



DOUBTFUL DUTY: PHYSICIANS' LEGAL
OBLIGATION TO TREAT DURING AN EPIDEMIC

Ariel R. Schwartz

NOTE

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INTRODUCTION

Over the course of the twentieth century, the medical community “appeared to be winning the battle against communicable diseases” with antibiotics and vaccines.¹ Yet, in the last few decades, new infectious diseases

* Law Clerk to the Honorable Kermit V. Lipez, U.S. Court of Appeals for the First Circuit; J.D. 2007, Stanford Law School. I would like to thank Professor Hank Greely, Professor Norman Spaulding, and Nancy Leong for their generosity in providing me with

and conditions such as Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS), Severe Acute Respiratory Syndrome (SARS), Ebola, and avian influenza (most notably virus H5N1) have created grave new threats. Although HIV/AIDS is not particularly contagious if appropriate precautions are taken,² avian influenza, SARS, and Ebola are believed to be *highly* contagious, fatal, and sometimes without mechanisms to prevent transmission.³

With the threat of an epidemic looming, the question of physicians' legal duties during an epidemic of a highly infectious disease becomes critical. While there is a rich body of literature in medical journals concerning physicians' ethical obligations in epidemics and extensive case law regarding the question of physicians' legal duties to HIV/AIDS patients under the Americans with Disabilities Act of 1990 (ADA), few scholars or policymakers have discussed the appropriate legal frameworks for addressing physicians' duties to treat highly infectious diseases such as avian influenza, Ebola, and SARS. That this

feedback and suggestions for this Note. I am grateful to my family for their support and to Ethan Siller for his ideas and encouragement at every stage of this project. Finally, I appreciate the efforts of the dedicated members of the *Stanford Law Review*.

1. Lawrence O. Gostin, Scott Burris & Zita Lazzarini, *The Law and the Public's Health: A Study of Infectious Disease Law in the United States*, 99 COLUM. L. REV. 59, 97 (1999).

2. The risk from treating HIV/AIDS is much lower than the risk from treating other infectious diseases, in part because epidemiologists have developed highly effective techniques for reducing the risk of occupational exposure to and contraction of HIV/AIDS. Although the exact rate of transmission is a matter of contention, the Public Health Service estimates that exposure to HIV/AIDS from an infected needle stick or sharp object is approximately 0.3% and the rate of infection from contact with a mucous membrane or nonintact skin is 0.09% or less. *Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HIV and Recommendations for Postexposure Prophylaxis*, 54 MORBIDITY & MORTALITY WKLY. REP. (SPECIAL ISSUE) 1, 2 (2005), available at <http://www.cdc.gov/mmwr/PDF/rr/rr5409.pdf>.

3. Part of the reason the threat of avian flu is so worrisome is because subtypes of the flu have caused devastating global pandemics in the past. Ctrs. for Disease Control & Prevention, Questions and Answers: Reconstruction of the 1918 Influenza Pandemic Virus, <http://www.cdc.gov/flu/about/qa/1918flupandemic.htm>. In 1918, the United States lost over half a million people to the Spanish flu (H1N1). Worldwide, the death toll was approximately 20 million to 50 million people. *Id.* Some worry that the H5N1 subtype of avian flu could be even more devastating than the Spanish flu if H5N1 mutates to the point where it can be effectively transmitted from humans to humans. U.S. Dep't of Health & Human Servs., PandemicFlu.gov—General Information, <http://www.pandemicflu.gov/general/#factsheets>. Since 2003, the H5N1 subtype has been transmitted to humans in 329 cases, leading to 201 deaths, none of which has been in the United States. World Health Org., Cumulative Number of Confirmed Human Cases of Avian Influenza A/(H5N1) Reported to WHO, http://www.who.int/csr/disease/avian_influenza/country/cases_table_2007_10_02/en/index.html. There have been rare incidents in which a human has transmitted the H5N1 subtype to one other human. Unfortunately, H5N1 is anticipated to continue to mutate to the point where it has a high rate of transmission from person to person. Currently, the lack of statistical information makes it difficult to predict the timing and effects of an avian flu pandemic. See U.S. Dep't of Health & Human Servs., *supra*.

issue has received minimal attention from legal scholars and policymakers is troublesome since physicians will probably be needed to help control an epidemic. The current failure to address the issue of whether and to what extent physicians have a duty to treat people with fatal, highly infectious diseases could have devastating consequences during an epidemic.

This Note focuses on the impact of an epidemic on physicians because, as compared with other healthcare workers such as nurses, physicians are the most publicly visible and tend to have the most professional autonomy. Moreover, physicians as a group have tremendous influence over the development of local, state, and federal healthcare policy. However, a focus on physicians in no way suggests that they are the only group of healthcare professionals with an important stake in policies regarding duties to treat during an epidemic. The concerns of other healthcare professionals tend to be coextensive with the concerns of physicians. The healthcare industry employs millions of Americans, many of whom will be affected by the creation of legal frameworks compelling delivery of care.⁴ Greater clarity regarding physicians' responsibilities during an epidemic will help inform a discussion about the interests of other healthcare professionals.

By addressing the structural limitations of existing legal frameworks pertaining to physicians' duties and by discussing ways in which states can create emergency legal frameworks that compel physicians to provide treatment when appropriate, this Note begins to fill a void in the literature regarding physicians' obligations during an epidemic. Part I considers the willingness of physicians to treat during an epidemic by examining physicians' past attitudes towards epidemics, and the role the American Medical Association (AMA) has played in shaping the regulation of the medical profession.

Part II analyzes the inapplicability of existing statutory frameworks in an epidemic context. In particular, this Part examines why the ADA and similar state laws, which prohibit physicians from refusing treatment to patients with HIV/AIDS because they are seropositive for HIV, have limited applicability for determining whether physicians are required to treat patients with highly

4. As of May 2005, according to the Bureau of Labor Statistics, there were 6,547,350 people in the category of "Healthcare Practitioner and Technical Occupations," which included occupations such as doctors, dentists, nurses, occupational health specialists, pharmacy technicians, and radiation specialists. Bureau of Labor Statistics, U.S. Dep't of Labor, Occupational Employment and Wages, May 2005: Healthcare Practitioners and Technical Occupations, <http://www.bls.gov/oes/2005/may/oes290000.htm>. In addition to this category, 3,363,800 people, as of May 2005, were employed in "Healthcare Support Occupations," in such capacities as nursing aides, orderlies, and home health aides. Bureau of Labor Statistics, U.S. Dep't of Labor, Occupational Employment and Wages, May 2005: Healthcare Support Occupations, <http://www.bls.gov/oes/2005/may/oes310000.htm>. People in all of these occupations, totaling almost ten million workers as of 2005, would be more likely to become exposed to highly infectious diseases than the public at large, and the efficacy of safety precautions is still unknown.

infectious diseases. This Part also demonstrates that while hospitals have a legal obligation to treat people with infectious diseases and doctors have contractual obligations to hospitals, the care available from this set of relationships is unlikely to be sufficient during an epidemic.

Part III discusses the role that states and governors will play in managing an epidemic given current legislation and directives from the Department of Health and Human Services (HHS). Moreover, this Part addresses the contributions of the drafters of the Model State Emergency Health Powers Act (MSEHPA) in proposing a system that recognizes the need for governors to be able to declare a state of emergency during an epidemic and to require physicians to provide care as a condition of their professional licensure. Finally, Part III argues that the primary shortcoming of the MSEHPA, as it pertains to physicians, is that it fails to recognize physicians' property interests in their licenses and to provide them with the process they are constitutionally due.

This Note acknowledges that the degree of risk physicians should be required to confront during an epidemic as a condition of their licensure is hardly clear. Of course, uncertainty regarding what type of epidemic might transpire and how many people would be implicated greatly contributes to the challenge of establishing what role physicians should play. As evidenced by the muddle of laws that tangentially address physicians' obligations to treat people with highly infectious diseases, it is impossible to create a bright-line test for determining what exactly physicians should and should not be required to do during an epidemic. Therefore, during an epidemic, it would be appropriate to give the governor the opportunity to declare a state of emergency and to allow her, after great consideration, to assess whether and to what extent physicians should be required to provide treatment to patients with highly infectious diseases. Yet, this power of the governor should not be unbridled. Only by relying on traditional due process analysis can we create a system in which physicians provide appropriate care to patients during an epidemic.

I. HISTORICAL ORIGINS

The current lack of clarity regarding the legal standard that governs physicians' duties during an epidemic is in part a reflection of the persistent divisions among physicians concerning appropriate professional conduct. The question of whether and to what extent physicians have an ethical duty to treat patients during an epidemic has a long pedigree. Scholarship on the history of medical ethics reveals that the medical community has never come to a consensus on the nature and scope of its responsibilities during an epidemic.⁵

5. See generally Abigail Zuger & Steven H. Miles, *Physicians, AIDS, and Occupational Risk: Historic Traditions and Ethical Obligations*, 258 JAMA 1924 (1987) (discussing the history of physicians' responses to epidemics).

Physicians' interpretations of their professional responsibilities are relevant for understanding their legal duties because the medical profession in the United States exerts tremendous influence over the regulation of the profession.

A. Emergence of the American Medical Association

Since the mid-1980s, medical historians have accepted the Zuger-Miles hypothesis that prior to the twentieth century there was no "strong or consistent" tradition of physicians rendering care in epidemics due to a sense of professional responsibility.⁶ According to the Zuger-Miles hypothesis, physicians have tended to act according to their own individual predilections. For example, medieval doctors fled Venice in the fourteenth and fifteenth centuries to avoid becoming infected with the black plague, and physicians in the seventeenth century left London to escape the bubonic plague.⁷ In Philadelphia, during the yellow fever outbreak of 1793, some American physicians' responded as their European predecessors had.⁸ For example, three of the most famous doctors in Philadelphia went to the countryside to try to avoid contact with yellow fever.⁹

Yet, not all physicians fled disease-ridden cities.¹⁰ During the yellow fever outbreak in Philadelphia, most physicians probably stayed in the city.¹¹ Some stayed to tend to the ill out of a feeling of religious obligation.¹² Others, dubbed "plague doctors," provided care in exchange for monetary incentives.¹³ Another group of physicians was motivated by a sense of contractual duty to their patients.¹⁴ Since writers from the medieval period to the nineteenth century derided physicians who fled epidemics for their "avarice and cowardice,"¹⁵ perhaps some physicians stayed to avoid censure by the broader community.

In response to the multitude of physicians' reactions during epidemics, the AMA, founded in 1847, sought to codify expectations for physicians' behavior. The AMA's first Code of Ethics was groundbreaking in part because it "served formally to enshrine the potential for *professional* obligations, distinct from

6. *Id.* at 1924.

7. *Id.* at 1925.

8. *Id.*

9. *Id.*

10. See Samuel J. Huber & Matthew K. Wynia, *When Pestilence Prevails: Physician Responsibilities in Epidemics*, 4 AM. J. OF BIOETHICS W5, W6 (2004).

11. Zuger & Miles, *supra* note 5, at 1925.

12. Huber & Wynia, *supra* note 10, at W6.

13. See generally Daniel M. Fox, *The Politics of Physicians' Responsibility in Epidemics: A Note on History*, HASTINGS CENTER REP., Apr.-May 1988, at 5, 5-7 (arguing that historically some physicians treated people, especially low income people, with highly infectious diseases because of contractual agreements with civic leaders).

14. Zuger & Miles, *supra* note 5, at 1926.

15. *Id.* at 1924-25.

matters of personal choice, charity, or religion.”¹⁶ The Code stated: “[W]hen pestilence prevails, it is [physicians’] duty to face the danger, and to continue their labors for the alleviation of the suffering, even at the jeopardy of their own lives.”¹⁷

The impetus for trying to codify expectations in the Code is highly contested. Some historians view the Code of Ethics as an example of “public relations exercises designed to pacify the public and to gull legislators into supporting orthodox medicine’s monopolizing proclivities.”¹⁸ Others view the original Code as articulating a “radical reformist vision of American medicine” that sought to protect the public from unorthodox, uneducated practitioners.¹⁹

In either case, once codified, the AMA’s standard became a touchstone in the debate about professional ethics and has facilitated a certain conception of professional obligation among physicians and the public at large.²⁰ Although only a quarter of physicians are members of the Association, the AMA’s words and actions influence professional standards within the medical community,²¹ especially to the extent that its words are reinforced by legislative initiatives and programs developed by the AMA.²² Drs. Steven J. Huber and Matthew K. Wynia²³ argue that the Code facilitates a sense of professional identity that:

separate[s] professional duties from personal choices . . . [as well as a] public expectation of the duty [that] implies reliance on physicians to perform according to a social contract, for which physicians as a group are rewarded

16. Huber & Wynia, *supra* note 10, at W6.

17. JOHN BELL & ISAAC HAYS, CODE OF ETHICS (1847), reprinted in THE AMERICAN MEDICAL ETHICS REVOLUTION 324 app. at 333 (Robert B. Baker et al. eds., 1999).

