversy when she landed at Newark Liberty International Airport and was detained under New Jersey's mandatory quarantine. Hickox arrived from Sierre Leone, West Africa, where she had provided direct care to Ebola patients while volunteering in Africa. At the time she disembarked at the Newark airport, she presented with a low-grade fever. As a result, Hickox was quarantined pursuant to the governor's executive order.

After consulting with legal counsel, she challenged successfully the quarantine order and it was lifted after four days, allowing her to leave New Jersey. Upon returning to her home state of Maine, Governor Paul LaPage asked her to self-quarantine by remaining in her home for the full 21-day period.

On Oct. 29, 2014, Maine's District Court Chief Judge Charles LaVerdiere issued a temporary court order imposing stricter limits on Hickox, requiring her "not to be present in public places" such as shopping centers or movie theaters, except to receive necessary health care. The temporary order permitted her to engage in "non-congregate public activities" such as walking or jogging, but said she had to maintain a three-foot distance from people. Hickox was also ordered not to leave the municipality of Fort Kent without consulting local health authorities. On Oct. 30, 2014, Judge LaVerdiere ruled in favor of Hickox but ordered her to submit to "direct active monitoring," coordinate travel with public health officials, and immediately notify health authorities should she become symptomatic. Judge LaVerdiere concluded isolating Hickox was too stringent and that Maine's local health officials failed to prove the need for a stricter order enforcing an Ebola quarantine.

Quarantine: An Antiquated and Outdated Public Health Measure?

Before the development and widespread use of antibiotics, quarantine was the method determined most appropriate to protect the public from the spread of infection. First used in the 14th century in Italy, quarantine was the default mechanism for containing untreatable disease, and was the primary mechanism for controlling European outbreaks of tuberculosis and the bubonic plague.[2] Quarantines rested on the premise that the most effective method of controlling the spread of infectious diseases was to place distance between healthy individuals and those who are infected or have been exposed to contagions. Advances in modern medicine have made it unnecessary (except in extreme cases) to employ quarantines in the modern era.

The authority to regulate public health generally, and quarantine specifically, has been left to local authorities as far back as the American Revolution.[3] Today, it is reasonable for those exposed to Ebola to expect that when the government seeks to implement readiness strategies to combat public health crises, it will determine the least restrictive and most appropriate means to protect the public while ensuring the rights of individuals are safeguarded.

In the face of the Ebola crisis, the efforts of various federal, state, and local government agencies and officials to respond appropriately and expediently have renewed the debate over the effectiveness and necessity of imposing quarantine on individuals exposed to deadly diseases, such as Ebola. Specifically, the question society still grapples with is whether quarantine is a reasonable application of state-based police powers to ensure the welfare and safety of the general public against pandemics. Over the years, individual rights and freedom have significantly evolved and the Warren Court receives much of the credit for the expansion of the individual rights enjoyed today.

Controlling Case on Quarantine

The seminal case on a state's action to limit individual rights in order to protect the public health is *Jacobson v. Massachusetts*.[4] In *Jacobson*, the Court upheld the Cambridge Board of Health's authority to require vaccination against smallpox during a smallpox epidemic.

In *Jacobson,* the Commonwealth of Massachusetts was confronted with the deadly smallpox epidemic. In an effort to protect its citizens, Massachusetts required compulsory vaccination against smallpox. Mr. Jacobson refused to be vaccinated, fearful the vaccine might harm his health, and he was fined.

The United States Supreme Court concluded Jacobson could not have his cake and eat it too. In essence, the Court said he could not receive the benefits of being protected from smallpox as a result of his neighbors having been vaccinated while he avoided the personal risk to himself that was inherent in the vaccination. The Court opined that part of being in a civilization meant giving up some personal freedom in exchange for belonging to that society. Arguably, the same can be said today in the case of Hickox and the Ebola risk she posed when returning to the United States.

The legal question, however, is whether the quarantine of Hickox was reasonable under the circumstances. A discussion on reasonableness must take into consideration, *inter alia*, the 14th Amendment, which reads, "no State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws."

The Role of Government in Public Health

State and local governments are primarily responsible for maintaining public health and controlling the spread of diseases within their borders. Among other state public health emergency preparedness powers, every state, the District of Columbia and most territories have laws authorizing quarantine and isolation,[5] usually through the state's health authority.

It is a state's police power that allows it to pass and enforce isolation and quarantine, health, and inspection laws to mitigate or prevent the spread of diseases. Although *Jacobson* addressed the issue of a mandatory vaccination against smallpox, the Court's holding mentioned quarantines, and its rationale can be applied similarly to the issue of mandatory quarantines.

The federal government has authority as well, through the Centers for Disease Control and Prevention (CDC), to monitor and respond to the spread of communicable diseases across national or state borders, or if the state government is unwilling or unable to effectively respond. The CDC's authority to exercise quarantine and isolation powers for specific diseases derives from the Federal Public Health Service Act and a series of presidential executive orders, recently updated in 2014. Under these orders, federal quarantine and isolation powers currently apply to the following diseases: cholera; diphtheria; infectious tuberculosis; plague; smallpox; yellow fever; viral hemorrhagic fevers (Lassa, Marburg, Ebola, Crimean-Congo, South American, and others not yet isolated or named); influenza caused by new or reemerging flu viruses that are causing, or have the potential to cause, a pandemic; and severe acute respiratory syndromes.[6]

In light of the World Health Organization having declared Ebola a public health emergency of international concern, it is prudent that federal, state, county, and local governments, first responders, the private sector and the entire healthcare industry work together to coordinate efforts in combating the further spread of Ebola. Similar to the Commonwealth of Massachusetts' response to the smallpox epidemic in the early years of the 20th century,[7] states have responded to the global spread of Ebola and the increase in the number of Ebola-linked deaths.