18. Robert B. Baker, *The American Medical Ethics Revolution*, in THE AMERICAN MEDICAL ETHICS REVOLUTION, *supra* note 17, at 17, 17.

19. *Id.* at 18.

20. Robert Veatch, a Professor of Medical Ethics at Georgetown University, questions the soundness of physicians as the source of their own professional codes of conduct and by extension their role in developing the legal standards by which they are judged. Robert M. Veatch, *Who Should Control the Scope and Nature of Medical Ethics?*, in THE AMERICAN MEDICAL ETHICS REVOLUTION, *supra* note 17, at 158, 158-59, 163. Dr. Mark Siegler, the Director of the MacLean Center for Clinical Medical Ethics at the University of Chicago Hospitals, believes that doctors are uniquely qualified to control the scope and nature of medical ethics because many of the most crucial ethical decisions arise in the context of the physician-patient relationship. Siegler argues that the most ethical outcomes can be obtained through a shared, non-adversarial exchange between patients and physicians. Mark Siegler, *Medical Ethics as a Medical Matter*, in THE AMERICAN MEDICAL ETHICS REVOLUTION, *supra* note 17, at 171.

21. See Chalmers C. Clark, *In Harm’s Way: AMA Physicians and the Duty to Treat*, 30 J. MED. & PHIL. 65, 66-67 (2005).

22. See Robert Baker & Linda Emanuel, *The Efficacy of Professional Ethics: The AMA Code of Ethics in Historical and Current Perspective*, HASTINGS CENTER REP., July-Aug. 2000, at S13, S13-S17.

23. Dr. Matthew K. Wynia is the Director of the AMA’s Institute for Ethics and a Clinical Assistant Professor of Medicine at the University of Chicago Hospitals. American Medical Association—Staff Biosketches, <http://www.ama-assn.org/ama/pub/category>.

and, by extension, the breach of which is anticipated to lead to rescinding of professional prerogatives granted the group by society.²⁴

Evidence of the Code's efficacy can be found during the period between 1847 and 1957, when the Code clearly articulated a duty to treat despite personal risk.²⁵ During this period, records indicate that physicians provided care in a number of epidemic contexts, including during the Spanish Flu of 1918 and during times of heightened tuberculosis outbreaks.²⁶ Perhaps doctors during this period were more inclined to provide care than their predecessors because they had entered the profession with an understanding that they would be expected to tend to patients even if it posed a threat to their own health.

In 1957, however, the strong language of self-sacrifice in the Code was perceived to be in tension with the goal of contractual freedom, so the Code's reference to epidemics was relegated to an interpretive note.²⁷ By 1977, this interpretive note was withdrawn as a "historical anachronism."²⁸ This withdrawal may have been in part a reflection of the widespread view that the medical community was winning the war against communicable diseases.²⁹

Amidst the AIDS crisis of the 1980s, the AMA declined to amend the Code to explicitly require physicians to provide care to patients with HIV/AIDS. Instead, in 1987, the AMA's Council on Ethical and Judicial Affairs (CEJA) issued an opinion that said, "A physician may not ethically refuse to treat a patient whose condition is within the physician's current realm of competence solely because the patient is seropositive [for HIV/AIDS]."³⁰

Similarly, in the 2002 revisions to the Code, the AMA chose not to directly address physicians' duties during emergencies, such as the recent attacks on the World Trade Center and the Pentagon. Instead, the AMA drafted a Declaration of Professional Responsibility, which listed as one of its principles that physicians should "[a]pply [their] knowledge and skills when needed, though doing so may put [them] at risk."³¹ This comment clearly encompasses

24. Huber & Wynia, *supra* note 10, at W5 (footnote omitted).

25. *See id.* at W7; Zuger & Miles, *supra* note 5, at 1926.

26. *See* Huber & Wynia, *supra* note 10, at W7; Zuger & Miles, *supra* note 5, at 1926.

27. *See* John D. Arras, *The Fragile Web of Responsibility: AIDS and the Duty to Treat*, HASTINGS CENTER REP., Apr.-May 1988, at 10, 10-14; Huber & Wynia, *supra* note 10, at W7.

28. Huber & Wynia, *supra* note 10, at W7. *See generally* Baker, *supra* note 18 (chronicling the many changes to AMA Code of Ethics, which was later renamed the Principles of Medical Ethics, and highlighting the goals and reasoning behind these amendments).

29. *See* Gostin et al., *supra* note 1, at 97.

30. COUNCIL ON ETHICAL & JUDICIAL AFFAIRS, AM. MED. ASS'N, CEJA REPORT A-I-87: ETHICAL ISSUES INVOLVED IN THE GROWING AIDS CRISIS 1 (1987), available at http://www.ama-assn.org/ama1/pub/upload/mm/369/ceja_ai87.pdf.

31. COUNCIL ON ETHICAL & JUDICIAL AFFAIRS, AM. MED. ASS'N, CEJA REPORT 5-I-01: A DECLARATION OF PROFESSIONAL RESPONSIBILITY 3 (2001), available at http://www.ama-assn.org/ama1/pub/upload/mm/369/ceja_5i01.pdf.

scenarios in which the risk to the physician would be low and the benefit to the patient would be high. Yet, the AMA offers little guidance on how physicians should weigh their competing responsibilities in a scenario in which the risk to the physician would be high, as would be the benefit to the patient. The AMA's level of generality and vagueness is not coincidental. In the official comments accompanying the *Declaration of Professional Responsibility*, the authors note that "[g]reater specificity would compromise the universal applicability of the *Declaration* and possibly divide rather than unite physicians."³²

The AMA states that the principles articulated in the *Declaration* are enforceable only by the signatories within the profession and as such "differ[] from codes of ethics used in the adjudication of legal and ethical issues by professional boards and courts of law."³³ This comment is illustrative of the AMA's struggle to create a more expansive understanding of ethical duty while also recognizing the possible legal consequences of such an articulation. The AMA, in its failure to address specifically when and to what extent physicians should be required to provide care during an epidemic, has effectively ceded some of its influence on this matter to the government.

B. *Relationship Between Law and Ethics*

Physicians' view of their own ethical duty is relevant because physicians have tremendous autonomy in regulating the behavior of those in the medical profession. The policy of the Rhode Island Board of Medical Licensing and Discipline exemplifies physicians' influence over the laws that govern them: "No single list or source can offer practicing physicians guidance in every conceivable circumstance. However, the Board relies upon the American Medical Association's code of ethics as the legal standard."³⁴

A brief discussion of physicians' involvement in the development of legal standards helps demonstrate the importance of physicians' conception of their duty to treat during an epidemic. Generally, physicians' legal influence arises in two contexts: (1) associations of physicians act in gatekeeping capacities by determining who can enter and remain in the profession, and (2) courts rely on customs within the medical profession and the judgments of practitioners.

Physicians, primarily through the AMA, serve as gatekeepers of the profession by virtue of their participation in and influence over medical education and licensure. The AMA controls the accreditation process for medical schools and the licensure requirements for those who want to enter the profession.³⁵ The stated rationale for the authority vested in the AMA is that it

32. *Id.* at 1.

33. *Id.*

34. Rhode Island Dep't of Health, Board of Licensure and Discipline, <http://www.health.ri.gov/hsr/bmld>.

35. Monica Noether, *The Effect of Government Policy Changes on the Supply of*

allows the profession to maintain high standards, which then benefit members of the public as consumers of medical services.³⁶ Economists debate whether this cartel-like behavior has the intended effect of controlling quality rather than simply driving up healthcare costs.³⁷ Similarly, the efficacy of the AMA at exerting complete control over the supply of physicians is contested.³⁸ Nonetheless, the active role of physicians as gatekeepers for the medical profession is widely agreed upon.³⁹

Another factor that contributes to physicians' influence over the legal standards to which they are held is the courts' deference to professional standards. Just as a lay defendant accused of committing a tort is judged against the behavior of a hypothetical reasonably prudent person acting under the same or similar circumstances, a physician accused of committing malpractice is judged against the standard of care a reasonable physician with similar specialized knowledge or skill would provide.⁴⁰ While each state's tort laws governing malpractice differ, the prevailing standards of care in a physician's medical community are highly influential when determining whether a physician has committed malpractice.⁴¹ Through this process, the courts have institutionalized deference to physicians' communal assessments of their professional responsibilities.

Finally, physicians' understanding of their own responsibilities is influential because of the Supreme Court's reliance on the judgment of medical professional associations, especially the AMA, when considering some of the thorniest medical ethics issues. As discussed by physician-lawyer M. Gregg Bloche, the Supreme Court has cited the AMA's amicus briefs in recent cases dealing with physician-assisted suicide, Fourth Amendment rights relating to hospitals' refusals to disclose to the government the results of patients' drug

Physicians: Expansion of a Competitive Fringe, 29 J.L. & ECON. 231, 233 (1986); see also Shirley Svorny, *Licensing Doctors: Do Economists Agree?*, 1 ECON. J. WATCH 279, 284 (2004).

36. See Noether, *supra* note 35, at 233; Svorny, *supra* note 35, at 280-81.

37. See Svorny, *supra* note 35, at 285-89; see generally Noether, *supra* note 35 (describing growth in the supply of physicians in the United States in the 1960s and 1970s due to an increase in the size of American medical school classes and the number of foreign medical graduates).

38. Noether, *supra* note 35.

39. See Michael Moran, *The Health Professions in International Perspective*, in REGULATING THE HEALTH PROFESSIONS 19 (Judith Allsop ed., 2003).

40. WILLIAM L. PROSSER, HANDBOOK OF THE LAW OF TORTS § 32 (4th ed. 1971).

41. John A. Siliciano, *Wealth, Equity, and the Unitary Medical Malpractice Standard*, 77 VA. L. REV. 439, 446-47 (1991). The process of defining what constitutes a physician's medical community has been highly contested. In *Shilkret v. Annapolis Emergency Hospital Ass'n*, the Maryland Court of Appeals provided a clear summary of the history of "the strict locality rule," which judged physicians' conduct by the standards of their region. 349 A.2d 245, 246 (Md. 1975). Yet, the court asserted that due to greater uniformity of physician training and specialization, a physician's behavior should be judged by the national standard of care. *Id.* at 252-53.

tests, and the appropriate role of a physician's judgments when considering abortions and treating the mentally ill.⁴²

As recently as *Gonzales v. Oregon*, the Supreme Court cited the AMA's position that "[p]hysician-assisted suicide is fundamentally incompatible with the physician's role as a healer" to support its conclusion that providing a prescription to produce death does not constitute a legitimate medical purpose.⁴³ In *Stenberg v. Carhart*, the AMA's position that an intact dilation and extraction abortion "not be used unless alternative procedures pose materially greater risk to the woman" served as one of the focal points of the Court's analysis.⁴⁴ Although the Court's holding that the Nebraska law regulating intact dilation and extraction abortions did not have an adequate exception for the life and health of the mother was not entirely consistent with the AMA's position, the Court's decision did consider the standards set forth by the AMA.⁴⁵

This pattern of the Court looking to the AMA for guidance is noteworthy because it suggests that should issues relating to the treatment of patients with highly infectious diseases reach the Supreme Court, the Court is likely to consider the AMA's understanding of physicians' responsibilities. Unfortunately, as indicated above, the AMA's guidelines provide only a murky set of standards for how physicians should view their responsibilities during an epidemic when both the risk to the physician and the benefit to the patient would be high.

C. Reluctance to Treat

During an epidemic, physicians undoubtedly would have to make some difficult decisions about whether to provide care. Many physicians would have a host of competing responsibilities to their families, their uninfected patients, their infected patients, and themselves. Moreover, they probably would feel woefully uninformed about the risks associated with providing care to infected patients and whether their care would even be effective. The premise that some physicians would try to avoid treating patients with highly infectious diseases is

42. See M. Gregg Bloche, *The Supreme Court and the Purposes of Medicine*, 354 NEW ENG. J. MED. 993 (2006).

43. 546 U.S. 243, 286 (2006) (citations omitted) ("[V]irtually every medical authority from Hippocrates to the current American Medical Association (AMA) confirms that assisting suicide has seldom or never been viewed as a form of prevention, cure, or alleviation of disease, and (even more so) that assisting suicide is not a legitimate branch of that science and art." (quotation marks omitted)).

44. 530 U.S. 914, 935 (2000) (citation omitted).

45. See generally *Stenberg*, 530 U.S. 914 (finding a Nebraska statute that criminalized "partial-birth" abortions unconstitutional on the grounds that the statute did not have an exception for when the life or health of the mother required such a procedure and that it imposed an undue burden on the right to have an abortion by limiting a woman's ability to choose a common abortion procedure).

based on physicians' historic responses in epidemics, as discussed above,⁴⁶ and recent studies that indicate that some physicians remain reluctant to treat patients with certain infectious diseases.

A study conducted in the late 1990s by the American Civil Liberties Union's AIDS Project found that twenty-three percent of U.S. medical residents "indicated that they would not care for persons with AIDS if they had a choice."⁴⁷ One might argue that these results are poor indicia of physicians' behavior during an epidemic because the physicians in the study may have been influenced by prejudicial attitudes towards people with HIV/AIDS. However, the ACLU study indicates that fear of becoming infected with AIDS, not prejudice, was the compelling factor for physicians who wanted to deny treatment. This fear of infection would probably also influence physicians treating patients with highly infectious diseases.

A physician might feel even more reluctant to expose herself to a patient with a highly infectious disease than to a patient with HIV/AIDS out of fear that she will contract the highly infectious disease and then pose a risk to the health of her family and her other patients. HIV/AIDS transmission is primarily limited to one's sexual partners and is easier to control than the transmission of a highly infectious disease. Also, the risk of transmitting HIV/AIDS from doctor to patient is very low.⁴⁸

In contrast, a highly infectious disease like avian flu would put a doctor's entire family at risk, especially young children and the elderly. In a Toronto study of physicians working at three academic hospitals during the SARS outbreak, almost one-third of physicians worried about transmitting the disease to their families.⁴⁹ This survey also indicated that those with children in their homes felt more fearful of infecting their families.⁵⁰

Also, contracting a highly infectious disease would jeopardize a physician's ability to treat her non-infected patients. With appropriate precautions, a physician with HIV is capable of continuing to provide treatment to non-infected patients.⁵¹ However, a physician who contracts avian flu or SARS might be physically incapacitated, quarantined, or present too great a

46. One could hope that modern doctors' reactions to epidemics would differ from their predecessors' due to changed notions of professional responsibility, greater faith in technology, increased social pressure, or myriad other factors. However, current trends in medicine suggest that such a sea change should not be expected.

47. Doran Smolkin, *HIV Infection, Risk Taking, and the Duty to Treat*, 22 J. MED. & PHIL. 55, 56 (1997) (citation omitted).

48. See Am. Bar Ass'n AIDS Coordinating Comm., *Calming AIDS Phobia: Legal Implications of the Low Risk of Transmitting HIV in the Health Care Setting*, 28 U. MICH. J.L. REFORM 733, 733 (1995) ("[O]nly one health care worker has ever been documented as the source of HIV transmission to a patient.") .

49. Sherry L. Grace et al., *The Occupational and Psychosocial Impact of SARS on Academic Physicians in Three Affected Hospitals*, 46 PSYCHOSOMATICS 385, 389 (2005).

50. *Id.* at 390.

51. See Am. Bar Ass'n AIDS Coordinating Comm., *supra* note 48.

risk to her patients. Some of these concerns were articulated by Toronto physicians who provided care to SARS patients. In a survey, they characterized their “main concerns” should they become sick with SARS as (1) creating a lack of medical services for non-SARS patients, (2) loss of income because of quarantines, and (3) suspension of medical services—none of which were concerns that were discussed in the infectious disease literature regarding HIV.⁵²

Despite the AMA’s lack of clarity regarding what constitutes ethical behavior during an epidemic and some physicians’ reluctance to treat people with HIV/AIDS, it is possible that an adequate proportion of physicians would be willing to provide care voluntarily during an epidemic. The SARS study found, “[r]emarkably, few physicians reevaluated their career choice, and most felt it was their duty to treat . . . infectious patients regardless of the personal risks.”⁵³ In the United States, such an attitude might prevail during an epidemic. But history suggests that there may well be a shortage of physicians willing to treat people voluntarily. Therefore, it is imperative that legislators, public health authorities, and physicians develop a clear framework for determining physicians’ legal obligations during an epidemic.

II. IN THE ABSENCE OF AN “EMERGENCY”

In the absence of a public health emergency such as an epidemic, the Americans with Disabilities Act provides the primary framework for determining whether physicians have a duty to treat patients with a particular disease. The ADA is arguably “the most significant civil rights legislation since the enactment of the Civil Rights Act of 1964,”⁵⁴ because it greatly expanded legal protections for physically and mentally disabled Americans.⁵⁵ The ADA has been interpreted to require physicians to treat patients infected with a host of diseases, including HIV/AIDS.⁵⁶ However, as this Subpart will demonstrate,

52. See Grace et al., *supra* note 49, at 389.

53. *Id.* This survey polled Canadian physicians who worked in a public teaching hospital. Their views regarding their duties during an epidemic might differ from the views of physicians in the United States, especially those who are in private practice. Therefore, it is quite possible that the survey responses are not representative of the attitudes of physicians in the United States. See *infra* note 87.

54. David W. Webber & Lawrence O. Gostin, *Discrimination Based on HIV/AIDS and Other Health Conditions: “Disability” as Defined Under Federal and State Law*, 3 J. HEALTH CARE L. & POL’Y 266, 271 (2000).

55. See Americans with Disabilities Act (ADA) of 1990, 42 U.S.C. § 12101 (2000).

56. *Bragdon v. Abbott*, 524 U.S. 624, 655 (1998). The Court held in *Bragdon* that “respondent’s infection substantially limited her ability to reproduce” because of concerns about transmission; therefore, HIV constituted a disability because it limited the “major life activity” of reproduction. *Id.* at 639-41. The Court did not reach the issue of whether asymptomatic HIV is inherently a disability. See *Toyota Motor Mfg., Ky, Inc. v. Williams*, 534 U.S. 184, 198 (2002) (noting that *Bragdon* declined “to consider whether HIV infection is a *per se* disability under the ADA”).

case law and policy rationales relating to doctors' legal responsibilities under the ADA to treat people with HIV/AIDS would not apply to patients with highly infectious diseases such as SARS, Ebola, and avian influenza, despite the fact that these diseases probably would constitute disabilities under the ADA.⁵⁷

Similarly, since state nondiscrimination laws overwhelmingly mirror the federal statutory scheme, they do not impose additional requirements on doctors. The final Subpart argues that while the Emergency Medical Treatment and Active Labor Act requires hospitals to provide care to patients with highly infectious diseases, hospitals' contractual relationships with physicians would not be enough to ensure that an adequate number of physicians would be available to provide care during an epidemic.

A. *Americans with Disabilities Act*

The central provision of the ADA states: "No individual shall be discriminated against on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation by any person who . . . operates a place of public accommodation."⁵⁸ The ADA defines a "disability" as "a physical or mental impairment that substantially limits one or more of the major life activities of such individual"⁵⁹ and defines "public accommodation" as encompassing the "professional office of a healthcare provider."⁶⁰ For a plaintiff to win a claim under this section, she must demonstrate that she: (1) has a disability, (2) was discriminated against because of this disability, (3) was in fact denied the pertinent goods or services, and (4) the party discriminating against her was the owner or operator of a public accommodation.⁶¹

Currently there is no case law concerning the threshold question of whether a patient with a highly infectious disease has a disability under the ADA, but courts are likely to find that she does. Federal law does not list specific health conditions or diseases that constitute a disability, in part because such a list would be extremely controversial and inherently outdated in light of the perpetual proliferation of new medical conditions.⁶²

57. HIV/AIDS is used as a point of reference because much of the recent case law regarding physicians' legal duties to treat people with infectious diseases was developed in the context of physicians refusing to treat people with HIV/AIDS. Yet, from an epidemiological standpoint, highly infectious diseases such as SARS and avian flu are extremely different from HIV/AIDS.

58. 42 U.S.C. § 12182(a) (2000).

59. 42 U.S.C. § 12102(2)(A) (2000). This provision also includes people who have "a record of such an impairment; or [are] being regarded as having such an impairment." 42 U.S.C. § 12102(2)(B)-(C) (2000).

60. 42 U.S.C. § 12181(7)(F) (2000).

61. *Sharrow v. Bailey*, 910 F. Supp. 187, 191 (M.D. Pa. 1995).

62. *See Webber & Gostin, supra* note 54, at 267. HHS explains that it did not try to list

With regard to what constitutes a disability under the ADA, the Supreme Court has focused on the need for individualized assessments.⁶³ Therefore, it is difficult to determine whether having any given highly infectious disease would constitute a “disability” under the ADA in part because of the myriad unanswerable questions about the characteristics of the diseases at issue. On one hand, most highly infectious diseases like avian flu or SARS would “substantially limit[] one or more of the major life activities,”⁶⁴ which suggests that people infected with these diseases would be covered under the ADA. Another person might survive the highly infectious disease but continue to be substantially limited in her major life activities because of the lingering physical effects of the disease or because of prejudice towards her as a former carrier. Therefore, she would probably be protected under the ADA. On the other hand, a person’s affliction with such a disease might be temporally limited because she would be able to experience a full recovery and hence she would not be covered under the ADA.⁶⁵

Overall, it seems likely that a highly infectious disease would affect one’s major life activities in a permanent way, thereby qualifying under the ADA as a disability. However, regardless of the Court’s position on this threshold matter, physicians are unlikely to be required to provide care to people with highly infectious diseases. If a patient with a highly infectious disease is deemed not to be covered under the ADA, then a doctor may refuse to treat him without worrying about violating antidiscrimination laws. If the ADA is deemed to

all the diseases that would be considered disabilities because of the “difficulty of ensuring the comprehensiveness of any such list.” 45 C.F.R. pt. 84, app. A (2005). Although this regulation was promulgated in reference to the Rehabilitation Act, the guidelines for interpreting the ADA are primarily derived from the standards set forth under the Rehabilitation Act of 1973 and thus apply in this context to the ADA. The Rehabilitation Act prohibited discrimination against a person with disabilities “solely by reason of her or his disability . . . [for] any program or activity receiving Federal financial assistance,” including programs run by the federal government itself, such as Medicare and Medicaid. 29 U.S.C. § 794(a) (2000). The ADA expanded the scope of the Rehabilitation Act by prohibiting discrimination in all public accommodations, rather than merely in federally funded programs. In writing the ADA, Congress explicitly stated that except where otherwise noted, “nothing in this chapter shall be construed to apply a lesser standard than the standards applied under title V of the Rehabilitation Act of 1973 (29 U.S.C. 790 et seq.) or the regulations issued by Federal agencies pursuant to such title.” 42 U.S.C. § 12201(a) (2000). Courts have taken this part to mean that the ADA and Rehabilitation Act are “interpreted substantially identically.” *Lesley v. Chie*, 250 F.3d 47, 54 (1st Cir. 2001) (citing *Katz v. City Metal Co.*, 87 F.3d 26, 31 n.4 (1st Cir. 1996)); *see also* *Bragdon v. Abbott*, 524 U.S. 624, 632 (1998) (“The [congressional] directive requires us to construe the ADA to grant at least as much protection as provided by the regulations implementing the Rehabilitation Act.”).

63. *Toyota Motor Mfg., Ky, Inc. v. Williams*, 534 U.S. 194, 199 (2002) (“It is sufficient for individuals attempting to prove disability status under this test to merely submit evidence of a medical diagnosis of an impairment Congress intended the existence of a disability to be determined in . . . a case-by-case manner.”)

64. 42 U.S.C. § 12102(2)(A) (2000).

65. *Toyota Motor Mfg.*, 534 U.S. at 198 (holding that an impairment must be permanent or long-term to qualify as a disability under the ADA).

cover those patients, as discussed below, physicians nonetheless will probably be able to deny care to these patients as well.

B. Direct Threat

The fact that a patient has a disease that is defined as a disability under the ADA does not mean a physician is legally obligated to treat that patient. A physician can invoke an affirmative defense that allows her to deny treatment because the patient presents a significant risk to her health:

Nothing in [the ADA] shall require an entity to permit an individual to participate in or benefit from the goods, services, facilities, privileges, advantages and accommodations of such entity where such individual poses a direct threat to the health or safety of others. The term “direct threat” means a *significant* risk to the health or safety of others that cannot be eliminated by a modification of policies, practices, or procedures or by the provision of auxiliary aids or services.⁶⁶

According to the Supreme Court in *Bragdon v. Abbott*, this section of the ADA codified the Court’s view in *School Board of Nassau County v. Arline* regarding “the importance of prohibiting discrimination against individuals with disabilities while protecting others from significant health and safety risks, resulting, for instance, from a contagious disease.”⁶⁷ The operative word in this balancing test is “significant.” As the Court notes, “[b]ecause few, if any, activities in life are risk-free, *Arline* and the ADA do not ask whether a risk exists, but whether it is significant.”⁶⁸

The determination of what constitutes a significant risk is to be made on an individual basis using objective medical standards.⁶⁹ A physician’s judgment in assessing risk is not entitled to deference if her views are at odds with the prevailing medical consensus. The Supreme Court in *Bragdon* stated that a

66. 42 U.S.C. § 12182(b)(3) (2000) (emphasis added).