While *Jacobson* addressed compulsory vaccinations, today the issue is states' impositions of mandatory quarantines to control the spread of infection, and often, fatal diseases, like Ebola. Both the compulsory vaccination and Ebola quarantines were purportedly done to protect the public's health and not for punitive purposes. Some question how mandatory quarantines can be deemed unreasonable when mandatory vaccination was declared reasonable by the highest Court in *Jacobson*.

Acknowledging much has changed since the *Jacobson* decision, including individual rights that evolved under the Warren Court and, specifically, the standard of review for public health activities when exercised under police powers, where should the policy of mandatory quarantines currently stand? Clearly, when evaluating alleged constitutional violations reportedly done in the name of public health, states must use the least restrictive means to limit expressed or implied constitutional rights in the pursuit of furthering compelling state interests in protecting the public health.

While quarantine is well-established as lying within the police power of a state to provide for the general health and welfare, there continues to be a lack of uniformity in the conditions and procedures that states (and the District of Columbia) exercise to control a public health emergency. However, all states must exercise their quarantine powers by addressing legal issues:

- The definition and proper uses;
- The provision of due process;
- The conditions of quarantine; and
- Resultant liability

While the Court may ultimately decide the issue of quarantine in general, and specifically whether states must make adjustments to further balance individual rights against the public health, states retain the power to impose quarantines in the interest of public health. The 10th Amendment, which expressly states "the powers not delegated to the United States by the Constitution, nor prohibited by it to the states are reserved to the states respectively, or to the people," is where the states derive its police powers. States must exercise their police powers prudently.

Conclusion

If *Jacobson* stands for the proposition that a state's police powers allow it to react in the event of public health emergencies, then it should be legally permissible for a governor to impose a quarantine to protect the public health. Furthermore, the *Jacobson* decision also settled another controversy when it affirmed that states can create bodies that are given the authority to protect the public health through reasonable regulations. If, however, as many argue, *Jacobson* was decided during a

time when society was very different, and its rationale cannot be applied to mandatory quarantines, there may be a wave of sea change that could render quarantines unconstitutional for violating individuals' rights and further compromise a public health agenda that is struggling to fulfill its core mission.[8]

Under *parens patriae*, a slippery slope will follow if the obligation of the state to act as 'parent of the country' is compromised by disallowing for the use of quarantines. In the face of a highly infectious and deadly disease like Ebola, should we strive to strike a perfect balance between private and public rights? This question remains unanswered.

Suffice it to say, the exercise of quarantine powers clearly raises sensitive issues about civil liberties. Individuals have rights to due process of law and, generally, quarantines must be carried out in the least restrictive setting necessary to maintain public health. Interestingly, in 2007 in a survey conducted for the Trust for America's Health, "nearly 9 out of 10 Americans say they would abide by a voluntary quarantine and stay home in the case of an outbreak of a pandemic flu. Willingness to accept this type of quarantine exists across the public at high levels. [However], among the 10 percent who say they would not adhere to the government's request of a voluntary quarantine, most indicate that they could not stay at home due to fears of losing needed income (64 percent) or losing their jobs altogether (39 percent)."[9] Obviously, there is a percent that will not self-quarantine for less compelling reasons.

NBC News medical reporter Dr. Nancy Synderman is a recent example of the ineffectiveness of relying on self-quarantines. Synderman, upon returning from Liberia where she was covering the Ebola story, agreed to self-quarantine for 21 days—the incubation period for Ebola symptoms to present. Nonetheless, just three days into her 21-day self-quarantine, Synderman knowingly put the public at risk to pick up takeout food from a local restaurant. Significantly, Synderman had been in Liberia in October reporting on the Ebola outbreak when a cameraman in her crew came down with the deadly virus.

Based on the foregoing, measures should be in place to quantify and qualify the risk of persons who are most at-risk of spreading a deadly infectious disease and then the government should be permitted to act accordingly. In the case of Hickox, considerable factors to weigh are the degree of restriction of her personal liberty and whether the restriction would be deemed unconscionable. ■

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Endnotes

1. http://www.who.int/mediacentre/factsheets/fs103/en/.
2. *See Id*.
3. *Id*. at 685.
4. 197 U.S. 11 (1905).
5. Isolation is distinguishable from quarantine, and this article focuses exclusively on the latter. However, to provide context the following definitions are provided. The Centers for Disease Control and Prevention defines isolation as "separat[ing] ill persons who have a communicable disease from those who are healthy." To illustrate the slight distinction, quarantine is define as "separt[ing] and restrict[ing] the movement of well persons who may have been exposed to a communicable disease to see if they become ill."
6. CDC and New Jersey League of Municipalities.
7. *Jacobson v. Massachusetts*, 197 U.S. 11 (1905).
8. Public Health Strategy and the Police Powers of the State, Jorge E. Galva, JD, MHA; Christopher Atchison, MPA; Samuel Levey, PhD, SM, Public Health Reports, 2005 Supplement 1, Volume 120, Page 20
9. http://healthyamericans.org/reports/bioterror07/.