67. *Bragdon*, 524 U.S. at 649 (citing Sch. Bd. of Nassau County v. Arline, 480 U.S. 273, 287 (1987)).

68. *Id.*

69. In *Chevron U.S.A., Inc. v. Echazabal*, the Supreme Court highlighted the need for a “particularized enquiry into the harms the employee would probably face.” 536 U.S. 73, 86 (2002). This reinforced the holding in *Arline*, 480 U.S. at 287-89, which was codified in the Code of Federal Regulations:

In determining whether an individual poses a direct threat to the health or safety of others, a public accommodation must make an individualized assessment, based on reasonable judgment that relies on current medical knowledge or on the best available objective evidence, to ascertain: the nature, duration, and severity of the risk; the probability that the potential injury will actually occur; and whether reasonable modifications of policies, practices, or procedures will mitigate the risk.

28 C.F.R. § 36.208(c) (2005); see also *Bragdon*, 524 U.S. at 649; *Echazabal v. Chevron USA, Inc.*, 336 F.3d 1023 (9th Cir. 2003) (reversing the district court’s grant of summary judgment because the employee had raised a material question of fact as to whether the employer had met its burden of proof regarding the employee representing a direct threat to himself).

physician's "belief that a significant risk existed, even if maintained in good faith, would not relieve him from liability."⁷⁰

Over the past two decades, the medical and legal communities have come to accept that if healthcare workers comply with the recommended precautions, HIV/AIDS does not constitute a significant risk to the treating physician; therefore, physicians cannot legally refuse treatment to a patient based solely on her HIV/AIDS status.⁷¹ However, no such consensus exists with regard to highly infectious diseases, nor is it likely that such a consensus will form in the near future.

If a doctor had refused to treat a patient with SARS in 2002, the standard against which his decision would have been evaluated is whether he met his "duty to assess the risk of infection based on the objective, scientific information available to him and others in his profession."⁷² The SARS outbreak in 2002 and 2003 illustrates the difficulty of ascertaining what constitutes significant risk when treating a relatively new disease. Although medical experts believe the SARS outbreak was managed "expeditiously" in terms of the publishing facts about the outbreaks, physicians had limited objective, scientific information about the risks of transmission because such information was mostly unknown.⁷³ After the SARS outbreak, experts still were unable to determine whether the healthcare workers who comprised up to fifty percent of the deaths from SARS in Toronto and Hong Kong became infected because they did not take appropriate precautions before the risk of exposure was known or whether they became infected despite complying with all CDC guidelines.⁷⁴

The SARS outbreak suggests that it is difficult, if not impossible, to determine whether a new infectious disease constitutes a significant risk to healthcare providers that cannot be eliminated by modification of policies, practices or procedures even when the medical community is acting competently and rapidly. In *Bragdon*, the Supreme Court recognized the limitations of CDC guidelines by commenting that "[g]uidelines do not necessarily contain implicit assumptions conclusive of the [risk of transmission]."⁷⁵ The Court further asserted that even when the CDC recommended specific precautions for preventing the transmission of

70. *Bragdon*, 524 U.S. at 649.

71. *Id.*

72. *Id.*

73. Henry Masur, Ezekiel Emanuel & H. Clifford Lane, *Severe Acute Respiratory Syndrome: Providing Care in the Face of Uncertainty*, 289 JAMA 2861, 2861 (2003). Throughout the outbreak, the CDC continually updated its recommendations and provided additional information. *Id.*

74. *Id.* at 2861-62.

75. *Bragdon*, 524 U.S. at 651. Elaborating on this point with regard to HIV, the Court noted: "The Guidelines set out CDC's recommendation that the universal precautions are the best way to combat the risk of HIV transmission. They do not assess the level of risk." *Id.* at 651-52.

HIV/AIDS, this did not preclude the possibility that there were additional measures that could have further reduced healthcare providers' risk of transmission.⁷⁶ The lingering uncertainty regarding the risk associated with exposure to SARS and the Court's recognition of the limitations of guidelines demonstrates that CDC guidelines are helpful but not sufficient for evaluating what constitutes significant risk.

Another aspect of assessing significant risk requires weighing a physician's ability to help an infected patient against the risk to the physician. Even physicians and ethicists who unequivocally advance the position that doctors have an ethical duty to treat patients with HIV/AIDS recognize that "the duty to treat is not . . . absolute."⁷⁷ In response to the SARS outbreak, a group of physicians at the National Institutes of Health noted that "[i]f the danger of serious injury or death is too high, such risk could and should limit that primary duty [to treat] . . . [especially for] infectious agents . . . that are not always amenable to therapy and can even cause death."⁷⁸ According to these physicians, the point at which a significant risk prevails over the duty to treat is "a matter of judgment and consensus."⁷⁹ In an extremely time-sensitive context in which there is inadequate time for the medical community to find "medical or other objective evidence"⁸⁰ to facilitate a consensus that the disease presents a significant risk, a physician might be justified in assuming that the risk outweighs her duty to provide care if she reasonably believes that the disease is deadly, highly infectious, and immune to treatment.

Bragdon could be read to support the position that when there is a dearth of information regarding the potential risk to the healthcare provider and about the available treatment for the infected patient, the physician does not have a duty to treat. If "the risk assessment must be based on medical or other objective evidence,"⁸¹ then inadequate information would mean that the individualized assessment required by *Arline*⁸² would be impossible, thus absolving the physician of her duty to treat. Under this interpretation of the significant risk rationale, courts could find that the direct threat provision of the ADA enables doctors to refuse to treat patients who have, or are reasonably believed to have, new highly infectious diseases.⁸³

76. *Id.*

77. Masur et al., *supra* note 73, at 2862.

78. *Id.*

79. Ezekiel J. Emanuel, *Do Physicians Have an Obligation to Treat Patients with AIDS?*, 318 NEW ENG. J. MED. 1686, 1688 (1988).

80. *Bragdon*, 524 U.S. at 649.

81. *Id.*

82. *See supra* note 69 and accompanying text.

83. One might worry that this logic of diminished duty when dealing with patients with fatal diseases undermines physicians' duty of care to patients with HIV. Yet this logic is not compelling in the HIV/AIDS context for several reasons: (1) there has been adequate time in which the medical community has by consensus decided there should be a duty to treat patients with HIV/AIDS; (2) there are well-tested techniques by which a physician can

The Supreme Court's use of significant risk to determine if there is a legal duty to treat is a method by which the courts have combated the discrepancy between the perception of risk and the actual risk. This rationale was articulated by the Court in reference to the role of the Rehabilitation Act: "Congress acknowledged that society's accumulated myths and fears about disability and disease are as handicapping as are the physical limitations that flow from actual impairment. Few aspects of a handicap give rise to the same level of public fear and misapprehension as contagiousness."⁸⁴ Although doctors' perception of their risk of contracting HIV/AIDS from patients is hard to quantify,⁸⁵ anecdotal evidence suggests physicians' perception of risk was far in excess of the actual risk.⁸⁶ Consequently, creating a legal duty was seen as a way to remedy the disparity. With other highly infectious and frequently fatal diseases, there is no reason to believe the perception of risk would be higher than the actual risk.⁸⁷

In conclusion, should a highly infectious disease present itself in the United States, it is likely that physicians would be able to deny care to patients with the disease due to the absence of sufficient objective, scientific information regarding the risks of transmission. A physician might reasonably believe that a significant, but unknown, risk outweighs her ethical and legal responsibilities under the ADA. Yet, as discussed in Part III, the absence of a duty to treat under the ADA does not mean that doctors would be completely absolved of a legal duty to treat patients during an epidemic.

C. Specialists

Another method by which physicians could avoid treating people with new highly infectious diseases would be through referrals. If a doctor believes that she lacks the expertise to deal with a patient's condition, then she has the right to refer the patient to a specialist.⁸⁸ The legislative history of the ADA supports

dramatically slow the progression of HIV; and (3) healthcare providers' perception of risk when treating HIV/AIDS was higher than the actual risk of transmission, which is statistically very low.

84. *Sch. Bd. of Nassau County v. Arline*, 480 U.S. 273, 284 (1987) (internal citations omitted).

85. See generally Scott Burris, *Dental Discrimination Against the HIV-Infected: Empirical Data, Law and Public Policy*, 13 *YALE J. ON REG.* 1 (1996). This pre-*Bragdon* article highlights the ubiquity of discrimination by dentists against patients with HIV/AIDS and the need for antidiscrimination laws to address this problem.

86. Lawrence O. Gostin, *The AIDS Litigation Project*, 263 *JAMA* 2086, 2089 (1990).

87. In the SARS context, it is possible that the perception of risk among the doctors in Toronto was lower than the actual risk. A study finds that despite having a fairly high risk of contracting SARS and being among colleagues that had contracted SARS, physicians working in the large teaching hospitals in Toronto had a disproportionately "low perceived susceptibility, a sense of invulnerability to contracting SARS, or an optimistic bias." Grace et al., *supra* note 49, at 389.

88. *Lesley v. Chie*, 250 F.3d 47, 53-54 (1st Cir. 2001).

giving physicians the discretion to make referrals “if the disability itself creates specialized complications for the patient’s health which the [referring] physician lacks the experience or knowledge to address.”⁸⁹ Confronted with a new, highly infectious disease, a physician’s behavior would not be inherently discriminatory and, therefore, not be in violation of the ADA if she denied treatment and instead referred the patient to a colleague who was better equipped to provide care.

With diseases like SARS, avian influenza, and Ebola, community-based general practitioners would probably be the first physicians to encounter the infected patients.⁹⁰ At least initially, general practitioners could deny treatment without violating the ADA if they were to assert a lack of expertise. Even the distribution of treatment guidelines by federal and state public health entities would not automatically invalidate a physician’s claim that she lacks expertise.⁹¹

However, physicians’ ability to refer patients with a specific disease does not give them unbridled discretion. In *Lesley v. Chie*, a pregnant woman with asymptomatic HIV believed that her doctor was in violation of the ADA when he referred her to nearby Worcester Memorial Hospital.⁹² The standard for evaluating discriminatory behavior in this context was that “a patient may challenge her doctor’s decision to refer her elsewhere by showing the decision to be devoid of any reasonable medical support. . . . [However, a] showing of medical unreasonableness must be framed within some larger theory of disability discrimination.”⁹³ Moreover, according to the First Circuit, “mere disagreement with prevailing medical opinion” regarding the level of expertise needed to treat a specific condition does not lead to an inference of discrimination.⁹⁴ Thus, the court held that the doctor’s medical judgment was reasonable insofar as he believed that Worcester Memorial Hospital had expertise that he lacked in the administration of AZT during childbirth, a

89. H.R. REP. NO. 101-485, pt. 2, at 106 (1990); see also *Lesley*, 250 F.3d at 54.

90. See generally Robert F. St. Peter et al., *Changes in the Scope of Care Provided by Primary Care Physicians*, 341 NEW ENG. J. MED. 1980 (1999) (discussing the primary care physician’s role as a gatekeeper who determines whether a patient should see a specialist and analyzing the expansion of the primary care physician’s responsibilities insofar as she is expected to treat a greater range of ailments without seeking assistance from a costly specialist).

91. See *Lesley*, 250 F.3d at 50-51. The First Circuit decided that the doctor did not have the requisite level of expertise even though the Massachusetts Department of Public Health said, “It was the Department of Public Health’s intent when it issued the Clinical Advisory that these established steps to prescribe and monitor AZT be immediately implemented by any licensed obstetrician, including community obstetricians such as Dr. Chie.” Brief for Dep’t of Public Health of the Commonwealth of Massachusetts as Amicus Curiae Supporting Appellant, *Lesley*, 250 F.3d 47 (No. 00-1254), 2000 WL 35565510.

92. *Lesley*, 250 F.3d at 49.

93. *Id.* at 55. This was a holding under the Rehabilitation Act, but as previously noted, the standard for interpreting the Rehabilitation Act and the ADA are the same.

94. *Id.* at 57.

procedure that greatly decreased the chances of HIV being transmitted from mother to child during delivery.⁹⁵

The test for reviewing a physician's decision to refer a patient is distinct from the direct threat test because the courts will defer to the judgment of the physician if she chooses to refer her patient to a specialist.⁹⁶ In order to be valid, the referral need not result in the patient actually receiving the necessary care. Consequently, if a physician were to refer a patient with avian flu to a specialist, such as an infectious disease specialist, and that specialist could not treat additional patients because her schedule was full, then the referred patient would be unlikely to receive care unless she were able to find a physician willing to treat her. This doctrine, which is lenient in its allowance of referrals, provides another method by which physicians could avoid treating people with new highly infectious diseases.

D. State Laws

Thus far, the analysis has focused on the absence of a federally based duty for physicians to provide care during an epidemic. Another potential source of duty could be state laws. However, states have generally declined to provide increased protection to people with highly infectious diseases either by significantly amending their state disability laws or by allowing patients to recover under a theory of abandonment liability.

Although some states have defined "disability" more broadly than the ADA, no states have changed the scope of the ADA's direct threat exception. Many of the states that have sought to be more inclusive than the ADA have focused on either explicitly or implicitly defining HIV as a disability. In *Discrimination Based on HIV/AIDS and Other Health Conditions*, Daniel W. Webber and Lawrence Gostin survey each state's definition of disability and conclude that "the majority of state enactments closely track the ADA definition of disability."⁹⁷ A few states, such as New York, New Jersey, and Iowa, have ensured protection for people with HIV by defining disability more expansively.⁹⁸ New York differs from the ADA insofar as it excludes the requirement that a disability must limit "a major life activity."⁹⁹ New Jersey explicitly defines HIV/AIDS as a disability.¹⁰⁰ Iowa's Civil Rights Act is the

95. *Id.* at 57-59.

96. Under the direct threat approach, the physician's assessment of a patient's condition, especially with regard to whether the patient poses a direct threat to others, does not receive deference. *See supra* note 72. A court will not defer to a physician's good faith belief that there was a substantial risk if such a belief conflicts with the prevailing view in the medical community. *Id.*

97. Webber & Gostin, *supra* note 54, at 287.

98. *See id.* at 288, 290.

99. N.Y. EXEC. LAW § 292(21) (McKinney 2006).

100. N.J. STAT. ANN. § 10:5-5(q) (West 2006).

most expansive of the three because it not only lists HIV as a disability, but also states that “[t]he inclusion of a condition related to a positive human immunodeficiency virus test result in the meaning of ‘disability’ under the provisions of this chapter does not preclude the application of the provisions of this chapter to conditions resulting from other contagious or infectious diseases.”¹⁰¹

While all of these state statutes ensure protection for people with HIV, they do little more than the federal statutes to protect people with highly infectious diseases because, as mentioned earlier, courts are likely to find that the federal definition of disability is sufficiently inclusive. The major point of doctrinal tension with regard to highly infectious diseases is how to define “direct threat” and healthcare practitioners’ responsibilities when there is a direct threat. My survey of states’ laws as well as Webber and Gostin’s work suggest that the term or concept of direct threat either has been used in state statutes in a manner that is consistent with the ADA’s standard or not at all.¹⁰² As such, state disability laws do not impose upon physicians a duty to treat during an epidemic.

Alternatively, under the tort doctrine of abandonment liability, states could require physicians to provide care once they have begun treating a patient. Yet case law suggests that such an approach would be unsuccessful. Typically, a physician is allowed to terminate unilaterally a relationship with her patient as long as it is not for discriminatory reasons; however, she must give the patient ample notice in order to allow the patient to find another physician.¹⁰³ Once a sufficient period of time has elapsed, the physician can terminate the relationship even if the patient has not been able to find a new physician.¹⁰⁴ Failure to give adequate notice can constitute a tort of abandonment.¹⁰⁵ In order to prevail, a plaintiff typically has to prove that the abandonment was the proximate cause of the patient’s illness or death.¹⁰⁶

A survey of the case law on abandonment liability reveals that this cause of action has been successfully invoked in a limited number of situations. In *Meiselman v. Crown Heights Hospital*, the court found that the defendant doctor and hospital were liable for a tort of abandonment because they had prematurely discharged a severely ill boy rather than continue with treatment once they determined that the father was unable to pay the hospital bills.¹⁰⁷

101. IOWA CODE § 216.2(5) (2005).

102. Webber & Gostin, *supra* note 54, at 303.

103. *See, e.g.*, Payton v. Weaver, 182 Cal. Rptr. 225, 229 (Cal. Ct. App. 1982).

104. *Accord id.*

105. Lynch v. Bryant, Nos. 91-5667, 5683, 6054, 1993 U.S. App. LEXIS 1878 (6th Cir. Jan. 28, 1993); Biby v. Halstead Hosp., Inc., No. 92-1042-MLB, 1993 U.S. Dist. LEXIS 21089 (D. Kan. Nov. 22, 1993).

106. *Biby*, 1993 U.S. Dist. LEXIS 21089, at *10; Tierney v. Univ. of Mich. Regents, 669 N.W.2d 575, 577-78 (Mich. Ct. App. 2003).

107. 34 N.E.2d 367 (N.Y. 1941); *see also* Le Juene Road Hosp., Inc. v. Watson, 171

Another possible abandonment scenario, one which the Tennessee Court of Appeals views as the “classic illustration of abandonment,” is a situation where a doctor becomes alarmed because she has made an error while providing treatment and instructs the patient to seek another doctor without trying to help remedy or stabilize the situation.¹⁰⁸

Failure to provide care because a doctor believes that no further treatment is warranted is not considered to be a tort of abandonment.¹⁰⁹ In *Hartsell v. Fort Sanders Regional Medical Center*, the Tennessee Court of Appeals found that the doctor had not abandoned a premature infant when he removed the breathing tube from the infant patient because he believed the treatment to be futile.¹¹⁰ Moreover, the court determined that the relationship was not severed because nurses and a neonatologist stayed to monitor the infant’s health.¹¹¹

As such, it would be unlikely for a physician to be liable for abandonment if she were to decline to provide care to a patient with a highly infectious disease, assuming that there were not effective treatment options for the patient.¹¹² Based on the current construction of state disability laws and the ways in which the tort of abandonment has been interpreted, state laws do not require physicians to treat people with highly infectious diseases.

E. Emergency Medical Treatment and Active Labor Act

The Emergency Medical Treatment and Active Labor Act (EMTALA) can theoretically be used as a way to compel physicians to provide care during an epidemic. Nevertheless, like the federal regulations under the ADA, this approach is unlikely to succeed. Under EMTALA, hospitals that receive Medicare reimbursements are required to provide emergency treatment to all people who come into the emergency room until they are at least stabilized.¹¹³ This means that those hospitals are required to (1) assess whether a patient has a condition that is an emergency and (2) stabilize the patient if she is in an

So. 2d 202 (Fla. Dist. Ct. App. 1965) (finding that a hospital that undressed, examined, and gave medication to plaintiff in anticipation of removing his appendix wrongfully discharged him upon discovering that he could not pay for the surgery).

108. *Hartsell v. Fort Sanders Reg’l Med. Ctr.*, 905 S.W.2d 944, 949 (Tenn. Ct. App. 1995) (discussing *Burnett v. Layman*, 181 S.W. 157 (Tenn. 1915), a case in which a surgeon was held liable for abandonment after he accidentally ruptured the patient’s urethra and then departed from the scene while the patient was bleeding even though he believed the patient needed additional treatment).

109. *Id.*

110. *Id.*

111. *Id.*; see also *Lynch v. Bryant*, Nos. 91-5667, 5683, 6054, 1993 U.S. App. LEXIS 1878, at *9-13 (6th Cir. Jan. 28, 1993).

112. If in fact effective treatment options were available, the physician might be subject to a medical malpractice suit.

113. Sara Rosenbaum & Brian Kamoie, *National Health Challenges in Population Health: Finding a Way Through the Hospital Door, The Role of EMTALA in Public Health Emergencies*, 31 J.L. MED. & ETHICS 590, 590-91 (2003).

emergency condition.¹¹⁴ Consequently, the hospitals would have a responsibility to treat people with highly infectious diseases if their conditions were deemed to be an emergency because there is no exception under EMTALA for direct threats or significant risks.

Physicians' relationships to hospitals are a contractual mechanism through which physicians may be obligated to provide treatment to people with highly infectious diseases. In exchange for staff privileges at local hospitals, physicians are often required to be "on-call" to provide emergency services for a set duration during a given time period.¹¹⁵ Since the hospital is required to treat all patients who enter the emergency room, a physician, pursuant to her contract with the hospital, may have a duty to treat those patients. If an on-call physician negligently acts in a way that is inconsistent with the hospitals' EMTALA obligations, both the hospital and the physician can be subject to a \$50,000 penalty.¹¹⁶

Physicians' duty to treat under EMTALA is voluntary to the extent that it only applies if a physician has contractually agreed to provide emergency room services to a hospital. So, a hospital's duty extends to the physician only if she is on-call.¹¹⁷ As the Fifth Circuit notes, a physician "is free to negotiate with [a hospital] regarding his responsibility to facilitate a hospital's compliance with EMTALA."¹¹⁸

From a contractual standpoint, a physician's refusal to treat patients with highly infectious diseases would be likely to jeopardize her staff privileges at a given hospital. Without staff privileges, she might be unable to practice medicine in that region because she would be unable to admit patients to the hospital for the purpose of administering care. This contractual relationship between physicians and hospitals creates strong professional, financial, and social pressures to ensure that emergency room patients with highly infectious diseases are treated.¹¹⁹

Perhaps if physicians were to realize that they are contractually bound to treat patients with highly infectious diseases at the hospital, they would be more willing to treat them in their outpatient practices because they would recognize that exposure to these highly infectious diseases would be inevitable. Also, if physicians were to learn in the hospital context techniques intended to

114. 42 U.S.C. § 1395dd(a)-(b) (2000); *Burditt v. U.S. Dep't of Health & Human Servs.*, 934 F.2d 1362, 1366 (5th Cir. 1991); MARK A. HALL ET AL., *HEALTH CARE LAW AND ETHICS*, 123-28 (6th ed. 2003).

115. HALL, *supra* note 113, at 113.

116. 42 U.S.C. § 1395dd(d)(1) (2000).

117. *Hiser v. Randolph*, 617 P.2d 774 (Ariz. Ct. App. 1980); HALL, *supra* note 113, at 113.

118. *Burditt*, 934 F.2d at 1376.

119. Craig W. Dallon, *Understanding Judicial Review of Hospitals' Physician Credentialing and Peer Review Decisions*, 73 TEMP. L. REV. 597, 607-09 (2000) (highlighting the importance of hospital staff privileges to physicians' ability to treat patients).

minimize their risk of contracting a highly infectious disease from patients, they might be more open to integrating those techniques into their outpatient practices.

One could then question whether the issue of physicians' legal duties to treat patients with highly infectious diseases under the ADA is moot if the contractual relationships under EMTALA are sufficiently strong. Yet, physicians' legal duties under the ADA are still relevant. With many of these highly contagious diseases, each incidence of exposure would pose a risk. Hence, the greater the number of contacts a physicians has with infected patients, the greater the chance of contracting the disease. As such, physicians might want to minimize their exposure by limiting the number of affected patients they treat. Therefore, physicians might restrict themselves to the minimum requirements the hospitals impose.

Even if all the contractual duties were enforced, the care provided under EMTALA is still unlikely to be sufficient during an epidemic. Interpretive guidelines for EMTALA, issued by the Department of Health and Human Services, indicate that hospitals have a fair bit of flexibility in how they meet their staffing responsibilities under EMTALA. HHS's current policies enable hospitals to deny treatment even if there is a tremendous need.

In 2002, the Center for Medicare and Medicaid Services (CMS), a division of HHS, articulated the following guidelines:

CMS does not require that a hospital's medical staff provide on-call coverage 24 hours/day, 365 days/year. If there comes a particular time that a hospital does not have on-call coverage for a particular specialty, that hospital lacks capacity to treat [a] patient needing that specialty service and it is therefore appropriate to transfer the patient because the medical benefits of the transfer outweigh the risks . . . Medicare does not set requirements on how frequently a hospital's medical staff of on-call physicians is expected to provide on-call coverage . . . We are also aware that there are some hospitals that have limited financial means to maintain on-call coverage all of the time. CMS allows hospitals flexibility to comply with EMTALA obligations by maintaining a level of on-call coverage that is within their capability.¹²⁰

This guidance suggests that the hospitals are not obligated to require physicians to provide additional on-call coverage even if the emergency room has a flood of infected patients. Moreover, during an epidemic, hospitals might be allowed to maintain pre-epidemic levels of care or even to reduce the level of care they provide in spite of a surge in need.¹²¹

120. Memorandum from Dir., Survey & Certification Group., Dep't of Health & Human Servs., to Associate Reg'l Adm'rs 2 (June 13, 2002), available at <http://www.cms.hhs.gov/SurveyCertificationGenInfo/downloads/SCLetter02-34.pdf>.

121. Hillary R. Ahle, *Anticipating Pandemic Avian Influenza: Why the Federal and State Preparedness Plans Are for the Birds*, 10 DEPAUL J. HEALTH CARE L. 213, 246 (2007); Rosenbaum & Kamoie, *supra* note 113, at 595-98 (detailing the various legislative and administrative actions that have created uncertainty regarding hospitals' obligations under EMTALA during an epidemic).

If CMS were to allow hospitals to maintain pre-epidemic levels of care, staffing could become a serious problem. Current levels of staffing already fail to meet the needs of patients. A study conducted by the United States General Accounting Office reported that fifty-nine percent of hospitals surveyed reported problems with on-call specialty coverage in the 2001 fiscal year.¹²² In hospitals, physicians are typically limited to performing procedures that are within the purview of their specialty.¹²³ What constitutes a physician's specialty is determined by the hospital credentialing process, which relies on a combination of specialty board certifications and peer review.¹²⁴ A physician who acts outside her scope of responsibilities could jeopardize her hospital privileges.¹²⁵ Unless hospitals were to relax their standards regarding what a given physician could do during an emergency, the shortage of specialists could have tragic consequences.

In summary, although the ADA was crafted to provide patients with protection from being denied care based on a disability, the ADA would fail to do so in cases where people were suffering from highly infectious diseases. Doctors could either use the direct threat rationale or explain that the disease is beyond their area of expertise in order to avoid providing treatment during an epidemic. If the doctor were to choose the latter approach, she might still be exposed to the disease. However, she would not be obligated to continue treatment and continue to put herself at risk. Regardless of which rationale a physician were to adopt in an attempt to avoid providing care, the ADA or the state anti-discrimination laws would be unlikely to compel a physician to provide treatment to people with highly infectious diseases. Also, as discussed above, while many physicians are contractually bound to provide care in the emergency room, the staffing shortages at hospitals might be so great as to make physicians' duty under EMTALA a band-aid on the gaping hole of a physician shortage.

122. U.S. GEN. ACCOUNTING OFFICE, HOSPITAL EMERGENCY DEPARTMENTS: CROWDED CONDITIONS VARY AMONG HOSPITALS AND COMMUNITIES, 50 *tbl.16* (2003), available at <http://www.gao.gov/new.items/d03460.pdf>.

123. William P. Gunnar, *The Scope of a Physician's Medical Practice: Is the Public Adequately Protected by State Medical Licensure, Peer Review, and the National Practitioner Data Bank?*, 14 *ANNALS HEALTH L.* 329, 342-43 (2005).

124. *Id.* Specialty boards are non-governmental bodies that determine requirements and policies for board certification in a given field. Certification is usually based on attending an accredited medical school, completing an accredited residency, and passing an exam administered by the specialty board. A physician typically wants to obtain board certification because it can help increase her salary, allow her to obtain staff privileges at a hospital, lower her malpractice insurance, increase the number of referrals she receives, and generally help her status as a practitioner. *Id.*

125. *Id.*

III. EMERGENCY LEGAL FRAMEWORK

Consistent with the AMA's 2002 statement that physicians should "[a]pply our knowledge and skills when needed, though doing so may put us at risk"¹²⁶ and the ADA's requirement that physicians not shelter themselves from risk unless the risk is significant, physicians should be required to provide care as part of their professional obligation even if doing so would expose them to some risk. The question then remains: what should the government be allowed to demand of physicians during an epidemic?

Recent state legislation and legislative proposals would give governors tremendous power to suspend or modify state laws in an emergency for the purpose of responding to the risk of an epidemic outbreak. Most notably, Professors Lawrence O. Gostin and James G. Hodge Jr. of the Center for Law and the Public's Health at Georgetown and John Hopkins Universities have drafted legislation that gives a governor the right to require in-state physicians to complete whatever tasks the state's public health authorities request of them. Under this legislation, a physician's failure to comply would result in the revocation of her license.

The primary shortcoming of this legislative proposal, as it pertains to physicians' obligations during an epidemic, is that it fails to recognize physicians' property interests in their professional licenses and therefore does not create a scheme by which physicians are provided with adequate due process protection. A more effective legislative scheme would recognize that physicians' duty to treat is linked to their professional license, so their property interest must be considered and weighed, consistent with traditional notions of due process. One of the core attributes of due process analysis is a recognition that there are competing interests at stake and that these interests must be weighed. To abandon this constitutional safeguard in an epidemic context would undermine the intended goal of encouraging physicians to treat patients during an epidemic.

A. Shortcomings in Existing State Emergency Plans

Since September 11, the SARS outbreaks in 2002, and Hurricane Katrina, lawmakers have realized the need to update laws governing the prevention, management, and mitigation of emergencies. The basic federal emergency framework is outlined in the Public Health Service Act of 1944.¹²⁷ This Act assigns tremendous responsibility and power to the executive branch, most notably the Secretary of HHS, during an epidemic context. Under the Public Health Security Act,

126. COUNCIL ON ETHICAL & JUDICIAL AFFAIRS, AM. MED. ASS'N, CEJA REPORT 5-I-01: A DECLARATION OF PROFESSIONAL RESPONSIBILITY 3 (2001).

127. 42 U.S.C. § 201 (2000).

The Surgeon General, with the approval of the Administrator [Secretary], is authorized to make and enforce such regulations as in his judgment are necessary 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.¹²⁸

In conjunction with this responsibility, the Secretary is directed to work with the states “in the prevention and suppression of communicable diseases,” support the states in their quarantine efforts, and advise them on matters of public health.¹²⁹ In the HHS Pandemic Influenza Plan, a “blueprint” for how to prepare and respond effectively to a pandemic,¹³⁰ HHS indicates that primary responsibility for managing the epidemic within a given jurisdiction should be left to state and local authorities.¹³¹

The Public Health Act and HHS’s emphasis on state initiative is not surprising given that healthcare regulation has primarily been within the purview of the police powers reserved to the states by the Tenth Amendment.¹³² During an epidemic, the federal government’s role under the HHS plan is primarily to advise and support state and local governments that are directly managing epidemics in their region.¹³³ Consistent with that vision, the Secretary of HHS announced in April 2006, “Any community that fails to prepare—with the expectation that the federal government can come to the rescue—will be tragically wrong.”¹³⁴ Therefore, states’ and local governments’ emergency response plans are of the utmost importance when considering physicians’ legal duties during an epidemic.

Health experts worry that many states’ and local governments’ plans and accompanying regulations are woefully inadequate. For example, the Rand Corporation’s study of California’s emergency preparedness reveals serious shortcomings despite the fact that the state has devoted “significant resources to

128. 42 U.S.C. § 264(a) (2000).

129. *Id.* § 243(a). The full text of the section reads:

The Secretary is authorized to accept from State and local authorities any assistance in the enforcement of quarantine regulations made pursuant to this Act which such authorities may be able and willing to provide. The Secretary shall also assist States and their political subdivisions in the prevention and suppression of communicable diseases and with respect to other public health matters, shall cooperate with and aid State and local authorities in the enforcement of their quarantine and other health regulations, and shall advise the several States on matters relating to the preservation and improvement of the public health.

130. U.S. DEP’T OF HEALTH & HUMAN SERVS., HHS PANDEMIC INFLUENZA PLAN 1 (2005), available at <http://www.hhs.gov/pandemicflu/plan/pdf/HHSPandemicInfluenzaPlan.pdf>.

131. *Id.* at 34-39.

132. See U.S. CONST. amend. X; *Jacobson v. Massachusetts*, 197 U.S. 11 (1905) (allowing the Commonwealth of Massachusetts to require residents to receive a smallpox vaccination for the purpose of limiting the spread of the disease); *Gibbons v. Ogden*, 22 U.S. (9 Wheat) 1 (1824).

133. See generally U.S. DEP’T OF HEALTH & HUMAN SERVS., *supra* note 130.

134. Ceci Connolly, *U.S. Plan for Flu Pandemic Revealed; Multi-Agency Proposal Awaits Bush’s Approval*, WASH. POST, Apr. 16, 2006, at A1.

preparedness activities.”¹³⁵ Some of the problems facing California include: (1) local governments are not sure what they are supposed to do in an emergency nor do they know how to complete many crucial tasks;¹³⁶ (2) low-income minority groups are among the people most at risk during an epidemic, but little has been done to include them in the epidemic planning process;¹³⁷ and (3) the California State Department of Health lacks strong leadership to facilitate coordination and resource sharing within the state, hence local jurisdictions do not believe that they can count on the state agency in an emergency.¹³⁸ According to a 2005 study by the nonpartisan, nonprofit organization Trust for America’s Health (TFAH), California is not the outlier but rather the norm with respect to emergency preparedness. Only two states, Rhode Island and South Dakota, are deemed to have “plans, incentives, or provisions to encourage healthcare workers to continue coming to work in the event of a major infectious disease outbreak.”¹³⁹

B. *Model State Emergency Health Powers Act*

Professors Gostin and Hodge share TFAH’s concerns about states’ capacities for managing an epidemic. They believe that many states’ laws are antiquated and fragmented since the laws had been developed defensively in response to specific, historic threats. Therefore, Gostin and Hodge have worked to create legislation that addresses pertinent legal issues that would arise before, during, and after an epidemic.¹⁴⁰

Shortly after the first confirmed anthrax cases in October 2001 and at the behest of the CDC’s General Counsel, the Center began drafting the Model State Emergency Health Powers Act (MSEHPA) under the leadership of Gostin and Hodge.¹⁴¹ The MSEHPA was created in order to “facilitate the detection, management, and containment of public health emergencies while appropriately safeguarding personal and proprietary interests.”¹⁴² The MSEHPA is temporally divided into three sections—a state’s powers prior to the declaration of a state of emergency, the process of declaring a state of

135. NICOLE LURIE ET AL., RAND CORP., PUBLIC HEALTH PREPAREDNESS IN CALIFORNIA: LESSONS LEARNED FROM SEVEN HEALTH JURISDICTIONS 4 (2004), available at http://www.rand.org/pubs/technical_reports/2005/RAND_TR181.pdf.

136. *Id.* at 5.

137. *Id.* at 6.

138. *Id.*

139. SHELLEY A. HEARNE ET AL., TRUST FOR AMERICA’S HEALTH, READY OR NOT? PROTECTING THE PUBLIC HEALTH FROM DISEASES, DISASTERS, AND BIOTERRORISM 28 (2005), available at <http://healthyamericans.org/reports/bioterror05/bioterror05Report.pdf>.

140. Lawrence O. Gostin et al., *The Model State Emergency Health Powers Act: Planning for and Response to Bioterrorism and Naturally Occurring Infectious Diseases*, 288 JAMA 622, 623-24 (2002).

141. *Id.* at 622.

142. *Id.* at 625.

emergency, and a state's authority during a state of emergency. Under the MSEHPA, during a state of emergency as potentially defined solely by the governor,¹⁴³ the governor can "[s]uspend the provisions of any regulatory statute" governing state business and agency actions if "strict compliance . . . would prevent, hinder, or delay necessary action[s]" by the public health authorities as they respond to a public health emergency.¹⁴⁴

Many states have found either parts of or the whole MSEHPA to be helpful. As of July 2006, legislators in forty-four states and the District of Columbia had introduced bills that replicate some of the language or the principles in the MSEHPA.¹⁴⁵ Sixty-six of these bills had passed in thirty-eight states and the District of Columbia by July 2006.¹⁴⁶ Some experts worry that the MSEHPA does not adequately protect civil liberties and patients' privacy.¹⁴⁷

MSEHPA section 608(a) addresses physicians' legal duties in an emergency. It provides that during a public health emergency, public health authorities can exercise the power "[t]o require in-state health providers to assist in the performance of vaccination, treatment, examination, or testing of any individual as a condition of licensure, authorization, or the ability to continue to function as a health care provider in [the] State."¹⁴⁸ In essence, the proposed statute requires in-state physicians to complete whatever tasks a state's public health authority requests of them and allows the state to revoke the license of those who do not comply.

The drafters of the MSEHPA should be commended for their efforts to address a legal issue that in most states' emergency health plans has been overlooked or punted due to controversy.¹⁴⁹ For example, the three most populous states—California, Texas, and New York—all have emergency

143. THE MODEL STATE EMERGENCY HEALTH POWERS ACT § 401 (Ctr. for Law & the Public's Health 2001), available at <http://www.publichealthlaw.net/MSEHPA/MSEHPA2.pdf>.

144. *Id.* § 403(a)(1).

145. CTR. FOR LAW & THE PUBLIC'S HEALTH, THE MODEL STATE EMERGENCY HEALTH POWERS ACT (MSEHPA): STATE LEGISLATIVE ACTIVITY 1 (2006), available at <http://www.publichealthlaw.net/MSEHPA/MSEHPA%20Leg%20Activity.pdf>.

146. *Id.*

147. George J. Annas, *Bioterrorism, Public Health, and Civil Liberties*, 346 NEW ENG. J. MED. 1337 (2002); Daniel S. Reich, *Modernizing Local Responses to Public Health Emergencies: Bioterrorism, Epidemics, and the Model State Emergency Health Powers Act*, 19 J. CONTEMP. HEALTH L. & POL'Y 379 (2003).

148. THE MODEL STATE EMERGENCY HEALTH POWERS ACT § 608(a) (Ctr. for Law & the Public's Health 2001), available at <http://www.publichealthlaw.net/MSEHPA/MSEHPA2.pdf>.

149. In the course of my research, I was unable to find states that clearly articulate whether physicians have a legal duty to provide care during an epidemic and the consequences of failing to comply. Perhaps this lack of precedent explains why the drafters did not cite any authority for section 608(a) whereas they referenced state statutes in the interpretive notes of other MSEHPA provisions.

preparedness plans that fail to delineate the demands that the governors or state health authorities can place upon physicians.¹⁵⁰ However, MSEHPA gives too much power to the governor and state health authorities.

C. Proposals for Procedural Safeguards

The governor in conjunction with public health authorities should have the ability to declare a state of emergency as provided by the MSEHPA¹⁵¹ if she believes that there is a new infectious agent that could cause “substantial future harm” to a large population.¹⁵² During an epidemic, the medical community may not have the opportunity to engage in a consensus-based model of determining what constitutes objective, medical evidence as laid out in the ADA, especially if a particular viral strain has recently mutated. In a state of emergency, the governor would be able to circumvent the consensus process and determine the level of benefit obtained from providing care to the infected patients as compared to the degree of risk to the physicians.

The principle guiding the governor’s decision should be that physicians would only be required to provide care to patients with highly infectious diseases if the benefit to the patients and those who might be infected by the patients outweighs the risk to the physician, taking into account the risk she faces as person living in a region with an epidemic, duties to other patients and family, as well as the medical resources to which the physician has access. If the governor decides that physicians should be required to provide a particular type of care in a particular type of context, the governor should be required to articulate her determinations and the basis for these determinations.

Under the MSEHPA framework, the consequence of noncompliance is delicensure. Such a consequence is appropriate because the role that is being asked of physicians is directly tied to their professional status. Unfortunately, under the framework laid out in the MSEHPA, the governor’s power to place demands on physicians as a condition of licensure would be virtually unbridled.

150. This is not to say that these state plans do not detail a clear role for physicians during an epidemic, but rather there is no discussion of the states’ authority to require physicians to provide certain services. CAL. DEP’T OF HEALTH SERVS., PANDEMIC INFLUENZA PREPAREDNESS AND RESPONSE PLAN (2006), *available at* <http://www.dhs.ca.gov/ps/dcdc/izgroup/pdf/pandemic.pdf>; N.Y. STATE DEP’T OF HEALTH, PANDEMIC INFLUENZA PLAN § 11 (2006), *available at* http://www.health.state.ny.us/diseases/communicable/influenza/pandemic/docs/pandemic_influenza_plan.pdf; TEX. DEP’T OF STATE HEALTH SERVS., PANDEMIC INFLUENZA PREPAREDNESS PLAN: DRAFT (2005), *available at* http://www.dshs.state.tx.us/idcu/disease/influenza/pandemic/Draft_PIPP_10_24_web.pdf.

151. THE MODEL STATE EMERGENCY HEALTH POWERS ACT § 401 (Ctr. for Law & the Public’s Health 2001), *available at* <http://www.publichealthlaw.net/MSEHPA/MSEHPA2.pdf>.

152. *Id.* § 104(m)(2)(iii).

Physicians are not a suspect class and therefore laws pertaining to them are not subject to a heightened level of scrutiny under the Equal Protection Clause.¹⁵³

Nonetheless, the MSEHPA plan as it pertains to physicians would be deemed unconstitutional because it curtails physicians' property interests in their license without at least the minimum due process to which the physicians are entitled under the Fourteenth Amendment. While it is beyond the scope of this Note to engage in a complete analysis of the prodigious jurisprudence on what process is due in a given circumstance, it is clear that at minimum physicians are constitutionally entitled to a post-deprivation administrative hearing with the opportunity for judicial review if the state wants to revoke their licenses because they refused to provide care during an epidemic.¹⁵⁴

Unless a state were to conscript the entire population during an epidemic, under the MSEHPA, it would be likely that a state would be treating healthcare providers differently from non-healthcare providers by requiring them to treat infected patients during an epidemic. However, healthcare providers are not a suspect class and therefore laws governing their obligations "cannot run afoul of the Equal Protection Clause if there is a rational relationship between disparity of treatment and some legitimate governmental purpose."¹⁵⁵ Given this highly deferential standard, a court would be likely to uphold laws modeled after the MSEHPA, deeming them to be rationally related to the purpose of managing an epidemic. Therefore, the Equal Protection Clause offers minimal protection to physicians in the context of legislation like the MSEHPA.

The Due Process Clause, however, affords physicians greater protection from delicensure during and after an epidemic. The process for determining whether there is a property interest at stake is set forth by the Supreme Court in *Board of Regents of State Colleges v. Roth*: "Property interests, of course, are not created by the Constitution. Rather, they are created and their dimensions

153. See U.S. CONST. amend. XIV, § 1.

154. Under the MSEHPA, a governor would be able to suspend regulatory statutes, including statutes that pertain to a physician's responsibilities in an emergency. See THE MODEL STATE EMERGENCY HEALTH POWERS ACT § 403(a)(1) (Ctr. for Law & the Public's Health 2001), available at <http://www.publichealthlaw.net/MSEHPA/MSEHPA2.pdf>. The Model Act reads:

During a state of public health emergency, the Governor may (1) suspend the provisions of any regulatory statute prescribing procedures for conducting State business, or the orders, rules and regulations of any State agency, to the extent that strict compliance with the same would prevent, hinder, or delay necessary action (including emergency purchases) by the public health authority to respond to the public health emergency, or increase the health threat to the population.

Id. Therefore, physicians would probably be unable to bring statutory due process claims in response to the governor compelling them to provide care during an epidemic. For this reason, the Note focuses on physicians' constitutional claims. However, physicians may also be able to challenge the constitutionality of legislation that gives the governor discretion to suspend the existing statutory requirements.

155. *Cent. State Univ. v. Am. Ass'n of Univ. Professors*, 526 U.S. 124, 128 (1999) (quoting *Heller v. Doe*, 509 U.S. 312, 320 (1993)) (holding that Central State University's decision not to bargain over the issue of faculty workload could survive rationality review).

are defined by existing rules or understandings that stem from an independent source such as state law”¹⁵⁶ One such understanding is the interest one has in the license granted by the state.

The jurisprudence regarding an interest in one’s license is a subset of the broader set of rights related to the right to engage in one’s chosen profession.¹⁵⁷ In the context of motor vehicles licenses, the Supreme Court in *Bell v. Burson* held:

Once licenses are issued, . . . their continued possession may become essential in the pursuit of a livelihood. Suspension of issued licenses thus involves state action that adjudicates important interests of the licensees. In such cases the licenses are not to be taken away without that procedural due process required by the Fourteenth Amendment.¹⁵⁸

Many states have explicitly recognized that one has a property interest in a medical license and consequently a due process right under the Fourteenth Amendment. The Georgia Supreme Court has held, “The right to practice medicine is . . . a valuable property right,”¹⁵⁹ a right of such importance that it should be treated “in the nature of criminal proceedings.”¹⁶⁰ Similarly, the Supreme Court of Pennsylvania in 2004 stated:

This Court has recognized as well established the principle that ‘due process is fully applicable to adjudicative hearings involving substantial property rights’ Such property rights perforce include the right of an individual to pursue a livelihood or profession, thus triggering the protective mechanism of procedural due process.¹⁶¹

The Wyoming Supreme Court found that the right to practice medicine was a property right and therefore “[i]t follows that the provisions of the Constitution of the United States and the Constitution of the State of Wyoming pertain and require that due process of law be afforded prior to revocation of such a property right.”¹⁶²

A physician’s property interest in her medical license is not, however, a fundamental right. In the 1926 opinion *Lambert v. Yellowley*, the Supreme

156. 408 U.S. 564, 577 (1972).

157. *Schwartz v. Bd. of Bar Exam’rs of N.M.*, 353 U.S. 232, 239 (1957) (recognizing the Fifth and Fourteenth Amendment rights of a New Mexico man not to be denied arbitrarily the right to practice law in the state).

158. 402 U.S. 535, 539 (1971) (citing *Goldberg v. Kelly*, 397 U.S. 254 (1970); *Sniadach v. Family Fin. Corp.*, 395 U.S. 337 (1969)); see also *Barry v. Barchi*, 443 U.S. 55 (1979) (finding a New York State law that allowed the New York State Racing and Wagering Board to suspend the license of a driver in the harness horse racing league without a prompt post-suspension hearing to be unconstitutional).

159. *Yeargin v. Hamilton Mem’l Hosp.*, 171 S.E.2d 136, 139 (Ga. 1969) (quoting *Hughes v. State Bd. of Exam’rs*, 134 S.E. 42, 46-47 (Ga. 1926)).

160. *Wall v. Am. Optometric Ass’n, Inc.*, 379 F. Supp. 175, 184 (N.D. Ga. 1974), *aff’d*, 419 U.S. 888 (1974) (internal quotations omitted).

161. *Khan v. State Bd. of Auctioneer Exam’rs*, 842 A.2d 936, 945 (Pa. 2004) (quoting *Soja v. Pa. State Police*, 455 A.2d 613, 615 (Pa. 1982)).

162. *Devous v. Wyo. State Bd. of Med. Exam’rs*, 845 P.2d 408, 415 (Wyo. 1993).

Court addressed this issue directly, holding that “there is no right to practice medicine which is not subordinate to the police power of the states.”¹⁶³ Since, the Supreme Court has expressed a reluctance to recognize additional fundamental rights, especially in the realm of property rights.¹⁶⁴ The Court’s position in *Lambert* still is controlling, as exemplified by the Third Circuit’s affirmance of a district court opinion which held that the healthcare providers “err[ed] . . . in classifying the right to practice one’s chosen profession as a fundamental right.”¹⁶⁵

As such, the substantive due process analysis in this context would consider whether the government action is arbitrary or shocks the conscience.¹⁶⁶ Such a standard would make it hard for physicians to prevail in a challenge against a governor’s actions because they would have to show the government “abus[ed] its power, or employ[ed] it as an instrument of oppression.”¹⁶⁷ But in an emergency context, such judicial review could be meaningful. During an epidemic there would be a heightened risk that the governor, subject to intense pressures from multiple parties, including alarmed constituents and federal officials trying to contain an epidemic, might act in an arbitrary or irrational fashion. So, even a minimal level of scrutiny as applied

163. *Lambert v. Yellowley*, 272 U.S. 581, 596 (1926).

164. See *Washington v. Glucksberg*, 521 U.S. 702 (1997); *Collins v. City of Harker Heights*, 503 U.S. 115, 125 (1992) (“As a general matter, the Court has always been reluctant to expand the concept of substantive due process because guideposts for responsible decisionmaking in this unchartered area are scarce and open-ended.”).

165. *Meier v. Anderson*, 692 F. Supp. 546, 549 (E.D. Pa. 1988), *aff’d*, 869 F.2d 590 (3d Cir. 1989).

166. *Collins*, 503 U.S. at 127, 128; see also *County of Sacramento v. Lewis*, 523 U.S. 833, 845-47 (1998) (finding that a police officer’s conduct in a high-speed automobile chase did not violate motorcycle passenger’s substantive due process rights because the official action was not constitutionally shocking). The Court went on to elaborate on its understanding of due process:

We have emphasized time and again that the touchstone of due process is protection of the individual against arbitrary action of government, whether the fault lies in a denial of fundamental procedural fairness, or in the exercise of power without any reasonable justification in the service of a legitimate governmental objective. While due process protection in the substantive sense limits what the government may do in both its legislative and its executive capacities, criteria to identify what is fatally arbitrary differ depending on whether it is legislation or a specific act of a governmental officer that is at issue.

Id. at 845-46 (internal citations and quotation marks omitted). In *Katz v. S.D. State Board of Medical and Osteopathic Examiners*, 432 N.W.2d 274 (S.D. 1988), the court discussed substantive due process as it relates to the medical profession:

When these laws regulating the medical profession are attacked, substantive due process requires that the exercise of the police power must not be unreasonable or unduly oppressive and that the regulatory means employed by the legislature must have a real and substantial relation to the objects sought to be attained. In addition, the legislature, under the guise of protecting the public health, may not arbitrarily interfere with a person’s right to pursue the medical profession or impose unreasonable restrictions upon the practice of medicine.

Id. at 278-79 (internal citations omitted).

167. *Collins*, 503 U.S. at 126 (quoting *Deshaney v. Winnebago County Dep’t of Soc. Servs.*, 489 U.S. 189, 196 (1989)).

by the courts provides an important check on the executive's power to delicense physicians if they do not comply with the governor's demands.

Unfortunately, as noted above, the MSEHPA proposal fails to recognize the need for procedural due process in the context of physicians' rights. A hearing would provide an opportunity for physicians to challenge the standards a governor uses in determining physicians' duties and would fulfill physicians' right to be heard in conjunction with the deprivation of their property interest.

The Court has consistently held that state deprivation of a property right must be accompanied by "notice and opportunity for hearing appropriate to the nature of the case."¹⁶⁸ What constitutes a constitutionally appropriate hearing is rooted in the factors laid out in *Mathews v. Eldridge*: (1) the private interest implicated by the official action; (2) the risk of erroneous deprivation from existing procedures and the potential value of additional procedural safeguards; and (3) the government's interest, including the potential burden of implementing additional or substitute procedural requirements.¹⁶⁹

If a governor were to reasonably anticipate that the epidemic would be short, then the delicensure process and the accompanying hearing could wait until after the threat subsides. Under these circumstances, a state should provide a post-epidemic but pre-deprivation hearing before taking away a physician's license.

If the duration of the epidemic was unknown and a state were to engage in delicensure during the epidemic, the state probably would not have to provide a pre-deprivation hearing. However, the state should be required to provide a post-deprivation hearing in a timely manner. The following analysis assumes that the length of an epidemic could not reasonably be anticipated by the governor and consequently that delicensure and the accompanying procedural due process would occur during the epidemic.

The *Mathews* test might be applied as follows during an epidemic of avian flu if the governor tries to require physicians to provide care along the lines outlined in the MSEHPA.¹⁷⁰ To start, it is clear that the interest of physicians in their medical license is high. At issue are physicians' livelihoods, reputations, and abilities to legally use their skills to treat patients—albeit the patients without avian flu. As noted by a Georgia district court, the interest in one's professional license is so high that it may be entitled to the same due process protection as criminal proceedings.¹⁷¹ Moreover, as discussed in Part I, most

168. *Jones v. Flowers*, 547 U.S. 220, 223 (2006) (quoting *Mullane v. Central Hanover Bank & Trust Co.*, 339 U.S. 306, 313 (1950)).

169. 424 U.S. 319, 335 (1976).

170. *See Nguyen v. State Dep't of Health Med. Quality Assurance Comm'n*, 29 P.3d 689 (Wash. 2001) (applying the *Mathews* test to a doctor whose license was revoked by the Medical Quality Assurance Commission).

171. *Wall v. Am. Optometric Ass'n, Inc.*, 379 F. Supp. 175, 184 (N.D. Ga. 1974), *aff'd*, 419 U.S. 888 (1974); *see supra* note 160 and accompanying text.

physicians who are currently practicing in the United States did not expect that providing care during an epidemic would be a condition of their licensure.¹⁷²

With regard to factor two—the adequacy of existing procedures—the baseline created by the MSEHPA provides no procedural safeguard for challenging a governor’s directives in a state of emergency with regard to the duty to treat. Even if the courts employ a highly deferential standard in assessing the governor’s judgment, physicians would still need the opportunity to challenge the governor’s assessment that the executive order advances the goal of trying to manage the epidemic. This is a core element of assessing risk during an epidemic. As discussed above, society, and more specifically the legal system, values physicians’ professional judgment. In a hearing, even if it is simply an administrative hearing, a physician’s ability to meaningfully contest the executive order as applied to her provides an essential safeguard against the power of the state’s executive.

Finally, in an extended avian flu outbreak, the government’s burden of providing a hearing would undoubtedly be great. The courts probably would be overburdened with quarantine cases and short-staffed due to illness, and relevant witnesses might be otherwise occupied managing the epidemic. It is in these circumstances that the Court’s statement in *Hodel v. Virginia Surface Mining and Reclamation Association* applies: “[D]eprivation of property to protect the public health and safety is ‘one of the oldest examples’ of permissible summary action.”¹⁷³ Yet, the emergency does not absolve the government of the obligation to provide a hearing to the parties whose property interests are curtailed during an epidemic. In *Hodel*, the mine operators whose mines had received immediate cessation orders were provided with a post-deprivation administrative hearing within five days of the deprivation and the opportunity for judicial review, which the court found to be constitutionally adequate.¹⁷⁴

An epidemic differs from a cessation order or another emergency where there is an isolated event, yet the ongoing nature of the crisis does not justify depriving physicians of their rights. Although an imperfect analogy, the recent

172. Physicians who become licensed after the passage of laws like the MSEHPA probably would not have exactly the same property interests in their licenses as compared to their counterparts who were licensed prior to the new regulations. Members of the latter group would expect their licenses to be subject to the police power of the state. However, to the extent that the MSEHPA goes beyond the scope of “police power,” these physicians did not expect that their property interest in their licenses would be subject to providing care during an epidemic. The newly licensed physicians would have acquired their property interest with an understanding that it was subject to the emergency health provisions. Likewise, a state may require previously licensed physicians to agree to provide care during an epidemic as a condition of renewal of their licenses.

173. *Hodel v. Va. Surface Mining & Reclamation Ass’n*, 452 U.S. 264, 299-300 (1981) (quoting *Ewing v. Mytinger & Casselberry, Inc.*, 339 U.S. 594, 599 (1950)). See generally *Mackey v. Montrym*, 443 U.S. 1, 17-18 (1979); *Ewing*, 339 U.S. at 599-600.

174. *Hodel*, 452 U.S. at 299, 303.

jurisprudence on enemy-combatants' rights during war as discussed in *Hamdi v. Rumsfeld*, indicates that even in extreme circumstances, "[a]ny process in which the Executive's factual assertions go wholly unchallenged or are simply presumed correct without any opportunity for the alleged combatant to demonstrate otherwise falls constitutionally short."¹⁷⁵ Such would be the risk if states implemented epidemic response plans that failed to give physicians an opportunity to challenge governors' assertions.

The states might find providing administrative or judicial proceedings difficult, but such proceedings should be logistically possible. Many states already have extensive procedures for determining whether a physician should have her license revoked. For example, California, New York, Ohio and Texas all have boards of medical licensure and discipline that are imbued with the legal authority to investigate, conduct hearings, and adjudicate issues relating to physicians' ability to retain their licenses.¹⁷⁶ After the boards make their determinations, the decisions can be appealed to their respective state judiciaries.¹⁷⁷

Preparations in anticipation of an epidemic are being made by the state courts. Most notably, the Public Health Law Bench Book for Indiana Courts provides clear guidelines for how a judge during an epidemic might relocate chambers, include litigants who might not be able to appear in person because of concerns regarding contagiousness, consolidate cases, and manage an increased caseload.¹⁷⁸ Similarly, the California courts have plans that provide guidance on managing staff shortages and prioritizing demands on the judiciary at various stages of an epidemic threat.¹⁷⁹ These plans are part of an important effort to ensure that due process rights are not abandoned during times of crisis.

Undoubtedly, issues of quarantine and isolation are likely to be among the courts' priorities during an epidemic.¹⁸⁰ One might argue that because

175. 542 U.S. 507, 537 (2004).

176. CAL. BUS. & PROF. CODE § 2227 (West 2007); N.Y. PUB. HEALTH LAW § 230 (McKinney 2007); OHIO REV. CODE ANN. §§ 4731.22, .23 (West 2007); TEX. OCC. CODE ANN. §§ 164.001-.206 (Vernon 2007).

177. CAL. CIV. PROC. CODE § 1094.5 (West 2007); N.Y. PUB. HEALTH LAW § 230.19 (McKinney 2007); OHIO REV. CODE ANN. § 119.12 (West 2007); TEX. OCC. CODE ANN. § 164.009 (Vernon 2007).

178. AMY R. SCHOFIELD & LINDA L. CHEZEM, CTR. FOR PUB. HEALTH P'SHIPS, PUBLIC HEALTH LAW BENCH BOOK FOR INDIANA COURTS § 5 (2005), *available at* <http://www.ojp.usdoj.gov/BJA/pandemic/INBenchBook.pdf>.

179. ADMIN. OFFICE OF THE COURTS, EPIDEMICS AND THE CALIFORNIA COURTS (2006), *available at* <http://www.dhs.ca.gov/ps/dcdc/dsb/pdf/Collaborative%20projects/FINAL%20Disease%20Health%20Plan.pdf>.

180. Under the MSEHPA, patients are provided with many procedural due process protections. For example, the state cannot vaccinate people during an emergency unless the state knows that the vaccine is not "reasonably likely to lead to serious harm to the affected individual." THE MODEL STATE EMERGENCY HEALTH POWERS ACT § 603(a)(2) (Ctr. for Law & the Public's Health 2001), *available at* <http://www.publichealthlaw.net/MSEHPA/MSEHPA2.pdf>. If the state public health authority wants to quarantine a person

quarantine and isolation pertain to liberty interests, the need to hear these cases should take precedence over hearing cases regarding physicians' property interests. Another possible critique is that procedural due process would be irrelevant during an epidemic because physicians' decisions to provide care would be made irrespective of the procedural due process they would be afforded.

Certainly there are some physicians who under no circumstances would provide care during an epidemic. They may perceive that the risk to their health outweighs their concern for their medical license. However, without clear standards, health authorities could easily make unreasonable demands of physicians in response to a tidal wave of public paranoia. Physicians potentially could refuse to comply and hope that afterward their position would be supported by the courts, thereby allowing physicians to maintain their licenses despite non-compliance. Such a scenario would undermine the very purpose of the MSEHPA's provision.

Providing a hearing during an epidemic would not just satisfy the procedural due process rights of those who would be subject to delicensure. It would also help inform those physicians who had yet to confront the dilemma of whether to provide care to patients with highly infectious diseases of the cost of failing to comply with states' demands. Ideally, once fully informed, more physicians would be willing to provide care during an epidemic.

Ironically, the clearest explanation of the shortcomings and the implications of the MSEHPA's treatment of physicians' duty of care is by Gostin himself. In a law review article by Gostin and his colleagues written contemporaneously with the MSEHPA, he notes: "Broad discretion and the absence of criteria also invite abuse of compulsory powers or their discriminatory use against stigmatized or marginalized groups, or create the perception of such abuse against the vulnerable even when health officials have no malevolent intentions."¹⁸¹

While physicians are not usually viewed as a "stigmatized or marginalized group," during an epidemic they could be particularly vulnerable if health authorities abuse their powers. Therefore, it is essential that physicians are ensured adequate due process protection.

for more than ten days, the state has to demonstrate that "by a preponderance of the evidence, isolation or quarantine is shown to be necessary to prevent or limit the transmission of a contagious or possibly contagious disease to others." *Id.* § 605(b)(5); see also Michelle A. Daubert, Comment, *Pandemic Fears and Contemporary Quarantine: Protecting Liberty Through a Continuum of Due Process Rights*, 54 *BUFF. L. REV.* 1299, 1349-53 (2007).

181. Gostin et al., *supra* note 1, at 116.

CONCLUSION

Given the persistent tension within the medical community over physicians' duties during an epidemic, as well as the medical community's influence over the laws that govern physicians, the lack of legal clarity about physicians' duty of care during an epidemic is not surprising. Nevertheless, allowing this uncertainty to continue could have devastating consequences for both the public and physicians. Gostin and Hodge's attempt to rectify this problem is a start, but provides few of the due process protections necessary for implementing such a legal duty. Some might argue that there is no plan that could compel all physicians to provide care during an epidemic and therefore it is futile to devote resources to such an endeavor. While perhaps it is impossible to facilitate complete compliance, failure to create a meaningful framework for determining physicians' duties during an epidemic increases the chance of noncompliance.

In an emergency context, there is no way to establish in a vacuum whether a given physician should be required to provide care. The competing factors that have been discussed above are numerous—the interests of the patients, the doctors' concerns about their health, the needs of non-infected patients, and the interests of the public at large. Ensuring appropriate procedural due process is a formalized way of weighing the various parties' interests during an epidemic, a mechanism that is constitutionally required when a physician's license is revoked.

Recent case law has reiterated that even in times of emergency and crisis, due process remains crucial. What exactly is required under *Mathews* remains an issue for future research. But if, at the behest of a governor, physicians are required to place themselves at risk during an epidemic, then it is essential that physicians be afforded the process they are due.